Edinburgh Community Link Worker Network

Social Isolation Management Project (SIMP) Evalution

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Introduction

Social isolation is a growing global concern. It is recognised that social isolation and loneliness have major public health implications as well as having a significant impact on a person's physical and mental health[1]. Social isolation can impact throughout the life course[2] however it is within the elderly population that it can really start to impact health and wellbeing[3]. Up to 50% of those aged over 60 are at risk of social isolation and approximately one-third of older people will experience some degree of loneliness later in life.

Social isolation has detrimental effects on health, having been identified as a risk factor for all-cause morbidity and mortality with outcomes comparable to smoking, obesity, lack of exercise and high blood pressure. Studies have also shown that the socially isolated have increased incidences of emergency admissions to hospital stays and more delayed discharges.

The Scottish Government paper "A Connected Scotland: Tackling social isolation and loneliness and building stronger social connections" reflects Scotland's experience of this and considers how we could begin to address these challenges. In direct response to this paper Edinburgh Health & Social Care Partnership and Merck, Sharp and Dohme (MSD) initiated a test of change looking at the impact of community link working on social isolation in an elderly population, in the south west of Edinburgh.

The programme's objectives were as follows:

- Prevent social isolation in at risk patients, i.e. over 75s
- Improve the health/quality of life of the socially isolated
- Build community capacity so that there is a robust infrastructure to support the socially isolated
- Upskill primary healthcare teams to help identify socially isolated patients and signpost to the appropriate support
- Reduce workload for GPs/Practice Nurses so that they can focus on healthcare management rather than dealing with social issues

1. Tackling social isolation and loneliness: consultation analysis
2. PHE resources support local action on health inequalities.
3. Landeiro F, Barrows P, Nuttall Musson E, et al Reducing social isolation and loneliness in older people: a systematic review protocol BMJ Open 2017;7:e013778

Introduction

The first report in this document outlines the initial phase of the programme and the early signals that the programme was developing into a realistic and scalable model for supporting the socially isolated elderly by improving their health and wellbeing as well as highlighting benefits to the wider health economy.

The second report describes how the programme responded to the COVID pandemic and adapted to meet the needs of the socially isolated population and those patients who were shielding.

This innovative programme helps to demonstrate the tangible benefits of implementing community link working practices in this vulnerable population.

Pre-Covid Analysis

This section focuses on data from the beginning of the SIMP Project (August 2019) to the beginning of the COVID pandemic (February 2020).

The following programme measures were identified:

- Change in GP/Practice Nurse appointments
- Practice team feedback
- Evaluation of gaps in service provision

1.Referrals

During the timeframe August 19 – February 20, the CLWs received 211 referrals. Figure 1 presents the number of referrals per medical practice, which ranges from 8 to 75.

Monthly referral data shows the number of clients referred to CLWs each month in comparison to the average of 30 referrals per month (Figure 2).

Figure 1: No of Referrals by Medical Practice

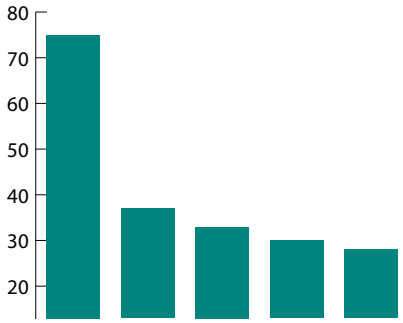
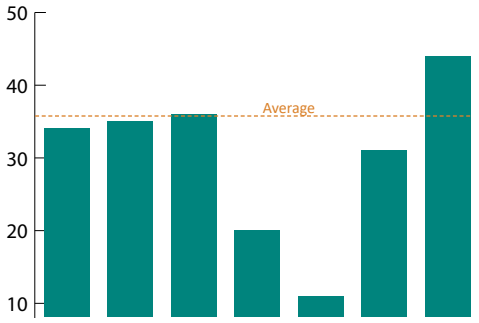


Figure 2: No. of Monthly Referrals



The majority of referrals to the CLWs came from GPs (76%) and nurses (20%). These referrals were made through a referral form (73%), email (12%) and telephone (1%), with 14% unknown.

