

# Final Report March 2010

## Exploration of the Community Health Outreach Worker and Health Case Manager roles

Prepared for  
Marion O'Neill, Senior Health Improvement Officer – Keep Well  
South West CHCP, Strata House, 135 Fifty Pitches Road, Glasgow G51 4EB

Contract No: 3035

---

# Executive Summary

---

## BACKGROUND AND OBJECTIVES

South West Glasgow CHCP is part of the second wave of pilot sites to implement the Keep Well approach to anticipatory care. This entails identifying individuals aged 45 – 64 who live in the most deprived areas, inviting them to a health screening, identifying health issues and referring patients to a range of health and wellbeing services.

Two roles support this programme, provided by Community Renewal on behalf of South West Glasgow CHCP: the Health Case Manager (HCM) role and the Community Health Outreach Worker (CHOW) role. The role of the Health Case Manager is to provide one to one support for those with multiple or complex needs. This involves intensive support to encourage patients to take up their referrals to health and wellbeing services. The Community Health Outreach Worker aims to encourage patients who have not responded to invitations from the GP practice to attend Keep Well screening and support them to attend other services. Their support is more limited, but involves a larger number of people than the HCM.

FMR Research was commissioned in summer 2009 to explore the impact of the HCM and CHOW roles on the patient journey through Keep Well.

## METHOD

The study consisted of the following:

- analysis of the databases held by the Community Renewal team and consideration of their paper based records;
- 18 semi-structured interviews with a variety of stakeholders, including CHCP staff, Keep Well staff, those on the local steering group, the HCM/CHOWs and patients;
- 3 focus groups, with programme providers and primary care staff (supplemented by individual interviews); and
- 110 structured telephone interviews with patients, half who had contact with HCM/CHOW roles and half who had not.

## KEY FINDINGS

The fieldwork identified a wide range of data and viewpoints to inform the aims and objectives of the study. Some of the key points raised are noted below, grouped by whether these were identified via the secondary data analysis, views of patients or views of other stakeholders.

### Secondary data analysis

#### *General points*

- Community Renewal hold client data in several separate and unlinked databases, rather than in one source. These databases are up to date to different degrees. In addition the team holds paper-based client files. This provided a real challenge in terms of trying to get an accurate picture of the number of clients and contact/attempted contact with them. We took a snapshot in time, from the start of the project on 1<sup>st</sup> March 2008 until 7 August 2009 when the total number of unique cases we could identify was 1087 (7 were on all databases), which included:
  - 106 on the HCM client spreadsheet;
  - 813 on the CHOW spreadsheets; and

- 
- the Access database recorded 986 clients in total, including 175 who were neither HCM nor CHOW clients (7 were on both HCM and CHOW spreadsheets and page 11 of the report illustrates the number of clients held on each database in a Venn diagram).
  - 23 clients were referred only to the HCM, 83 to both the HCM and CHOWs and 981 just to the CHOWs.

#### *The CHOW role*

- Whilst the number of CHOW clients has grown steadily over the course of the project, the number of active clients is still high, at around two-thirds, as cases have not been resolved, or are not recorded accurately in that way. According to the CHOW spreadsheets, of the 813 referrals to CHOWs:
  - 238 people have had appointments for screening made;
  - and of these 155 people have attended screening;
  - 132 had incorrect contact details;
  - 21 found their appointment to be unsuitable;
  - 158 people wished no further contact; and
  - 264 were still to be engaged.
- Two-thirds of CHOW cases which are logged as inactive were resolved within a week of referral, i.e. it was established that contact details were incorrect, an appointment was made or they declined to participate in Keep Well within a week of referral.
- There are very few recent CHOW referrals, with 92% (824 clients) having been active for more than 14 weeks.
- 60% (358) of CHOW clients marked as active had not been contacted for more than three months. 55% (535) of CHOW clients had been attempted to be contacted only once or twice and a further 26% (258), 3 or 4 times. Half of CHOW clients who made an appointment (51%, 122) required just 1 or 2 contact attempts in order to do so, so were relatively easy conversions.

