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Piloting a community health and well-being worker model in Cornwall: a guide for implementation and spread

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Abstract

Background This paper evaluates the introduction of ten Community Health and Well-being Workers (CHWW) in four pilot sites across Cornwall. The period evaluated was from the initial start in June 2022 until June 2023, covering the project setup and implementation across a range of Primary Care Networks (PCNs) and Voluntary sector partners (VSCO).

Methods All ten CHWWs and their managers at each site were interviewed ($n=16$) to understand the barriers and enablers to implementation and wider learning that could be captured around the project setup. Qualitative methods were used for data collection, including semi-structured interviews and focus groups. Transcripts were thematically analysed for cross-cutting themes, as well as site-specific effects.

Results In terms of learning, we cover the following key areas, which were of most importance to the successful implementation of the pilot: The CHWWs were introduced into an already established, successful social prescribing (SP) system by the time the CHWW project began. CHWWs can access some of the same training and office space as SPs, with overlapping meeting schedules allowing them joint input on some topics. It seemed that all the pre-work in terms of relationships and learning about a similar role helped a rapid implementation. Each site's CHWW management structure uses the same line management as the SPs. Roles were clustered together to remove duplication, maximise coverage and triaging of residents. The largest barrier to overcome was integrating VSCO staff into NHS systems. Conversely, hosting CHWWs within an NHS organisation has pros and cons, namely better access to NHS data and staff, but longer lead-in time for registration on systems, and more bureaucracy for procurement/spend.

Conclusions Looking to the future, the pilot's success has spread the programme to other integrated care areas in the country, with ongoing plans for further rollout and evaluation in the coming years.

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Background

This paper documents the introduction of a new public-health-informed Community Health and Well-being Worker (CHWW) model to one of Cornwall's Integrated Care Areas (ICAs). Originally, the model was developed in Brazil to engage people who are typically excluded from health services and actively try to get them registered within the system and participate in screening, vaccinations, etc [1]. The role involves the CHWWs going "door-to-door" in underserved communities to build relationships with the public and identify their needs, rather than waiting for them to enter the NHS system somehow (i.e. Accident and Emergency (A&E) or a General Practitioner (GP)). The CHWW role has three core and unique elements that separate it from other roles like social prescribing [2],

- **Universal** –All households are in the CHWW's mandate to approach, and unlike other similar roles, they do not just focus on specific or targeted conditions.
- **Comprehensive** – Covering 'any and all' issues that might arise within the household.
- **Integrated** – CHWWs don't operate in parallel; and are integrated into a primary care team with access to patient records.

In Brazil, this model has been highly effective in reducing mortality associated with cardiovascular disease, strokes, and infant mortality, with over 70% of the country having access to the service [3]. Beyond these specific effects, the role is known to reduce inequality of access to services (ibid.). Part of this success is related to communication skills and establishing trust with residents [4, 5]. The model has also been implemented in Ethiopia, Pakistan and Nigeria [6].

Higher-income countries started to take inspiration from this model of public health delivery, a process known as reserve innovation [7]. In the UK, the model has been widely used in Westminster (2251 patients in 662 households), with dozens of other sites also piloting the approach in some form. Outside of this, the role has been used to support the COVID-19 pandemic response [8]. Most of the literature on the CHWW roles focuses on its deployment in primary care and the NHS [9].

The CHWW model of care (as indicated above) was designed to integrate different parts of the healthcare system and improve its performance, particularly for the most vulnerable. It was also designed to support people's return to routine care.

Health Inequalities funding by the Health Foundation was granted to pilot the CHWW approach in four sites across the Central Integrated Care Area (ICA) in Cornwall using Voluntary and Community Sector Organisations (VSCO) for delivery in three sites and a Primary Care Network (PCN) in the fourth. Currently, the caseloads for the CHWWs are located in the 10% most deprived areas of the ICAs within Central Cornwall. Hence, ten Community Health and Well-being Workers have been recruited, trained and are in post to deliver this intervention. Part of the evaluation's remit focused on the initial setup and learning, with an eye on how to scale the project to a county-wide level [10]. No standardised guidance (like NICE) exists to determine how the CHWW role should be implemented. As such, this qualitative evaluation concentrated on learning how the project got off the ground and how staff were recruited and trained rather than the intervention's effects. The CHWW pilot in Cornwall adhered to the three principles given above. Rather than giving an in-depth breakdown of CHWWs as a role in this paper, which can be found in other submissions, we have prioritised presenting themes from the unique data set.

Aims and objectives

1. The objectives of the study were split into several parts, with the aim being to document the internal processes of how the pilot scheme was run and its ability to be scaled up. And to document the learning and reflections generated from the pilot - the experience of delivering, adoption of the role, what might be done differently in the future, barriers, and enablers etc.
2. To capture any learning that might support the programme to spread to a broader area if funding were made available.
3. To uncover what the alternative courses of action might have involved if funding had not been allocated to the CHWWs but rather the expansion of social prescribing, i.e. Why take this course of action instead of the most likely alternative?