Pre-Covid Analysis

The referral reasons were recorded and are detailed in Table 1. Social isolation and loneliness is the most common reason for a referral to the CLW with 86% of all referrals recording social isolation and loneliness as the reason.

Table 1: Referral reason

Referral reason	% of all referrals
Social isolation and loneliness	86%
Physical health (including long-term conditions)	7%
Physical disabilities (including sensory impairments)	4%
Trauma (e.g. sudden death, bereavement)	2%
Carers	1%
Housing	1%
Lifestyle issues (e.g. weight management, exercise)	1%
Mental health	1%

2. Engagements

The total number of engagements during August 19 – February 20 was 368. Figure 3 presents the number of engagements per medical practice, which ranges from 9 to 101.

Monthly engagement data shows the number of engagements to each month in comparison to the average of 53 engagements per month (Figure 4).

Pre-Covid Analysis

Figure 3: Engagements by Medical Practice

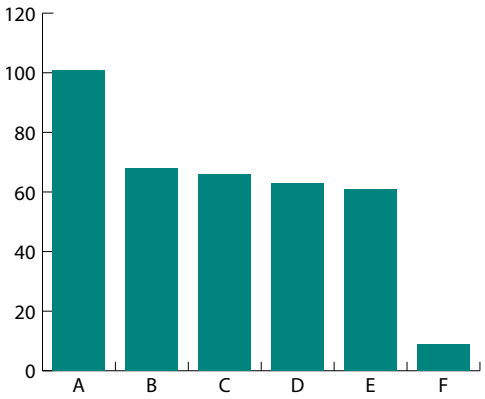
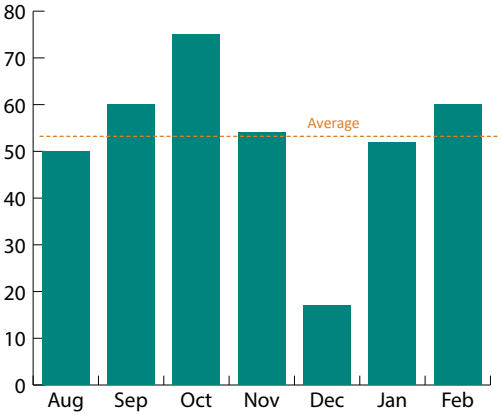


Figure 4: Monthly Engagements



Of these engagements:

- 174 were initial engagements and 197 were follow-ups
- The average engagements per client was 2.34
- The engagement length ranged from 5 to 180 minutes, with the average being 53 minutes

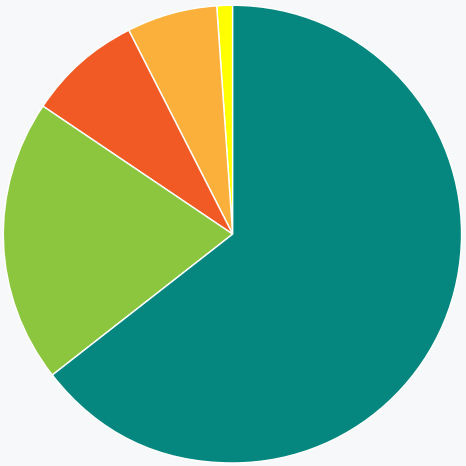


Figure 5: Types of Engagement

65%	home visits
20%	telephone calls
8%	appointments
6%	accompanied visits
1%	other engagements

Attendance rates

96%	all appointments
1%	did not attend
1%	cancelled
2%	not applicable

3. Engagements

During the timeframe August 19 – February 20, the CLWs received 211 referrals. Figure 1 presents the number of referrals per medical practice, which ranges from 8 to 75.

Monthly referral data shows the number of clients referred to CLWs each month in comparison to the average of 30 referrals per month (Figure 2).

