A qualitative study of discretion and values in the Community Link Worker role

Summary produced by Helen Richardson and Fiona Sinclair. Full text submitted to University of Glasgow (School of Social & Political Sciences) September 2020 as a dissertation by Dr Helen Richardson in part-requirement for a Master's in Global Health.

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Introduction

Dr Richardson submitted the above qualitative study as part of her MSc in Global Health and is herself a General Practitioner (GP). Her study aimed to address the following research questions:

1. How do Community Link Workers (CLWs) define their role, how do they set boundaries and are there difficulties in knowing how far to go. How does this relate to their formal job descriptions?
2. How do they make use of flexibility and discretion, and what factors enable or constrain this?
3. Are personal qualities, values and experience considered to be important in their role? Do they have particular values that motivate them and influence their use of discretion at work?

The research considers interviews with seven CLWs who are employed in Glasgow, and analysis of job descriptions. The project itself was a collaborative project with Health Improvement (p.6).

Dr Richardson sees that CLWs are a new role in health and social care and are required to work flexibly and make use of discretion in their work. The project intended to explore how CLWs did this, using Lipsky's theory of "street level bureaucracy" as a framework. Discretion as a theme was discussed as it is often the case that frontline workers are faced with the dilemma of how far to go for their patients/clients when their needs cannot be met, as a result of what Dr Richardson refers to as system issues (such as funding, governance, and performance indicators and where there are gaps in service provision) (p.6)

Community link working has been developed as a way of responding to the negative social determinants of health. Those who are often the most vulnerable can struggle to access public service systems which are "fragmented, complex and opaque" (Christie, 2011) and fall through the cracks, not receiving the help they need. This can leave healthcare professionals feeling increasingly overwhelmed and under-resourced – there is too much need and not enough to offer (p.5). Link workers as a resource can be a way of mitigating some of these issues and are part of the solution to creating a more joined up, integrated and person-centred approach to primary care.

CLWs are professionals who work in a primary care setting, offering one to one support to people to link them with services and supports in their communities with the aim of improving their health and wellbeing. This role can range from 'signposting' to services, to being involved in complex cases where a relationship of trust is built over multiple meetings. CLWs have been initially targeted in areas of deprivation to mitigate the impact of "social and economic inequalities on health" (Wyper, 2020). Dr Richardson notes that the Scottish Government has committed to providing 250 CLWs across Scotland by May 2021 (p.7).

Literature Review & Methodology

Gaps in the literature as identified by Dr Richardson:

- Limited research on how link worker roles should be defined to allow flexibility and creativity in helping clients but also to support knowing where the role ends. This can be exacerbated by gaps or under provision in other services to which link workers may wish to refer, resulting in CLWs 'absorbing work left by gaps in other services' (p.16)
- Street-level bureaucracy framework – states that street-level bureaucrats are those working in the front line of public services, interacting directly with the public, who have autonomy and discretion in their work with actions being influenced by judgement and discretion (p.17). Workers are however, bound to some extent by the structures and culture of the organisation in which they work. Workers can also be influenced in their use of discretion by 'individual characteristics, including gender, socioeconomic status, professional norms, personal interests and values.' A gap in the literature identified by Dr Richardson is that the street-level bureaucracy framework has never been applied in the study of the link worker role (p.18).
- Personal values such as 'empathy, non-judgement and trust' (p.21) are prominent in literature about CLW roles, but there does not appear to be any research on how CLWs themselves describe their own values and how 'these may affect their use of discretion at work,' (p.21). Dr Richardson believes this to be an important point to consider, in a role where employees are encouraged to bring their own personal values and qualities to the workplace, and also to work autonomously.