Key findings of the evaluation are qualitative, implementation-based, and place-based. Where possible, we also highlight cross-cutting features related to setting up projects and delivery. As this was a pilot evaluation, we also considered what a successful transition would look like following the 12-month implementation period. The biggest success marker for the project was when the NHS commissioners decided to transition from pilot to service rollout. This was determined by monthly data capture of 35 different metrics, including health and wellbeing scores, referral numbers, numbers of actively engaged participants, number of visits made by CHWWs, number of signposting/referrals, patient activation scores, use of personal health budget, etc. This public health data was recorded on a mixture of primary care electronic health

records and notes taken from CHWW interactions. These data aren't the subject of this paper, which focused on the qualitative information around the implementation rather than the longer-term healthcare and system outcomes. But it did influence the final decision-making process to scale the pilot into a fully-fledged service.

Methods

Study design and setting

To ensure that our work aligned with a wider set of research and evaluation, our approach was informed by previous evaluations of the CHWW model in other parts of England and discussions with the researchers who produced them [11]. This involved extensive stakeholder engagement, qualitative data collection across delivery and management roles, and a preference for evaluating progress in the first instance instead of healthcare outcomes.

The National Association of Primary Care (NAPC) has supported these activities through quarterly shared learning events. Our approach was designed to mirror existing evaluations and move towards a united body of literature on CHWWs. The interim report from Westminster was critical in designing the CHWW job role, description, interview, recruitment process, and initial training provisions for the position. Hence, knowledge exchange between sites has been occurring [12]. The key theories in this body of literature revolve around the conception of trust between healthcare practitioners and residents. I.e. the open and exploratory nature required by CHWWs to break down barriers, hesitations and, in some cases, trauma associated with interacting with the health care system, often referred to as empowerment [13]. Studies in other locations found that sufficient time and effort had to be put into interactions with residents for them to start to be willing to engage with healthcare referrals, i.e. pick up the referral/ attend appointments, etc.

The Westminster report also highlighted the tailored nature of approaches that were required. Different areas (that had different demographics, geographies, etc.) can require different techniques, and consequently, the way the residents were encouraged to take up referrals had to be different, i.e. as a role, CHWW skills need to be very varied, and there's no guarantee, what works in one area will be transferable to another. i.e. flexibility and a trial-and-error mindset were essential [12].

Sampling and data collection

All CHWWs and their managers were interviewed or participated in focus groups. In total, all ten CHWWs participated in a single focus group, four interviews with site managers were conducted individually, and two interviews were conducted with the programme delivery staff, totalling 16 participants (questions in supplementary documents). Following Bourdieu [14: 205], who suggested that if one is interested in the organisational structure, one must sample representative parts of that structure so as to keep it intact, we sampled fully across different types of project staff. The project recruitment was built around the existing pilot's training and site structure [14]. Focus groups were conducted at the monthly Community of Practice. This represented a time-efficient way to capture all their opinions at once. Similarly, every site was sampled from as there are only four (See Fig. 1). Sampling, then, aimed to capture all participants in the programme [15].

Data analysis

Data was collected by using in-person focus groups and interviews remotely via Zoom [20]. Consent was taken prior to interviewing. Participants were audio recorded and then transcribed. We used the automatic coding feature in Zoom, but quality assured the transcripts by checking for errors. Focus group in-person recordings were transcribed in-house. Thematic analysis of transcripts was used to write up the evaluation findings [16], capturing emerging themes. Transcripts were then analysed in relation to job roles and accounted for any contextual factors that might be relevant to each site.

Results

This paper used qualitative data sets exclusively. Interviews and focus groups were analysed for common thematic content [16]. It has been written using a narrative methodology that presents results as an emerging story, building a picture of the situation rather than a more linear approach to reporting [17]. In the following section, we have described some of the shared experiences of the CHWWs, their managers and organisations during the setup stages of the project and the first nine months of delivery after CHWW had been employed. As noted previously, of particular interest was how the CHWW role differs from other positions in similar positions, most notably social prescribing as an alternative approach. Given this paper's focus on implementation, results have been presented in the following order: cross-cutting themes, ordered by prevalence, followed by location-specific, place-based findings in relation to each site.