Figure 6: Age of Clients

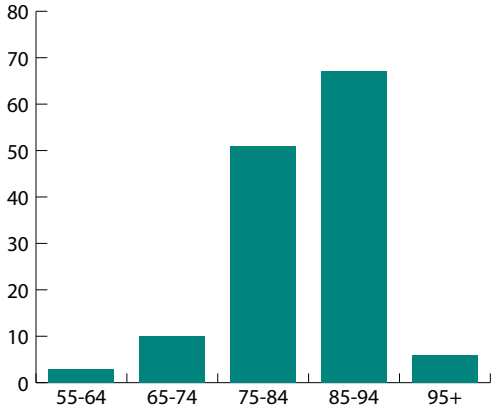


Table 2: Postcodes in Edinburgh and the percentage of CLW clients who live in them

Postcode	% of clients
EH13	37%
EH14	29%
EH10	26%
EH28	4%
Other	6%

4. Links & Outcomes

The most common onward referral destinations were:

- Social and community groups and activities (including lifestyle change, arts, gardening, cooking etc.)
- Activity-based referrals
- Befriending supports/services

Other common referral destinations included housing advice and support, carer support and transport advice and support.

Referral by sector:

74%	voluntary
23%	statutory
3%	private/fee paying

Pre-Covid Analysis

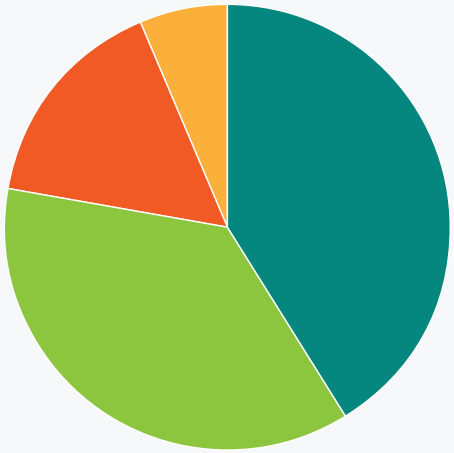


Figure 7: Referral Outcomes

41%	client considering
37%	client engaged
16%	other
6%	client declined

5. Short Warwick-Edinburgh Mental Wellbeing Scale (sWEMWBS) [4]

Clients were asked to complete the seven-item sWEMWBS scale which asks them to consider and rate seven statements relating to mental wellbeing. The clients rate the statements on a scale from one ('none of the time') to five ('all of the time') and are asked to complete the survey again after a period of engaging with the CLW. In order to score sWEMWBS the raw score is converted to a metric score, with the scale running from seven for the lowest levels of mental wellbeing to 35 for the highest.

Table 3

First sWEMWBS	Second sWEMWBS	% Difference
17	20.51	23.7%

15 clients completed the first and second sWEMWBS questionnaire and on average the client's mental wellbeing improved by a sWEMWBS metric score of 3.51, from 17 to 20.51. This translates to a 23.7% average increase (Table 3). The average score for over 75s in Scotland is 24.2 (based on the SSCQ 2017).

4. Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS)

Pre-Covid Analysis

When the raw sWEMWBS data is examined in Table 4 below there is a noticeable difference between the initial and second evaluation especially in the *"I've been feeling close to other people"*, *"I've been feeling optimistic"* and *"I've been feeling useful"* questions.

Table 4: Difference between the average raw sWEMWBS score per question (N=15)

Question	1st sWEMWBS	2nd sWEMWBS	Difference
I've been feeling optimistic about the future.	2.33	3.20	0.87
I've been feeling useful.	2.13	3.00	0.87
I've been feeling relaxed.	2.40	3.13	0.73
I've been dealing with problems well.	2.33	2.93	0.6
I've been thinking clearly.	2.53	3.20	0.67
I've been feeling close to other people.	2.53	3.53	1
I've been able to make up my own mind about things.	3.13	3.53	0.4