#### *The HCM role*

- Similarly, the HCM case load has steadily grown. However, only three clients (3%) had exited the service.
- The majority of HCM cases had also been active for more than 14 weeks (83%, 85 clients).
- For HCM clients, i.e. those with multiple and complex needs, only 27% (29 clients) were contacted prior to referral or within a week of referral. A further 12% (13 clients) were contacted within two weeks but 39% (41 clients) were not contacted for five weeks or more after referral and this data was missing for 9 clients. However, the Service Level Agreement (SLA) with Community Renewal identifies a waiting time guarantee for initial assessment, not just contact, of two working weeks from first contact. Only 39% (42) were contacted within two weeks, and not all of these would have completed the holistic assessment in this timeframe.
- Over half of HCM clients (53%, 51) had not been contacted for more than three months. Half of HCM clients who had attended appointments (50%, 26) had attended one or two only. Just ten individuals had attended five or more appointments.
- Nearly half (45%, 48 clients) of HCM clients had made little progress, i.e. had not completed the holistic assessment, whilst 55% (58) had completed it. The holistic assessment is the initial assessment conducted with clients in order to explore the issues they wish to address and to agree the order of priorities for action. Based on assessments made by Community Renewal, just 11 individuals had made substantive progress against their objectives and had reached the final or exit stage.
- Of those who had completed a holistic assessment, 67% (39) had issues around finance/debt/benefits, 36% (21) around exercise and 31% (18) had prioritised counselling. Money Matters was often a 'quick fix', a short intervention which could make a positive difference to people's quality of life/stress levels and so build trust in the service provided. Three-quarters of

---

those referred for finance/debt/benefits advice (29 of 39 individuals) had progressed this issue and the majority of those who had not had only just completed the holistic assessment stage of the service.

- 33 people were referred to the Bridging Service at the Keep Well screening, and 9 additional people were referred to this service following their holistic assessment. No-one who had been referred to the Bridging Service, which delivers Money Matters, at screening de-prioritised this at holistic assessment.
- It was interesting to compare the services referred at screening with those agreed as priorities at the holistic assessment. Whilst nurses referred 27 clients to Maintaining Mental Wellbeing at screening, ten of these did not prioritise this service with the HCM at holistic assessment. Only one additional person was referred to this service by the HCM. The HCM also referred just six additional people to the Stress Centre, which is surprising as 8 people were referred outwith the NHS, in addition to the HCM providing counselling directly to 8 clients. However, the HCM can fast-track clients to access a range of different therapies and counselling from the Stress Centre/Pathways. Three people who had been referred to Addictions by the nurse did not agree with this referral with the HCM at holistic assessment, although an additional three people did prioritise this service with the HCM who had not been referred at screening.

### **The patient perspective**

- Half of patients (48%, 49 respondents) heard of Keep Well when they were at their GP surgery for something else, 39% (40) heard via letter from the GP and 5% (5) first heard of it via a CHOW.
- 65% (70) definitely wanted to attend the Keep Well screening whilst 27% (29) were unsure. 77% (84) had no concerns about Keep Well before attending the screening.
- The screening was rated highly, with 77% (84) rating it as very good and 22% (24) as quite good. It was considered to be thorough, reassuring and patients felt valued from someone taking time to listen to them/show interest in their health.
- Live Active was the service which most patients had accessed (24%, 25 respondents, had done so and 14%, 12, hoped to do so), followed by Pharmacy and Maintaining Mental Wellbeing. The database also showed that Live Active was popular, with 19 clients referred at screening/including this in their holistic assessment priorities and a further 6 adding this priority at holistic assessment.
- Just over half of patients (55%, 61 respondents) reported that the nurse had told them of the support available from the Community Renewal team at the screening session. However, 14 participants (34%) did not wish support because they considered it to be unnecessary.
- Many patients were unable to isolate CHOW input from GP practice input and so were unable to rate the support provided. Of those who could, 67% (10 out of 15 respondents) stated that they attended the screening because of the CHOW input.
- Of the 13 patients able to rate the support provided from the CHOWs, the mean score was 8.77 out of 10. Twenty people rated the support provided by the HCM and the mean score was 8.80 out of 10.
- Of those who hadn't accessed CHOW or HCM support, 18% (9 respondents) felt CHOW support would have been of benefit and 16% (8 respondents) would have benefited from HCM support.
- When asked what difference Keep Well had made to their lives, the mean score was 6.25 out of 10, where 0 was no difference and 10 was a big difference. Whilst this cannot be fully attributable to the HCM and CHOW roles, some if it is likely to be due to the role played, particularly for HCM clients.