Engaging the community -trial & error

The active element of the CHWW's work separates it from areas such as social prescribing. Like any activity, there is a learning period to determine the best way to interact with the public. For example, learning to go door-knocking was described as "*quite nerve-racking*" initially. This was an area where staff employed a trial-and-error approach to engagement methods, seeing what

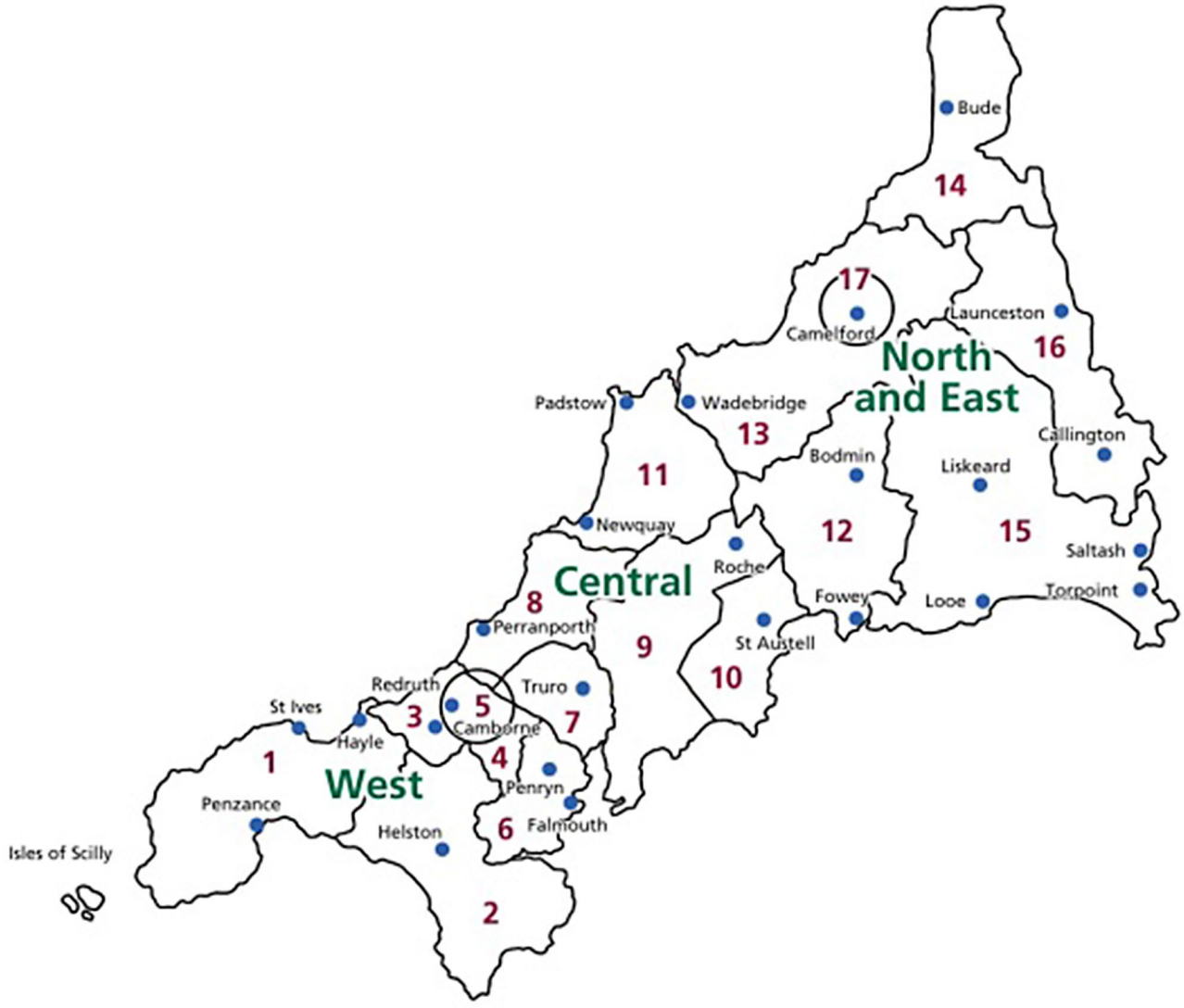

Fig. 1 PCN Map of Cornwall & the Isles of Scilly

did and didn't work and making adjustments in how to approach the public, owing mainly to the unpredictability of the activity - *"you just don't know what you are going to get."*

Often, people assumed that the CHWWs had come to promote their VSCO organisation: "*People have some preconceived ideas because of the organisation".* It is a double-edged sword as if the householder knew the organisation, it's *"not just a random person turning up at their doorstep, it gives us a bit of credence".* However, the CHWWs have to find a way to steer the conversation towards their objective and remove the idea that they were at the doorstep to promote an organisation. They worked on 'lines' that showed that they were "*not there to sell them something*" to overcome this initial hurdle.