Pre-Covid Analysis

6. Reductions in Hospital Admissions and Stays

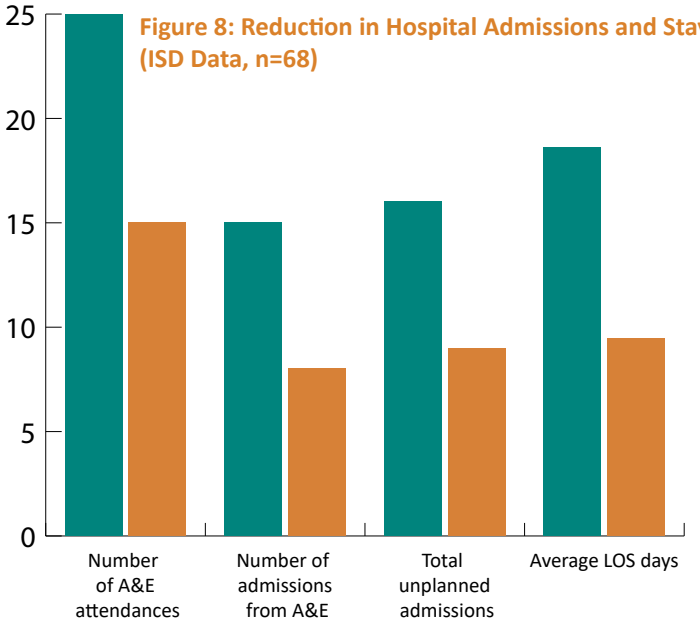


Figure 8: Reduction in Hospital Admissions and Stays Aug-Dec18 v Aug-Dec 19 (ISD Data, n=68)

Table 5: Cost Savings

	A&E Attendances[1]	Admissions from A&E[1]	Total Unplanned Admissions[1]	Average LOS (Days)[1]	No. of Delayed Discharges[1]	Total Encounters[1]	A&E costs[2]	Admission costs[2]
2018	25	15	16	18.6	4	1,231	£3,550.00	£686,891.80
2019	15	8	9	9.4	4	1,539	£2,130.00	£190,971.20
Saving 2019 vs 2018							**£1,420.00**	**£495,920.60**

1. Source: TRAK; GP Clinical IT System Vision
2. Scottish Health Service Costs Report

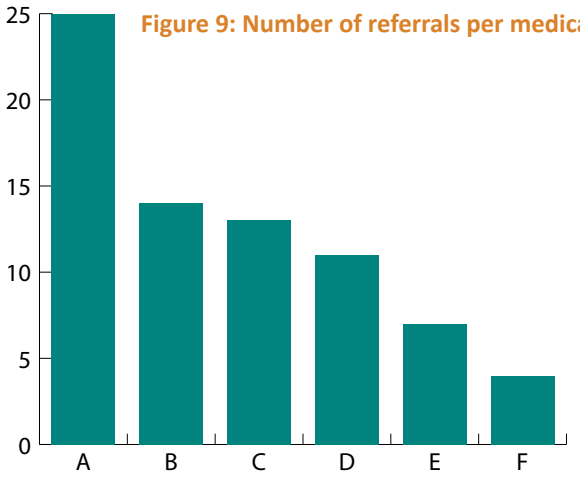
Covid Analysis

This section focuses on data collected between March 2020 and February 2021, to see how the project adapted throughout the COVID-19 pandemic.