---

## Views of other stakeholders (primary care staff, service providers, etc.)

- There was greater awareness and understanding of the CHOW role than of the HCM role as fewer stakeholders had any contact with this.
- Practices varied in the way they referred to the Community Renewal (CR) team and other services, with some referring a large number of patients quickly whilst others were more reticent. Live Active was frequently referred to, as it is a relatively 'easy' service to refer to, as the topic is quite tangible and easier to raise than things like addictions/alcohol problems, literacy or employability. Issues of physical fitness/weight problems were more common than addictions. Whilst Maintaining Mental Wellbeing clients are supported to one degree or another by the CR team, other services rarely used the CHOWs, which perhaps suggests that partnership working could be strengthened with other services.
- The reports provided by CR were considered to be vague by some services and stakeholders, as the progress made by clients was not quantified. Further, the reports did not contain consistent information for example, sometimes information was presented to show the cumulative referrals to the service whereas on other occasions only referrals since the last report were presented and changing the way in which things were reported on each occasion (sometimes cumulative, sometimes since the last report), which made it difficult to gauge progress in real terms.
- Whilst the theory of the Tracking Tool to record contact with clients at each step of the Keep Well journey is good, the reality has been quite different and it has not worked as well as hoped as there have been access issues and it is slow.
- There are formal meetings between services and practice managers, plus a variety of other meetings, but there doesn't appear to have been much discussion between practices generally in terms of how they do things and learning from each other.
- Some stakeholders found it difficult to rate the CHOWs and how effectively they have engaged with hard to reach patients, but those who felt able to comment rated them highly – an 8 or 9 out of 10. Few stakeholders felt able to comment on the HCM role as they had no direct experience of it.
- The fact that CR is external to the NHS was considered to have advantages, such as the experience of outreach work elsewhere and potential speed for change, and disadvantages, such as the lack of buy-in from practice staff.
- The Community Renewal team were positive that they work in partnership with both practices and services as part of the 'Keep Well family' but Keep Well is all that CR staff do and just a small part of the role of practices and services, so practices and services consequently felt less strongly aligned to the Keep Well programme. Partnership working has improved over the course of the project, as relationships have developed, staff have become familiar and the CR team has started to have an impact on attendance rates, etc., despite some tension at the start.
- The CHOW and HCM roles were perceived to add value to Keep Well, particularly the CHOWs as more people have attended screening than would have without their input, but stakeholders found this difficult to quantify or to know whether they provided value for money.
- Practices all delivered Keep Well in slightly different ways in terms of how they selected patients, how they contacted them, when/how many Keep Well sessions were run, how they referred to Community Renewal (CR), etc., but all were generally satisfied with the number of health checks conducted to date. The selection of participants by post code was considered to be arbitrary and unfair on occasion, as this included those they considered outwith the real target group and excluded those who they perceived to have a greater need for the service.

---

## Conclusions and recommendations

The project had a number of objectives and each of these is explored in turn below.

### **To identify the specific role the health case manager and community health outreach workers played in Keep Well**

The CHOWs were very much seen to be 'out in the field', contacting patients who had not yet engaged, and providing support to clients who needed it. They therefore had a low degree of contact with a high number of clients (over 1,000). However, contact was so minimal in some cases that patients who had been in contact with the CHOWs had not even realised that they had done so.

In contrast, the HCM had a much lower number of clients (just over 100 referred) but the support has been much more intensive for those who have so far been engaged. A mean of 2 hours has been spent on each client at the nil stage of progress, but this is skewed by one individual who has over ten hours of input as 25 of the 48 clients at this stage have had an hour or less of input. The mean contact time with the 8 clients at final stage was 27.25 hours and 29.8 hours for the three at exit stage. This was much lower for those at holistic (5.87 hours), early (8.6 hours) and middle (14.15 hours) stages.

Whilst many stakeholders and HCM clients were very aware of the specific roles played by the CHOWs and the HCM, others were not clear, even amongst the referring practices, particularly with the HCM role. Patients who had experience of the HCM were very clear on what he did.

### **To identify the benefits of these roles for the patient, practice and other service providers**

Stakeholders felt that patients will have benefited simply from having taken part in the screening and having had the opportunity to access further services, as this will either have reassured them about their health or provided an opportunity to address any problems. The CHOWs may have made this more accessible by explaining the screening and providing further support if required, and 155 more patients attended as a result. Participants were generally very positive about the HCM and CHOW roles, with 67% stating that the CHOW input helped them to attend screening and the majority felt they helped them to overcome any barriers they had to accessing services, such as travel issues or lacking confidence in attending alone. Of those who felt able to rate the service provided, the mean score was 8.77 out of 10 for CHOWs and 8.80 out of 10 for the HCM. The HCM has made a significant impact on a few individuals, with a person-centred approach.