Methods

- Seven CLW interviews were carried out between February and March 2020. Table 1 shows a breakdown of participants.
- The intention had been to conduct 8-12 interviews, but unfortunately, data collection had to be stopped early due to the impact of the COVID-19 pandemic. (p. 24)
- A second source of data was (four) job description documents used in the recruitment of CLWs in Glasgow –see Table 2. As participants were interviewed and employed between the years 2016-2019 it was deemed useful to include all four (p. 26)

Table 1: Participant Characteristics (p.25)

Gender	
Men	4
Women	3
Employing Organisation	
The Health and Social Care Alliance Scotland (ALLIANCE)	5
We Are With You (WAWY)	2

Experience in CLW role	2 months to 2.5 years
Practice size by patient population (approx.)	3000-8500
"Deep End" general practices[1]	7

Ethical Considerations

- The study was considered 'low risk' as those interviewed were identified as professionals, and not classed as being in vulnerable groups. All interviews took place during working hours
- Due to the small number of participants, maintaining anonymity was a particular concern. To avoid identification of individuals in the report, each participant is identified only by a pseudonym, and their place of work is not specified. Additional permission was sought from participants for use of direct quotes.
- All participants were aware that Dr Richardson was a practising locum GP, but had never worked at any of the participants' practices.
- Ethical approval for the study was obtained from the University of Glasgow's College of Social Sciences Research Ethics Committee before data collection commenced.

Results

There were five main themes identified from the data analysis of the seven interviews and review of the job descriptions documents (p.31).

1. Personal characteristics of CLWs
2. Describing the role
3. Flexibility and autonomy
4. Deciding where the boundaries are
5. Addressing resource limitations

1.) **Personal characteristics of CLWs**

The job descriptions themselves had more focus on individual qualities, skills and experience, rather than on qualifications. CLWs had been recruited from a wide range of experience backgrounds such as mental health, disabilities, young people, housing and community development. The CLWs interviewed felt this was a good thing as it allowed them to pool knowledge across the team; helpful in a role that could be varied and complex. They were

[1] The 100 general practices serving the most deprived populations in Scotland, based on the proportion of patients with postcodes in the most deprived 15% of Scottish data zones, see: https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

able to ask colleagues for help/advice if a problem appeared that they were unsure how best to approach (p.34)

Despite it not being a specific interview question, several interviewees talked about personal life experiences that helped them understand and empathise with their patients, and also influenced their values. These included growing up in socioeconomically deprived areas and supporting family members with social and psychological problems. All CLWs interviewed had a strong sense of existing inequality, a desire to see social justice and were committed to an approach that was non-judgemental, respectful and helpful (p.33). Some of these ideals were evident in the CLW job descriptions, and participants felt able to express their values in their work.

Overall, interviewees emphasised the importance of experience and values in their work, of "bringing you into the role" and relating to patients on a person-to-person level.

2.) Describing the role

The CLWs interviewed found they could be dealing with a myriad of issues, from simple to complex which gave some difficulty in defining their role – *"because really, I wouldn't know what, who was coming through the door sometimes"* (Rachel, p.34). Several participants described a feeling of being able to deal with almost anything to some extent – it was not about being able to 'fix' every issue, but that in their role they were able to be 'present' and listen to whatever needs came in (p.35).

Some CLWs felt that their role had not been fully understood by the practices and wider teams to start with. One described dealing almost exclusively with benefit enquiries at the beginning, but that in time they felt that their practice had begun to trust them more, and to understand the range of issues that a CLW could help with.

The CLW job descriptions focused prominently on relationships with the practice and community:

"Build relationships and processes between the GP practice(s) / cluster(s) and community resources, statutory organisations, other health services and voluntary organisations." (HSCP18 – REFERENCE, p.35).

This relationship building allows CLWs to help patients navigate through (often) complex service pathways. It also empowered CLWs to, where needed, challenge services and to advocate for their patients (p.36). CLWs used a person-centred approach – focussing on the issue(s) the patient had identified and working collaboratively to identify actions and supports appropriate to meeting that need. It was recognised that it was not the role of the CLW to set goals or decide priorities.

CLWs were also asked about their role in relation to reducing health inequalities:

"In general, the role was seen as a way of helping people "manage" in circumstances outside their control; and detached from theory and strategy around health inequalities" (p.37)

CLWs interviewed felt their role was more about supporting patients in mitigating some of the issues that arose as a result of health inequalities, rather than their work directly contributing to a reduction in them. They did highlight that they had been strategically placed to work in areas most affected by health inequalities.