1. Referrals

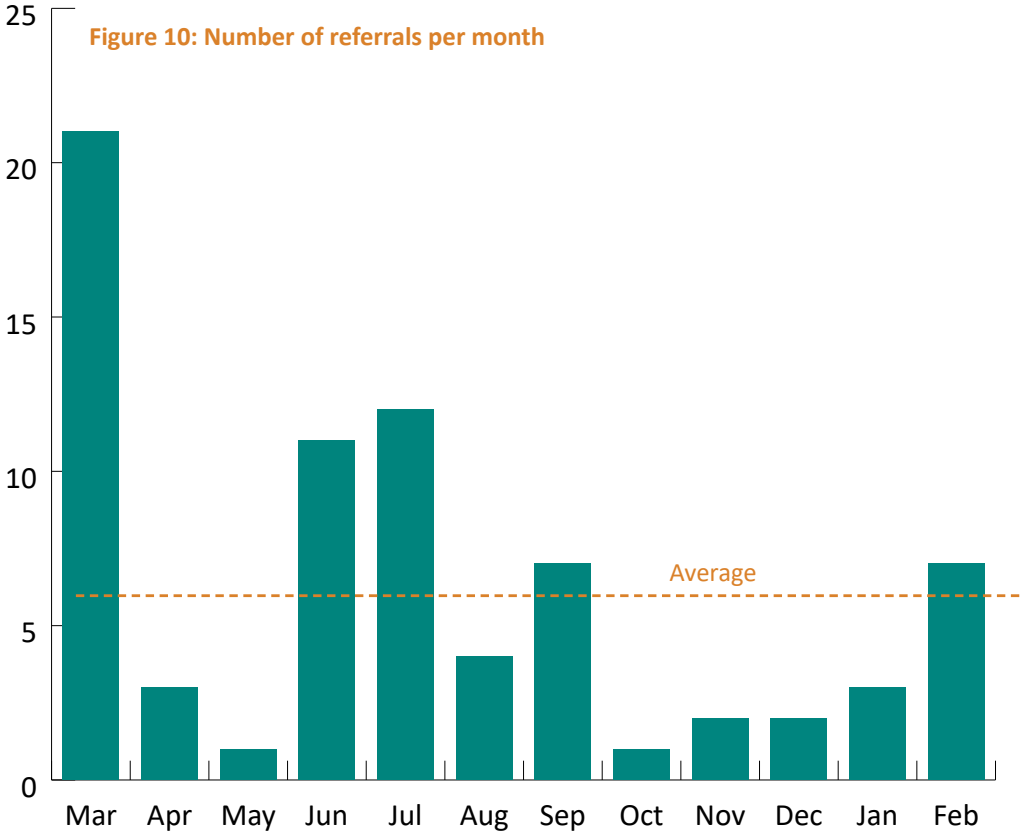
During the timeframe March 20 to February 21, the CLWs received 74 referrals. Figure 9 below presents the number of referrals per medical practice, which ranges from 4 to 25. Monthly referral data shows the number of clients referred to CLWs each month in comparison to the average of 6 referrals per month (Figure 10).

Figure 9: Number of referrals per medical practice (anonymised)



Covid Analysis

Figure 10: Number of referrals per month



The majority of referrals to the CLWs came from GPs (72%) and nurses (9%). These referrals were made through email (54%), a referral form (23%), COVID-19 signposting (5%) and telephone (1%), with 16% unknown.

The referral reasons were recorded and are detailed in Table 6. Social isolation and loneliness is the most common reason for a referral to the CLW with 59% of all referrals recording social isolation and loneliness as the reason.

Table 6: Referral Reason

Referral reason	% of all referrals
Social isolation and loneliness	59%
Mental health	16%
Trauma (e.g. sudden death, bereavement)	4%
Financial issues (debt, money management)	3%
Housing	3%
Carers	1%
Lifestyle issues e.g. weight management, exercise	1%
Physical disabilities (including sensory impairments)	1%
Substance use and misuse	1%

Covid Analysis

2. Engagements

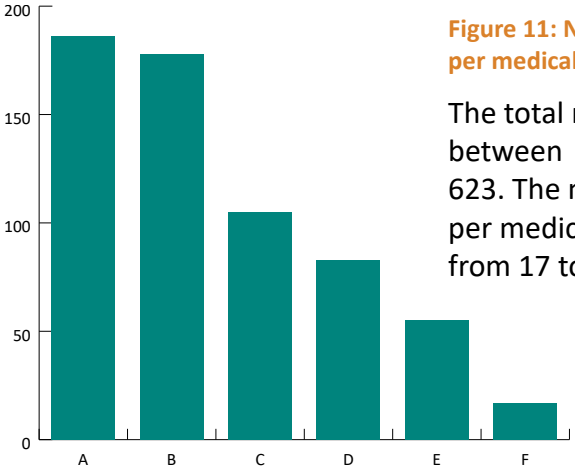


Figure 11: Number of engagements per medical practice (anonymised)

The total number of engagements between March 20 and Feb 21 was 623. The number of engagements per medical practice, ranged from 17 to 186.