Three distinct benefits were perceived for practices. Firstly, the Community Health Index (CHI) records held have been 'cleaned' by CHOWs as they have identified that 132 patients (16% of those referred and logged on CHOW spreadsheets) no longer live at the address the practice holds. The CHOWs have also encouraged 238 patients (29%) to attend a Keep Well screening appointment, whereas these patients had not responded to the practice invitations to attend (although only 155, 19% of those referred or 65% who made an appointment, had attended). Thirdly, patients are encouraged to improve their health, both via initial attendance and via HCM intervention.

Other service providers have also benefited from the two roles, via increased attendance of the Maintaining Mental Wellbeing checks and patients being ready to engage with services such as Live Active following HCM preparation. However, not all services saw the benefit, as some saw duplication and the roles being 'nothing special'.

---

### **To identify the disadvantages of these roles for the patient, practice and other service providers**

There was some confusion amongst patients, practices and other service providers around the role of the CHOWs and HCM, which is a clear disadvantage. Practices also reported some patients feeling harassed by the number of contacts by the CHOWs. Some patients were worried that there was something wrong with them because of this. Others just found the home visits too intrusive. This was a particular issue at the start of the project, when the CHOWs had few contacts to pursue, so contacted people repeatedly within a short space of time. We note that discussion has been ongoing around the maximum number of contacts, type of contact and frequency. We would suggest that up to ten contacts would seem reasonable given that this is a harder to reach target group, but this must consist of different types of contact (home visits, with cards left if the patient is not at home, and telephone contact attempts rather than letters) and must be done at different times of day and day of the week in order to reach those who work.

The only real perceived disadvantage of the HCM role was the possibility of dependency given the degree of disclosures made and support provided, apart from the low throughput of clients.

Another disadvantage which non-participants flagged up was that some of them felt they would have benefited from either the CHOW or HCM support but this was not offered to them.

The confusion over the roles may have contributed to the different degree of referral by practices and variation in degree of 'buy in' to what CR can offer – some practices have been high referrers and seen patients attend who would not have otherwise following CR input, but others have been reluctant to refer at all, perhaps seeing less of a role for CR in their practice. Another disadvantage of the roles for practices is that the patient is building a relationship with a third party rather than the practice directly, so the practice is out of the loop.

Some services felt there was overlap between their role and the HCM/CHOW roles, so whilst some felt that referrals were more appropriate via this route, other services felt that CR could be 'precious' about their clients and not pass them on as quickly as they should. Services were often slow to access the services of CHOWs as they preferred to make contact directly with their patients.

### **To identify the added value these roles have given to the Keep Well programme**

The approaches taken by the CHOWs (going to clients) and the HCM (working at the client's pace) were seen to add value to the Keep Well programme, as GP practices and services do not have the time and resources to work in this way. The consensus was therefore that clients had accessed the initial screening and wider services through the input of the CR team who would not have done so otherwise. The added value of the CHOWs was clearer in terms of numbers accessing screening, but less tangible for stakeholders to comment on in terms of the HCM, and the project statistics have reinforced the lower number of individuals who have benefited from the service. There is no question that the roles are perceived to have added value, but there may be more of a question over value for money given the substantial costs of the project.

### **Did these roles enable more hard to engage people to attend a Keep Well appointment and/or address their multiple and complex needs?**

Whilst there is no doubt that the CHOWs have encouraged a number of patients from some practices to attend screening who may not have otherwise, plus 'cleaned' the CHI database in terms of houses/people who are no longer at the address held, a high number of referrals are still logged as unresolved (two-thirds of all referred clients). Two-thirds of CHOW cases which are now inactive were resolved quickly and without a great deal of contact required.

---

This would suggest that the majority of the patients reached by the CHOWs may be relatively easy to engage or discount as they have moved. This may reflect the 80/20 rule – that 20% of the contacts require 80% of the effort, and these are likely to be the truly hard to engage patients. However, it is recognised that any inroads made into engaging with this client group are positive and practices certainly felt that patients attended screening who would not have done so otherwise.

We would also note that few home visits are conducted in the evening, particularly in the winter, and no weekend work was highlighted so the service does not extend far beyond that of traditional 9 – 5, Monday to Friday services and so may not reach those in employment and the harder to reach.