Changes in engagement approach

Two sites presented themselves as "*working alongside the GP*" in addition to their own charity to communicate that there was a health focus but not to tie themselves to the NHS explicitly. They suggest this was the most effective approach to date. i.e., to communicate it's a local charity working with a healthcare professional. Formally, the CHWWs, as voluntary sector providers, don't work with the GP; rather, it's other PCN staff members that patients have as a first contact, but it transpired that the public would not recognise the job roles of those different positions. One of the interviewees stated that residents think, "*If there's a GP involved, you must be able to do something."* It was thought that this gave their approach the "*officialness*" and "*gravitas*" that come with the GP being involved in the messaging to make the doorstep delivery effective. From a systems point of view, the irony is

that to avoid people going to the GP and overloading primary care, CHWWs had to trade on the name of the GP (that people recognise) to prevent them from actually going there. Because it is the only identifiable part of the healthcare system for most people who don't have an advanced understanding of the NHS structures.

This trial-and-error method was well encapsulated by one CHWW who said, "*we played around with how we introduced ourselves, we said 'would you like to hear about….' and they just said no and closed the door".* The approach was designed to build rapport from the start of the interaction by opening with a statement unrelated to the service itself, "*oh, your garden looks lovely…".*

Another factor that was accounted for is the effect of changes in weather on residents' receptiveness. Two areas found that door-to-door work is less effective in bad weather (rain and high winds). Door-knocking was one of the first engagement methods used. CHWWs discovered after walking in the rain that residents do not respond to door-to-door interaction when the weather is very bad, so it was not a time-effective method for staff to walk around in the wet. It was found to be better in these instances to be present at community hubs and attend community indoor events, which were more effective for generating leads, as that is where most people will congregate. Conversely, door knocking in good weather produced much better results, as residents were more willing to engage.

Leaflets were distributed in the target areas before door-knocking. Each area was permitted to customise the leaflets depending on local needs. For example, some areas used the faces of the CHWWs in the literature, anecdotally finding it more productive; other locations did not take this approach.

Learning for spread

This section covers how the pilot project could be scaled and spread to a county-wide delivery model, including insights into training, project structure, and funding, which might need to be adjusted.

Training

While different pilot sites encountered different issues in supporting their population in terms of training for CHWWs, one common issue was enrolment in training and the lead time required to book spots. For example, a site identified the need for CHWWs to prioritise mental health and suicidal ideation courses, but the interviewee stated that booking these courses had a waiting list of months in some instances. Starting in a new area could involve initial identification of need and in-advance enrolment of training requirements. Secondly, as interviewees stated that door knocking had been shown to work as part of the community engagement, more role-play about door interactions before sending teams out in the community was required.

Training management and co-ordination for scale

The CHWW Programme Manager designed and ran the programme induction, ongoing training and Continuing Professional Development (CPD). From the project bid stage, the CHWW Programme Manager participated in the recruitment process and role design. The introductory training was delivered face-to-face to support the CHWW's collegiate interactions. This was seen as an essential function of the training, establishing them as a community of practice and building skills/capabilities as individuals.

Fundamental to the CHWW Programme Manager's role was their previous experience of delivering the same training role, but for social prescribers, "*we are replicating that to a degree, but this has other strands to it.*" Hence, the CHWW model had an existing platform to build off due to the previously successful implementation of social prescribing. Each site had coordinated line management for social prescribers and CHWWs. As such, we found that at a site level, social prescribers and CHWW were coordinated via joint line management, and so were their training provisions, and this allowed the CHWWs to sit in a wider support net.

In the staff's opinion, it was possible to scale the CHWW programme county-wide because they had an existing model in the Social Prescriber programme - "*it's not like starting from scratch.*" It became clear through the data collection that training and scaling activities of the programme were facilitated by staff with experience delivering social prescribing initiatives in the past in Cornwall.

Scale and community hub & rurality

One VSCO manager suggested that the designated community hubs would be a great way to expand the CHWW programme in a spoke and hub model. They also highlighted that this would help with any issues regarding the current CHWW provision being predominantly urban. The model has an untested question about how to deliver support in very rural areas.

Local implementation

Learning from the project occurred both across and within sites. In this section, we cover some of the learning that we uncovered locally, specific to each area.

Site 1 (VSCO - inland, urban)

In this location, the provider's reputation was said to be very important in brokering initial relationships with residents. Because the VSCO partner is well known, this created a positive image from the beginning. For

successful interactions with households, VSCO brand recognition matters as an icebreaker. In this site, it was important that their message wasn't associated with GP practices, as one interviewee said, "*I think it is helpful for organisations that they aren't attached to the Primary Care Network*". In this instance, brand recognition worked better without the NHS association. However, we will see that this is not always the case.

In terms of the local approach to engaging residents, door knocking and leaflet dropping had minimal returns, but physical presence in the over 50s club produced "*a small queue of people wanting to speak to her* [the CHWW]", to which another added, "*being out in the community is really really key*". The CHWWs found successful engagement could come in any form, reaching out to all community assets, including crafting clubs, school nurses, or allotments. The strategy was to break down their total geographical area into natural neighbourhoods and work hard one at a time rather than spreading themselves thin over a larger area.