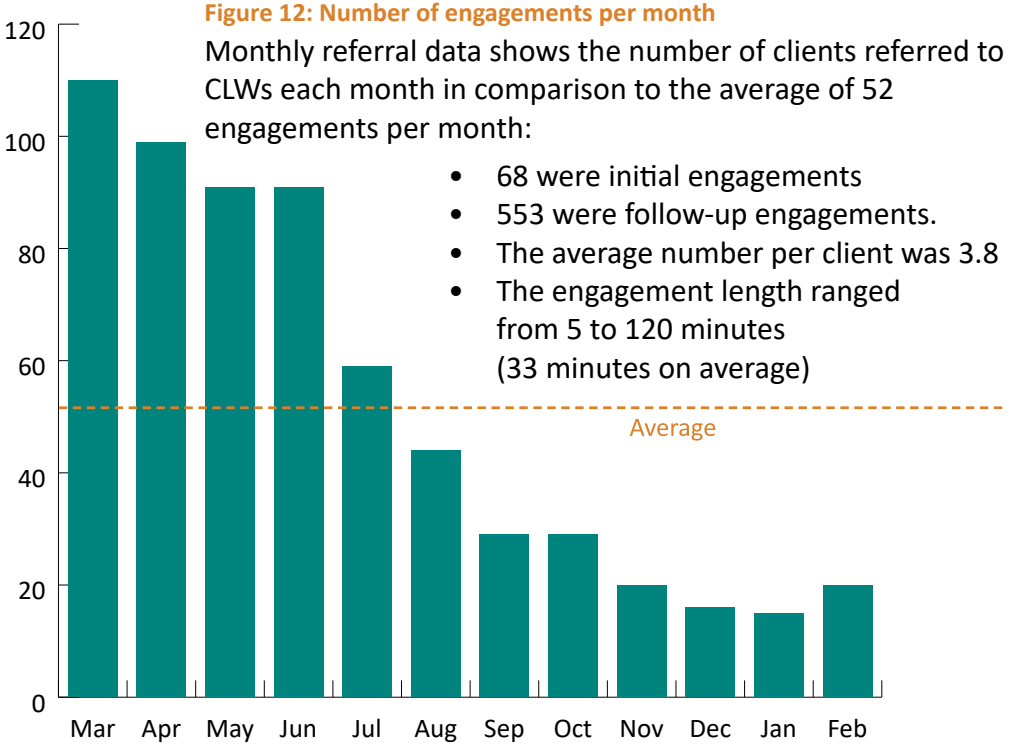


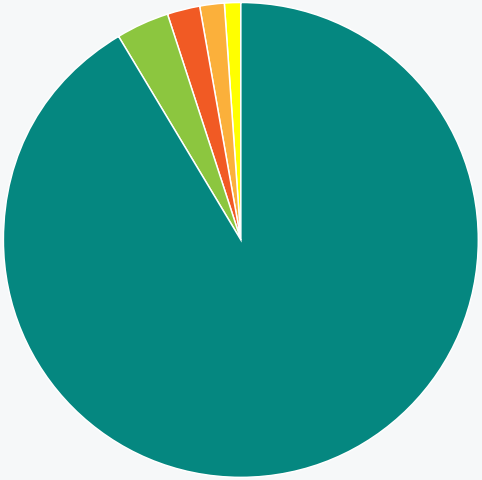
Figure 12: Number of engagements per month

Monthly referral data shows the number of clients referred to CLWs each month in comparison to the average of 52 engagements per month:

- 68 were initial engagements
- 553 were follow-up engagements.
- The average number per client was 3.8
- The engagement length ranged from 5 to 120 minutes (33 minutes on average)