Very few clients have exited the HCM service, and there was concern that there is a dependency on the HCM to do things for/with clients rather than them feeling empowered and confident enough to do them themselves, as the following quote illustrates:

*“I hope the HCM doesn’t foster dependence, that he improves the relationship patients have with their practice. He needs to foster empowerment plus respond to immediate needs.”*

This has created a ‘bottleneck’ of referrals, with some clients referred not being contacted for some time (38% five weeks or more), which is not ideal given the multiple and complex needs identified. The high proportion of clients at the very early stages of contact also reinforce this with just eleven individuals considered to have made substantive progress (i.e. at final or exit stage). The HCM role has been described as one which was developed to take a sensitive and empathetic ‘triage’ approach to addressing clients’ needs, by referring people to services appropriately whilst supporting them to attend. It was therefore intended to be a route for people to access services rather than an end service in itself, which it might be criticised for being at present due to the substantial amount of counselling and support provided by the HCM. The HCM is clearly assisting these clients and this is appreciated by them, but it is not necessarily the way in which this role was envisaged at the outset.

#### **Did these roles augment the longer term outcomes for participants compared to a non-participant group?**

We asked participants how much of a difference Keep Well had made to their lives and the mean score was 6.25 out of 10 (where 0 was no difference and 10 was a big difference). The CHOW and HCM roles were partly responsible for this, as earlier comments attest, although this is hard to quantify and, again, the number of clients affected in this way are low. Too few participants have exited the project to comment fully on this. It is also perhaps too early to say whether these role can have augmented the longer term outcomes for participants, as they may have improved outcomes in the shorter term, whilst supported by the HCM, but revert to previous health behaviours without ongoing input or when facing life challenges in future.

#### **How successful have the CHOWs and HCM been in tackling the inverse care law? Have they enabled those who need the NHS and the Keep Well support services most to make more use of them?**

Those stakeholders who felt able to comment awarded the CR team an 8 or 9 out of 10. Some practices felt that people had attended screening who would not have otherwise, although the total number of referrals did vary by practice. MMWB screenings were considered to be well attended in part due to the work of the CHOWs, although it is recognised that other factors have affected this, such as a change of venue and this does only relate to around twelve individuals per month.

Stakeholders generally felt less able to comment on the impact of the HCM as they had less contact with this role, but had heard of very positive outcomes for a few clients via CR reports or at meetings. The fact that these case studies reflect significant changes for a small number of people reinforces the analysis of the case



---

data which shows a large investment of time, effort and resultant progress in a small number of people but a large number of referrals who have received little attention to date, for a number of reasons.

Whether this addresses the inverse care law is hard to say, as some clients had already been referred and were engaged to different degrees with services, although they were not necessarily effectively engaged and fully supported.

**How has the service offered explored issues around the Fair for All strands, i.e. age, gender, ethnicity, sexuality, religion, poverty, disability, in relation to the solutions and support offered by these workers?**

The service provided by both the HCM and CHOWs is described as person centred by the Community Renewal team, and so responsive to the issues around the Fair for All strands. However, this data was not recorded explicitly to allow analysis and so the evaluation relies on anecdotal evidence only. When this issue was probed with CHOWs and service users, in particular, there did not appear to have been many variations on the solutions and support offered by these roles in terms of such things as age, gender, ethnicity, etc. Keep Well has a focussed target age group and access to interpreters has not been required, although practices with high BME numbers have staff with the appropriate language skills, so these patients may already be linked in well to their practices and not have been referred to the CHOWs.

Services reported that they had not received any BME referrals and men were also slow to be referred at the start of the programme, although this has picked up more now. Community Renewal staff could not recall any disability issues requiring extraordinary action, but those who were housebound or had special needs should not have been referred to the CHOWs in the first place (although one or two have been) as they should be in contact with the practice anyway (Keep Well aims to reach those who are not in contact with their General Practice) and practices could exclude anyone they considered to be inappropriate.

Key points to note which have not been covered by the above objectives are as follows:

- It has been extremely difficult to get a firm grip on the client data held by Community Renewal as they have a number of different ways to record client contact/progress, but do not do so in a clear, co-ordinated, consistent and current manner. The language used by the team around contact and engagement is also misleading, implying that it has been achieved rather than attempted when the latter is often the case.
- IT was an issue for many of the stakeholders interviewed, with complaints being made about the effectiveness of the Keep Well Tracking Tool in particular.
- Patients were very positive about the Keep Well health check.
- There appeared to be a lack of communication between participating practices and little shared learning seemed to have taken place between the South West and other Keep Well pilot areas such as the North and East.
- There would appear to be scope to extend the Keep Well model to other areas of primary care, as the CHOWs have made appointments with 238 patients (29% of those referred and logged on CHOW spreadsheets) whom practices could not (and 155 of these have attended).
- Generally, stakeholders felt the CHOW role should continue, although there were different views on who should provide this role and most would like to see the role developed and improved further. Stakeholders found it much harder to comment on the HCM role as they were less familiar with the impacts of the role, other than the few examples they had heard of.