Site 2 (VSCO in PCN inland, urban)

In this site, the CHWWs were hosted within a GP Surgery while still employed by the voluntary sector. This approach had benefits but also presented some challenges. The town's residents have a collective memory of the events surrounding the closure of GP surgeries; "*there is a lot of resentment about it*". Hence, introducing themselves as being explicitly associated with GP services was not initially well received.

While there was a clear difference here in approach with the previous site, there was also a similarity in that the CHWWs are in part bonded to the organisation's legacy of what has happened in their neighbourhoods. In summary, the NHS- relationship was described as helping "*in some ways, because access to doctors, for some people, if they have had a bad experience, it is a big barrier*".

Hosting a CHWW in a PCN also affected how budgets could be raised and spent compared to the voluntary sector. For example, printing all the communication material, such as calling cards, leaflets, etc., to distribute to residents in the first instance was slower for this site as they had to wait for the PCN to sign off on the spending. The finance regulation in an NHS organisation had "*more hoops*", which delayed some of their implementation.

Counter to this, one of the benefits of being in the PCN was the "*easy access*" to NHS staff and the systems they needed. The site found it was slower setting things up and was captive of the local NHS reputation, but had a more direct route into the healthcare system. Hence, there is a trade-off in having this relationship.

Site 3 (VSCO inland, rural and urban coastal settings)

In this site, there was lots of feedback concerning the communication strategy used to engage residents. They blended having an active approach to community engagement via door knocking to include having a physical presence in the VSCO community hub. Cold calling door knocking produced limited success. In some instances, it was more effective to be actively present in the community hub to engage people who came there. In other communities, door knocking could work differently, but on this site, they found face-to-face interaction at the charity community centre worked better, and it generated more referrals from people who knew other residents that they could approach. This method produced what was termed a "*credible referral*".

Interacting with the NHS played out differently at different pilot sites. The local NHS "*has been slow to pick up*" what the CHWWs were doing. This contrasts with site two because "*they [GPs] don't understand it… they haven't had that initial interaction to what the role [CHWW] could be*". One of the potential downsides of not being located inside a PCN is the reduced clarity of the CHWW role for GPs and primary care staff. It transpired that in this location, some GPs thought that the CHWW role would increase their workload rather than reduce it - "*there is more understanding and education to do in certain areas, but it is difficult to get into very busy places, to make sure the receptionist understand, that other roles understand.*"

Site 4 (VSCO in coastal town)

The site used a "*multifaceted approach*" to communication that goes beyond door-knocking (which was used in the first instance) and built on other ways to reach people. Due to its long-running history, the VSCO partner is already well-connected locally but has existing relationships with the other site delivery partners. Hence, the ecosystem and exchange of information partly pre-dates the CHWW pilot site partnership. Furthermore, they have also delivered programmes with some of the other VSCOs in the past, meaning that it's not just a network connection; in some instances, they have been delivery partners. The site also highlighted the role of having an active GP in the area who had already had a good relationship with the VCSO partner and was already exploring collaborative activities.

In addition to social prescribers, site four also had other types of community workers already in position who worked closely with the CHWWs. Specifically, they have a peer support worker at the front desk who triaged people entering the community centre needing help. This person directed cases to the CHWWs. Consequently, in addition to the social prescriber and CHWWs, there was an in-house support and signposting role. This

NHS-VCSO joint-funded role was an example of another NHS-VSCO collaboration but with a different, specific function. This position has been running for two years already, circa mid-2023.

Discussions

The extensive qualitative data within this paper has given rise to several points of learning for future replication. In this section, we discuss the specific themes that arose in the analysis and the cross-cutting barriers and enablers that were found, with supporting contextual evidence to expand the points.

Social prescribing and CHWWs

This implementation-based paper aimed to assess what viable alternatives could have been trailed instead of the CHWW intervention chosen. The closest existing approach to the CHWW role (which we have already covered) is the social prescribing role. While this role is not homogeneous [18], in general terms, the residents will be in some of the same pathways as the social prescriber's caseload.

There are a few things that distinguish social prescribing and the Community Health and Well-being Worker model. In the words of the participants, the CHWW model is "*a light-touch version of social prescribing*." However, they work in people's households rather than in a one-to-one interaction—"*social prescribers deal with more complexities [...] if it's not light-touch, they have to refer to a social prescriber*".