Figure 13: Types of attended engagements

91%	Telephone calls
4%	Home visits
2%	Email
2%	Appointments
1%	Other



Attendance rates:

92%	Attended
2%	Did not attend
5%	N/A

3. Demographics

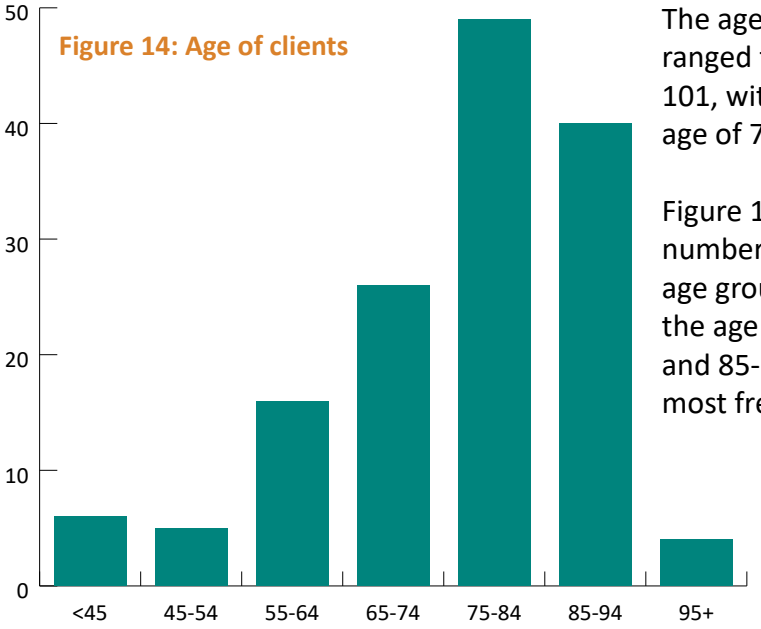
During the timeframe the CLW project engaged with 159 clients; 94 identified as female, 42 identified as male and 23 did not identify as male or female.

Postcode	% of clients
EH13	40%
EH14	36%
EH10	16%
EH28	4%
Other	6%

Table 7: Postcodes in Edinburgh and the percentage of CLW clients who lived the areas

Covid Analysis

Figure 14: Age of clients



The age of the clients ranged from 19 to 101, with an average age of 76.

Figure 14 presents the number of clients per age group, showing the age groups 75-84 and 85-94 to engage most frequently.

4. Links & Outcomes

Throughout this timeframe the CLWs provided 167 signposting suggestions to clients to a range of voluntary, statutory and private organisations and services. These are detailed in Table 8 below.The link workers also provided a further 110 welfare checks during this time.

Table 8: Signposting suggestions

Signposted To...	No. of links	Signposted To...	No. of links	Signposted To...	No. of links
Oxgangs Care	21	Foursquare visiting support	5	Health in Mind	2
Befriender	12	Morrisons phone line	5	Home Instead	2
VOCAL	11	Health All Round	4	National helpline	2
Call back	11	Cruse	3	RNIB	2
Vintage Vibes	7	Golden Years	3	Rowan Alba - CARDs	2
Food delivery services	6	Change, Grow, Live	2	Shielding helpline	2
Health Agency	6	Dementia helpline	2	Shopping Assistance	2
Social Care Direct	6	Dog walking - volunteer	2	Other	41

Case Studies

Norma

68 year old female

Referral from her GP:
Recently retired and 'lost' as to what to do with her time.

Outcome:
Norma has been volunteering with a local charity, offering IT support throughout lockdown.

Norma had worked all her life and recently retired. She had gone to her GP feeling 'lost' and not sure what to do with herself.

Engagements:
1 x phone consultation
1 x referral for employability support
1 x follow up call

Supported offered:
Empoyability support through CHAI

Lesley

89 year old female

Referral from her GP:
Anxious and no family available due to shielding.

Outcome:
The CLW linked Lesley with Cyrenians who delivered freshly prepared meals twice a week throughout lockdown. Lesley 'does not know what she would have done' without this support to access food during this time.