3.) Flexibility and autonomy

All those interviewed felt that being flexible in their work was of crucial importance to the role, especially in working with vulnerable patients with complex needs. Examples of flexibility included offering appointments in a range of locations to suit the comfort levels of those they were meeting, and also in keeping referrals open even if appointments had been missed (p. 38). This need to work flexibly was also referred to in the job descriptions.

CLWs felt supported to work autonomously, by both their employer and the practice teams. They felt that their job roles were not prescriptive, and appreciated the freedom to manage their own time and work activities, and to find the best way to manage their patients. They valued the autonomy and trust they were given and felt it supported their work. (p.39).

At times, this manner of working could be isolating – it may be that the CLW is the only member of staff in the practice working in this way - however there was frequent contact available with other CLWs within their employer organisation (p.39-40) and support from practice teams

Several responsibilities around monitoring and data collection were mentioned in the job descriptions but most CLWs did not mention these in the interviews Participants generally did not feel that they were driven by targets, for example in achieving a certain amount of referrals each month or in onward referrals. One mentioned that they had been given a 'suggested' number of appointments per person, but this was not mentioned in their job description and was not seen as a strict target (p.40)

4.) Deciding where the boundaries are

Dr Richardson discussed the concept of "going the extra mile" with the CLWs in order to find out where the boundaries might lie in a role that encourages flexibility and an autonomous approach. There did not seem to be a clear notion of where the boundary might be, or what constituted "going the extra mile". Rather it was found to be an individual judgement in each circumstance – examples given were visiting someone in hospital, helping someone move house, or working late to help a person experiencing suicidal thoughts. It seemed that CLWs were able to draw their own boundaries based on how useful their intervention might be for the patient in question. CLWs also felt able to ask colleagues for help in defining a boundary, to make sure it was not being overstepped if they felt unsure (p.40-41). Participants did not generally feel restricted by rules or protocols.

Boundaries regarding relationships with patients were referred to in the CLW job descriptions:

"…ability to develop a non-dependent relationship with awareness of personal and professional boundaries," (p.42-43)

Participants discussed ways of maintaining boundaries (e.g. switching off work mobile phones and weekends) and preventing dependence, but also felt it was important to tailor the support to the individual - from where the patient needed the help. For some, they would need a lot of support to progress, and others less so. One CLW interviewed explained that more intense support does not need to result in a dependent relationship if the support and expectations are carefully managed – making sure the patient is aware of the *"beginning a middle and an*

end…then that's absolutely fine" (George, p.43). If this relationship is managed well then the additional support can be empowering rather than dependency creating.

However, there was a recognition of where boundaries lay in terms of the work a CLW can do –and what needs to be done by other services. CLWs would collaborate and build relationships with other professionals and, in some cases, their roles might overlap, but in general they aimed to help the person access the professional or service with the most expertise in the problems identified. Certain activities were seen to be clearly the responsibility of other services – for example, housing provision or representation at welfare tribunals – but the CLW would help patients to access this support (p.42).

5.) Addressing resource limitations

All CLWs identified that there were shortages in the services they referred into. Particular examples given were mental health, social care and housing (p. 44). One CLW described the issue as being that some services could only respond to *"dire need,"* that it was only when people were at crisis point that a service could assist. Further issues identified were long waiting lists, referral criteria that were restrictive and service provision that was rigid. These issues combined did have an impact on the CLWs ability to work flexibly and autonomously (p.44).

While the setting up of new groups and activities was found in the CLW job descriptions, participants described going further to try and fill gaps in service provision. This could mean providing a "holding service"- providing support until a patient was able to access the main service. In some instances where patients had had poor previous experience with a particular service, they may not want to access it again. One CLW commented:

" …either the support isnae there because they're so stretched or…they've had such a terrible experience that, rather than going to see a psychiatrist or mental health team…they're choosing to do quite intense supports with me…but I just think, you need something more than this" (Sarah, p.45).

While CLWs found the flexibility and autonomy in their role valuable in terms of being able to "hold" patients, it was seen as far from ideal that the services to which they would hope to refer to were not always accessible.

Further discussions on resource limitations revealed that there was often a changing landscape of resources/services available due to the changing funding of organisations –the Third Sector was highlighted in particular. This required CLWs to remain aware of changing service provision within their referral networks. CLWs themselves had been affected by changing funding structures and at times, uncertainty regarding their own job security, in relation to short term funding (p.45).