In site two, their manager commented that, *"it [CHWW role] was originally described as light touch social prescribing, but how its panning out is, it can be even more complex than social prescribing, in the fact that you get to know the patients better, and all the intricacies of their life, their situation at home, their relationships to their families, you become a lot closer than the social prescriber would. The thing that makes the job role potentially easier than a social prescriber is the fact that rather than having 45 minutes in a clinic appointment to sort someone's life out and help them, you've got an extended period of time over many months, if years, where you can spend an hour or two with them regularly, so you've got that time to build that rapport, that time to really to link into other support services.*"

Hence, in this way, "*light touch*" doesn't mean the situations, nor the people involved are not complicated; rather, the role lacks the compression of delivering an answer in a 45-minute clinical session. The CHWW were also described as "*the eyes and ears of the community*" who can relay information, if needed, back to GP surgery staff. i.e., linking in with social prescribers, hence the shared line management, training and sometimes office space (part of their induction training involved meeting social prescribers to get a relationship with them), but also remaining distinct from them.

Another clear difference between the social prescribing role and the CHWWs is that "*they need huge observational skills*" because they work with all ages. It is a universal service as part of its core tenets [19], whereas social prescribing activities tend to go toward specific interventions for specific groups. Lastly, home visits are also much more regular for the CHWWs, whereas for social prescribers, this can be quite a rare event, and some may not do it at all.

The interviews with staff indicated the benefits of a community-based scheme rather than engaging with people inside the healthcare system (whether voluntary or NHS). Site four showed clearly why people wouldn't "*come through the door*" at the community hub due to:

1. The lack of information about VSCO services is partly caused by the new group of people accessing their services, who didn't need to know about them in the past because, economically and emotionally, they were keeping their heads above water. Further, the service provider is seeing more older people access the service as the state pension isn't increasing against inflation, meaning they need support more - "*we are seeing a new demographic of people*".
2. Resident's pride prevents accessing support. The issue is not a lack of knowledge that the services exist but rather a desire to engage, i.e., residents who haven't needed the voluntary sector before, who can struggle with their newfound vulnerability.
3. Anxiety about coming into a community setting, the CHWWs deal with issues pre-institutional interaction, i.e., catching things before they turn up at a voluntary sector service Hub, or coffee morning or the GP practice. I.e., a location where there might (or might not) be a Social Prescriber or other kind of link worker.

The CHWW role was all about engagement. However, the role seems to have been implemented in a way that works in unison with social prescribing teams. For example, the CHWW's manager in site two would triage cases that may be appropriate for both the SPs and CHWWs, deciding whether the person would benefit more from "*long-term intervention with a CHWW [...] or if they are diabetic or looking for weight loss support, they are probably better to come and see a social prescriber*" – this suggests as the role is scaled, the manager will have to do more of this triaging based on the long-term vs. short-term support required for the resident.

All pilot sites seemed to be in regular contact with the SPs in their areas in various forms, and some received referrals from them. Often, they can be in the same space

- both working in a community centre, hub or gateway for part of the week. As such, the locations of both roles can overlap. They updated each other about persons who are shared in a caseload and shared information about referral services and residents -"*we have a meeting once a week with our social prescriber.*" One site embedded the CHWWs within the SP team; there were 2-hour weekly meetings to discuss caseloads with them. – "*It is really useful, we are just in all in the same office*".

A point of note is that the area that had the most issues in generating buy-in from the NHS seems to have the most distant relationship from their SP - "*our relationship in [location] is quite different, given the relationship we've got with the surgeries*", they rang up social prescribers to talk to them. The relationship at this site was by no means bad between the SPs and CHWWs it's just more distant - "*we don't meet with them regularly because we don't have a relationship with the GP surgery, we contact them as we need*".

Similarly, in site four, the peer support worker, CHWWs, and the SP were all line managed by the same person and shared the same office. The charity designed it this way and generally tries to get people in similar roles to work in the same space, so no one is "*out on a limb*". Equally, everyone (staff and public) knows where the well-being office is, and they don't have to chase down individual people.

Since there are no guidelines (such as NICE) on how these different roles work together, they have taken it upon themselves to divide the workload as they see appropriate. Depending on their situation, i.e., community-based, in the front office, or working with complex referrals. Hence, it's a self-organising system and the frontline in a new delivery method. However, it was emphasised by one manager that the VSCO sector can work like this only because it has "*vigorous safeguarding in place*" as well as their training and CPD requirements; the organisational and individual governance underpins their freedom to operate and solve problems together.

In general terms, the trend in the pilot was to integrate the CHWW role into the pre-existing structures of social prescribing to avoid duplication and increase the coverage of services offered.

Working with the NHS

The initial focus of the CHWWs was to build up relationships with residents until they were embedded enough to have full caseloads. The risk of this, however, was that other staff in the system would likely start offloading work onto them. This was mainly a concern for sites more embedded in GP practices, where GPs had suggested that the CHWWs could be used elsewhere. The other teams didn't have the same issue of scope creep. This is one of the differences between being hosted in practice instead of a VSCO organisation, i.e., diversion and allocation of workload due to the CHWW working structure.