The Keep Well pilot in the South West of Glasgow and the investment in the Health Case Management and Community Outreach Worker services provided by Community Renewal are not yet complete. It is not therefore appropriate to make final

---

recommendations on the future as we only have access to some of the information required to make such decisions, but we offer the following recommendations for consideration:

#### **Community Renewal**

- Client management systems need to be streamlined, co-ordinated and comprehensively kept up to date in order to ensure the key management information is tracked and informs the service provided (as per the service level agreement). Access databases can easily be tailored to suit required recording and reporting and the team would benefit from being networked and therefore easily able to access one data source rather than replicating this in slightly different forms. The language used should also be tightened and defined more appropriately.
- The tracking tool needs to be updated and used appropriately by all players. If a lot of detail is input, it is key that appropriate tracking data is able to be generated to then inform practice. This is not happening for CR at the moment but it is unclear whether this reflects a training and/or access issue.

#### **The CHOW role**

- The CHOW role is to target harder to reach patients who have not responded to initial approaches by GP practices to attend a Keep Well screening and they do this primarily via home visit and telephone contact. As engagement has not been achieved with a large number of patients, and engagement was relatively easy/quick with the majority who did engage, we would suggest that more evening and weekend contact attempts need to take place in order to resolve a higher proportion of cases. The SLA does stipulate that an evening and weekend service will be provided by both CHOW and HCM roles to ensure the needs of those in employment are met.
- When it proves impossible to successfully contact a client, because the address is incorrect/no longer there/they have not been reached following the agreed number and type of attempts then they should be logged as no longer active on the database.

#### **The HCM role**

- A key issue to resolve is whether the HCM role should focus on assisting a small number of people to a large extent or a larger number of people in a less extensive way. Once this has been agreed, this needs to be monitored.
- Whilst clients have reported improvements in quality of life, the fact remains that Keep Well is not a counselling service per se, it is meant to be about people accessing a range of support services and the Community Renewal team are perceived by service providers to be slow to refer clients on to other services. The CR team can refer clients directly to the stress centre and Pathways, for example, for a range of services which appear to have been accessed outwith the NHS, such as reiki and EFT tapping. Greater clarity around this may be required, particularly as Keep Well clients can bypass the MMWB screening if the HCM attends a case conference with mainstream mental health services. They would therefore effectively be 'fast tracked', but this is not understood to have happened to date. This should perhaps be stated more clearly in the SLA, in which CR has signed up to ensure rapid referral to existing support services and which clearly states that the service provided by CR does not replace the role of existing health services when appropriate (although 'when appropriate' may need to be more clearly defined). This is key in terms of sustainability of service.
- Very few clients have exited the project and, regardless of the way forward, an exit strategy needs to be agreed so that clients are managed in an appropriate way and not 'dropped' suddenly as funding ceases, particularly as this is a more vulnerable client group. This should address managing the expectations of those already engaged in the service and agreeing a cut-off date for any further referrals to the service, for example.

---

### **Practices and services**

- Whilst there appear to be a number of Keep Well meetings, there also appears to be a need to improve communications and learning between practices and services, linking services wherever possible to assist in the sustainability of the approach. This is included in the Service Level Agreement with practice nurses but participation is low when opportunities to network are provided, despite this. Other methods to network, learn from each other and build stronger links between services should therefore be considered, such as a virtual learning network.

### **Addendum**

As with many projects, changes have been made as the project has progressed. Since the fieldwork was undertaken, three key points of progress should be noted, as follows:

- Additional HCM capacity has been established so this should help to address waiting lists.
- Tracking tool access has now been resolved for both CHOWs and HCM and reports can be requested from the Co-ordinator as required.
- A definition of 'uncontactable' has been developed to resolve concerns over the high number of contacts with some patients. It has been agreed that five attempts are made to contact a client and then no further contact is pursued.
- As at 18 February 2010, Community Renewal report that the number of clients referred to CHOWs was 1,089; 298 of these were found to have incorrect details and 302 appointments have been made.

---

---