Lesley has lived alone since her husband passed away. She has a very close family, but they were unable to visit due to shielding and lockdown restrictions. Her family were unable to secure online food delivery due to demand. Lesley was very anxious how she would access shopping/necessities.

Engagements:
1 x 45 minute phone call
3 x follow up calls - including an update to her family (as requested)

Supported offered:
Referral to Cyrenians food project

Case Studies

John

87 year old male

Referral from his GP:
Low mood, lonely, bereavement.

Outcome:
The CLW spent time on the phone with John identifying what he could benefit from. John felt less alone that were people out there who could help him get ghrough this.

Listening to John's needs and identifying what could be helpful. Explaining what counselling involved and the benefits of having a befriender.

Engagements:
4 x calls to John
3 calls to refer to services

Supported offered:
Befriending Service
Bereavement Counselling

Jean

89 year old female

Referral from her GP:
Low mood, isolated and lonely.

Outcome:
CLW spent time on the phone with Jean identifyin what support she was looking for and providing reassurance. Jean was happy to soon be getting a regular call from a befriender as she had been feeling increasingly isolated.

The CLW spent time listening to Jean's needs, identifying what would potentially help her and checking if anything else could be offered during this period of lockdown.

Engagements:
2 calls to Jean
2 calls to service for referral

Supported offered:
Befriending Service (phone)

Case Studies

Bob

70 year old male

Referral from his GP:
Social isolation and loneliness.

Outcome:
Bob's CLW supported him to access telephone food shopping where he could pick items over the phone and access priority delivery.
Bob continued to access this independently throughout lockdown.

Bob lives alone and has friendly neighbours who had been assisting him with shopping at the beginning of lockdown. He was grateful for their support, but missed the independence of being able to shop for himself.

Engagements:
2 x phone consultations

Supported offered:
Telephone Food Shopping

Moira

72 year old female

Referral from her GP:
Carer.

Outcome:
Moira's husband had not received a walking aid and bathing stool to make it easier at home to get out for walks.
Her CLS linked Moira up with a carer group for peer support.

Moira was very much looking for practical and emotional support in her caring role. She felt she was struggling with her caring role whilst being at home with her husband during lockdown.

Engagements:
3 x 45 minute phone calls

Supported offered:
Referral to Social Care Direct
Carers Support Team

Conclusion & Thanks

The world, let alone Edinburgh, is a very different place to where we were when we started to test community link working in a socially isolated elderly population. The signals from the pre-COVID phase of this programme highlighted the real benefits of community link working for the socially isolated elderly and the wider health economy. Initial improvements were seen in the health and wellbeing of this population, there were reductions in unplanned admissions, length of hospital stays and delayed discharges, and had the pandemic not hit, a more robust data set would have been collected to further support the programme.

However, in light of the pandemic, the programme was adapted to the meet the demands of the new environment and expanded to include those that were shielding. The programme utilised virtual technology to engage with its extended client base and flexed its approach to help support over 350 people who were struggling with social isolation, finding solutions to problems such as accessing food and hygiene products, engaging befriending services and helping with social benefits. Qualitative feedback from both clients and GP practices during the covid phase of the programme has been fantastic, highlighting the tangible benefits delivered by the community link workers, who should be commended for their efforts in this volatile and challenging environment.

As the programme concludes, 50% of practices participating in the SIMP programme have decided to continue with community link working.
The learning from the programme has also cascaded across the wider Community Link Worker Network in Edinburgh as the number of city wide practices opt to include a community link worker in their primary health care teams. It is hoped that this model of supporting those at risk in the population will extend further across Scotland and that other health/ local authorities will see the opportunity to support this population through Community Link Working.

This seems an apt moment to thank everyone involved in SIMP – the patients, the practice teams, voluntary sector colleagues, the Community Link Workers, the SIMP Steering Group and Merck, Sharp and Dohme.

Edinburgh Community Link Worker Network

Edinburgh Health and Social Care Partnership

Space

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