The issue speaks to the distinction between how the NHS and the voluntary sector function. i.e., One would typically require NICE guidelines to deliver standardised services. In contrast, voluntary work is better characterised by organisational flexibility and agility in responding to unplanned issues and needs. Discussions with interviewees suggested that the voluntary sector was the appropriate site for the pilot to host the CHWWs as the position was new and had no existing guidance outlining how to deliver it. As such, an organisational system that is highly adaptive and responsive was arguably the best choice.

The longer-term counterpoint to this was financial. One of the managers interviewed was keen to emphasise the CHWW's longevity and the fact that the NHS is a more stable organisation in terms of its funding mechanism from state reimbursement for the General Medical Contract. The voluntary sector can struggle with having to link multiple sources of short-term funding to survive. As such, the CHWW role will have to find an accommodation between a potentially more stable institution and one that does not as naturally lend itself to agile and adaptive delivery in the same way.

Lastly, this issue intersects with the ability of pilot sites to scale. Further dissemination of any programme relies upon evidencing results to commissioners and senior managers. Arguably, piloting in the voluntary sector enabled a more rapid implementation and the ability to show progress (of the 35 metrics captured) to budget holders. Whether this is the best format for the CHWWs in the longer term remains to be seen.

Barriers

Monitoring

A number of cross-cutting barriers were identified in this study, one of the primary concerns being the usage and setup of record-keeping systems to monitor delivery. From the start of the project having a recording system for data generated by the CHWWs was important to track impact and themes in each area to see any long-term trends and measure activity. Practically, this meant selecting software to use, which had to be negotiated and contracted. The time required to do this meant that it wasn't ready to go at the project start, so staff had to use a manual data capture system (Excel) and wait for an App-based system that could host data to come online later (and backdate it with the Excel sheet captures).

Equally, the sites were not contractually required to use the same system, and the NHS PCN used NHS-based software that is easier to set up and run. The other VSCO sites were waiting for a different system to come online, as the divided nature of different organisations running

data capture meant that setup and procurement decisions were not required to be harmonised.

NHS access

NHS-VSCO interaction was a theme that runs through this paper. Given the varied nature of each pilot site and the independence of the organisations in each area, there was going to be some potential for variability in what resources staff could access. For example, in one location, the local NHS staff didn't permit the CHWWs direct access to patient record systems, whereas all the others did. This barrier was easier to overcome in the site based in a PCN.

In an effort to share information with local NHS staff, CHWWs shadowed primary care staff to foster relationships between PCNs and VSCO sites. However, not all sites managed to arrange this, as the GP practices were not always available to participate. To scale and spread the approach, interacting with the NHS is important. However, it was more challenging in areas with significant pressure on primary care systems.

Duplication of roles

As noted elsewhere in this paper, other similar roles to the CHWWs already exist in terms of being community-based and service-triaging positions, with hybrid versions of the two also being trialled in Cornwall. As such, one of the concerns raised was around *"the divided nature of support in the county"*. Specifically, we have encountered community link officers working for community gateways employed by Age UK and the Integrated Care Board (ICB), high-intensity user service caseworkers employed by Cornwall Mind, and, lastly, social prescribers. The perceived risk was that the delivery of services could be *"a bit disjointed"*, as these different roles exist across network partners and can partly mimic areas that the CHWWs deal with. Because they cut across NHS and VSCO organisations, there is no systematic way to coordinate them outside the CHWW and SP roles. This last point speaks to why having one person coordinate the training and joint office spaces for the two groups was so crucial for a successful implementation.

Enablers

During the conversations with staff and practitioners, a number of enabling factors were mentioned. Regarding the NHS relationship with the CHWWs, the site embedded within NHS structures felt that being part of the PCN social prescribing team produced more positives than negatives. Having dedicated time every Thursday morning to go through case work with their social prescriber was reported to be very helpful.

The role of the CHWW's Programme Manager came across as very important, particularly their role in delivering communities of practice and how it facilitated collegiate relationships between staff, "*it makes me personally feel very supported, knowing that [name] or [name] is just at the end of the phone and are so personally invested in the project, they are passionate about it and that feeds into us.*" Hence, to make the project work, you need passionate, supportive people leading the programme and training provision, as well as the CHWWs themselves to have a passion for the role.

"*the majority of the people in the partnership are so enthusiastic about it… I think if you've got everyone pulling in the same direction then actual success is easy really*". In the staff's own words, "*the regular catch-ups we are having*" are beneficial as a space to think and reflect on what they are doing and make sure "*everyone is on the same page*". These meetings "*have been regular from the beginning and have definitely helped us progress*".