CLWs mostly felt that the flexibility encouraged in their role allowed them to manage their own referrals and busy workload. Their job descriptions included a requirement to ensure access to their service within an *"appropriate timescale"*, but this timescale was not specified. Only one participant had felt the need to start a waiting list, and even then had been able to see most referrals within a couple of weeks. (p.45).

Conclusion & points to consider

Referring to the original research questions:

1) **How do Community Link Workers (CLWs) define their role, how do they set boundaries and are there difficulties in knowing how far to go. How does this relate to their job description?**

- Findings from this and other studies highlight the difficulties in defining the CLW role, which is described as very broad, dealing with a wide variety of problems. This is supported by job descriptions which have attempted to capture this fluid and dynamic role. There is a delicate balance to be struck between allowing CLWs to be flexible and autonomous in their offering and also in defining a role where there is often no obvious end to the 'extra mile.'

- Role boundaries were sometimes ambiguous and CLWs in this study made use of individual judgement, or consensus opinion with colleagues, when deciding how far to go for patients - depending on individual circumstance.

- Participants found that other professionals' understanding of the CLW role could be limited at first. Other research (Public Health Scotland, 2020) has suggested this may relate to CLWs' lack of formal professional status. For some in this study, however, the lack of a formal role (like doctor or nurse) was seen as an asset – allowing them to relate to patients on a person-to-person ("human") level.

- Dr Richardson highlights that lack of role clarity is not unique to CLWs, in a context where many health and social care roles are rapidly changing. As such, the research emphasises the importance of good communication between professionals and teams, strategies for which may include – effective team meetings, shared workspaces, or, in the context of COVID-19, effective digital communication (p.60).

2) **How do they make use of flexibility and discretion, and what factors enable or constrain this?**

- Working flexibly was considered vital to providing person-centred care to vulnerable and complex patients. CLWs felt supported by their employing organisations and practices to work in this way and to use their discretion. They generally did not feel bound or restricted by protocols or targets, nor did they appear to experience dilemmas in which they felt their "hands were tied".

- This research identified that CLWs' flexibility and autonomy is ultimately constrained by the availability of other services. If their role is to be a conduit to other expert services then their ability to fulfil that role will be challenged by a lack of availability of services to refer on to. Where service shortages exist, the flexibility in their role allows CLWs to provide "holding services" to fill gaps - but this is not intended to be a main aspect of their role. This element of their work has been identified in other studies and is likely to expand if further funding cuts occur. In this context, maintaining a flexible, person-centred, and sustainable service could become increasingly challenging amid an increasing workload (p. 51).

3) **Are personal qualities, values and experience considered to be important in their role? Do they have particular values that motivate them and influence their use of discretion at work?**

- CLWs in this study considered experience and values to be important in their role. Diverse professional experience was considered an asset, but participants also emphasised the influence of personal life experience in their work.

- Personal values such as social justice, non-judgement and empathy were identified as important by CLWs in this study. The autonomy in the role of CLW allows individuals to "provide person-centred care and express their values in their work activity…which is likely to contribute towards job satisfaction." It has been noted that values may be compromised in other frontline roles (due to large caseloads, for example) (Lipsky, 1980:2010).

- Ideals such as non-judgement and empathy were also evident in the CLW job descriptions, suggesting that there is an organisational culture supporting such values.

- Dr Richardson suggests potentially useful future research:
    - to explore the values of the organisations employing link workers and how these interact with those of commissioning bodies and primary care teams (p.61).
    - to look more closely at the relationship between personal experience and values at work, and the differences between various health and social care workers.

Dr Richardson highlights that with lockdown restrictions and widening inequalities as a result of Covid-19, CLWs are likely to see an increase in their workload. Despite changing and challenging working environments, they have remained flexible and able to continue supporting their patients and practices during a tumultuous period. However, this flexibility may be stretched and tested further as we enter a deep recession. Anticipated cuts to services already struggling to meet demand could see CLWs struggle to continually fill in the gaps as more and more patients are unable to access the services they need. Whether this is sustainable or not remains to be seen.

References

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