NHS engagement

To make the programme work, it helps greatly if sites have a well-engaged local GP with a good relationship and understanding with the VSCO sector. In one location (site four), a local GP helped start their community well-being service before this pilot. The GP saw the value of the VSCO sector and its health and well-being support. This pre-existing relationship was flagged in the data as an enabler to support partnership working with the local PCN.

Strengths and limitations

This pilot study had a number of strengths and limitations. Firstly, as the pilot was located in one county, the information is geographically limited. The sampling was able to contact all the CHWW employees, but this totals ten individuals whose data is entirely qualitative, with all the limits on generalisability that come with this type of data. Quantitative data on residents was also collected but was limited in terms of sample size and statistical power. As such, it was chosen not to be included in this implementation study (which didn't look to evaluate clinical outcomes).

The data collection occurred during a period when COVID-19 was still prevalent. Participants requested the use of video-call interviews, i.e. remote interviewing, to avoid personal contact. In addition, we used the automated transcription feature, followed by transcript checking for quality assurance by the research team. Some have questioned the accuracy of the use of Zoom features to contribute to transcripts [14]. However, as researchers, we accommodated the requests of participants to use remote interviewing as a method. Furthermore, because thematic analysis was being used on topics that were not emotionally charged, we felt that automatic transcription would be sufficient to capture the depth

of the analysis required. It would be less appropriate for something like a conversation analysis of vulnerable groups.

In terms of strength, the study as a unit was complete, in that we surveyed all of the participants and their managers. The data from the evaluation directly contributed towards securing the full rollout of the CHWW model over an entire county.

Conclusions

This voluntary sector pilot of a community health and well-being worker role in Cornwall appeared to have succeeded to the extent that the primary barriers to implementation (such as building trust with residents to engage with services highlighted in the introduction) were overcome, resulting in the service being commissioned in several other Integrated Care Areas.

That is to state that the implementation was sufficient to secure its future commissioning. The convincing information that led to the spread came from a mixture of sources, including the qualitative data presented here, but also from quantitative sources documented by CHWWs, their voluntary sector hosts, PCN staff (using electronic record systems) and support by two Associate Clinical Fellows in the local authorities' public health team. Specifically, within the first 12 months of the pilot, the CHWWs knocked on 1873 doors, which yielded 376 houses actively engaged (21%). The three main areas of referrals from this group were finance, mental health and housing; the largest proportion of the cohort (15%) were 75 years old and over. This mixture of information results in different timelines; the qualitative data can paint an immediate picture, but the quantitative capture requires longer exposure to be able to draw a cause-and-effect relationship.

The data in this paper can't identify whether one model of working between the different sites is more advantageous than the other. The local implementation data suggests each model, whether inside a PCN or not, had its own limitations and advantages. The ongoing evaluation of the model may answer this question. Equally, another unknown element for scaling is that only one of the four pilot areas existed in a highly rural location. How the system works outside of urban conurbations is yet to be shown.

The pilot evaluation pointed out the central role of CHWWs working alongside social prescribers in terms of training, line management, and office space. It also showed the importance of building off similar existing programmes and primary care involvement from the start of the pilot as beneficial factors.

Looking to the future, knowing that social prescribing pilots have been successfully rolled out and scaled up in Cornwall already gives hope that the CHWW model could do the same here and in other parts of the UK.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12875-024-02595-y.

Supplementary Material 1

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Author contributions

JT-R and TB conceptualised the study, TB, DC and RB prepared the protocol, JT-R carried out the data collection and analysis, RB and DC supervised the study, JTR, TB, DC and RB wrote the original manuscript. All authors read and approved the final manuscript.

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Data availability

The datasets generated and/or analysed during the current study are not publicly available but are available from the corresponding author on reasonable request. This study was approved by the University of Plymouth Faculty Research and Integrity Committee, project ID: 4431. The interview schedules used in this study have not previously been published or used elsewhere. The study was carried out with the written informed consent of all respondents. The study was conducted in compliance with the Helsinki Declaration in its latest form and good clinical practice guidelines and followed the rules for informed consent. Informed consent was obtained from all study participants. All data were stored and processed per the requirements of European General Data Protection Regulation. The study owner is responsible for all study activities, including data collection that complies with UK law on handling personal data.

Declarations

Ethical approval

This study was approved by the University of Plymouth Faculty Research and Integrity Committee, project ID: 4431. The interview schedules used in this study have not previously been published or used elsewhere. It was carried out with the written informed consent of all respondents. The study was conducted in compliance with the Helsinki Declaration in its latest form and good clinical practice guidelines and followed the rules for informed consent. Informed consent was obtained from all study participants. All data were stored and processed per the requirements of European General Data Protection Regulation. The study owner is responsible for all study activities including that data collection comply with the UK law on handling of personal data.

Consent to participate

Not applicable.

Competing interests

The authors declare no competing interests.

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