Embedding community link workers (CLWs) in primary care: A qualitative case study of experiences, roles, challenges, and sustainability

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March 2026

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1.0 Wider research context

The research reported here forms part of a larger multi-site, mixed-methods, 3½-year National Institute for Health and Care Research (NIHR)-funded research study. The study evaluated the roll-out of Community Link Workers (CLWs) across primary care in England and Scotland. The research was led by Professor Paul Wilson and colleagues at the University of Manchester.

Four regions contributed to the qualitative component of the study: two in Scotland (Lothian, and Greater Glasgow & Clyde) and two in England (North East & North Cumbria, and West of England). Eight case study sites were involved across the four regions: six in England, and one each in Lothian and Greater Glasgow & Clyde.

This report addresses the Lothian case study findings in one city-wide HSCP.

As part of this mixed methods study, a previous mapping exercise across participating regions (including all four Lothian HSCP areas) examined key CLW activities, different delivery models, and the range of CLW services provided. These findings were published in 2025 in a special issue on social prescribing in the journal *Health and Social Care in the Community*. The online link to the special issue is provided here: https://onlinelibrary.wiley.com/doi/toc/10.1155/HSC.si.686984

Our article, *Mapping variation in delivery models and data recording of primary care social prescribing link worker (SPLW) schemes across five regions in England and Scotland*, is available here: https://onlinelibrary.wiley.com/doi/10.1155/hsc/9243925

Full details of the qualitative findings across all eight case study sites in England and Scotland - drawn from 130 in-depth interviews with key CLW stakeholders - are reported in our recently published paper in Lancet Primary Care: *Embedding social prescribing in primary care in England and Scotland: a qualitative study of experiences, roles, challenges, and sustainability*. This is the link to that paper:
https://www.sciencedirect.com/science/article/pii/S3050514326000233

The findings presented in this Lothian case study are based on in-depth qualitative interviews with 22 key stakeholders involved in CLW activities across the city's HSCP. The report provides a snapshot of their experiences, reflections, and perspectives as recipients of, referrers to, providers of, and employers of CLW supports. As with all qualitative research, these findings are not necessarily generalisable or directly transferable to other settings.

2.0 Background

In the context of Scottish NHS primary care and established professional groups currently working in GP practices, the deployment of Community Link Workers (CLWs), at scale, is a relatively new phenomenon. By June 2025, there were approximately 340 CLWs in Scotland [1], with 25 employed in the Lothian city-wide case study. [2] CLWs have been introduced at scale during a time of unprecedented demand on GP practices in Scotland. [3,4] This is happening when Scotland remains affected by a long-standing inverse care law, whereby the people and communities with the greatest health needs are often the least likely to receive high-quality primary care. As a result, those who most need healthcare support will be the least well served, deepening existing health inequalities. [5-7]

Since CLWs were introduced at scale in Scotland, four relevant major reports- from the British Medical Association (BMA), the Royal College of Psychiatrists (Scotland), the Health Foundation and the Scottish Human Rights Commission- have highlighted the growing pressures on service users and, consequently on primary care in general, and highlight how these pressures directly impact on CLWs given the nature of their role in GP practices.

The first report, "*The Country is Getting Sicker*" from the British Medical Association (BMA) was published in 2022. [8] It made the following observation;

> *Billions of pounds have been cut from public services and social security since 2010 leaving us without services that are essential for our health…. In some areas, and for some groups, life expectancy has declined. Something not witnessed outside wartime for 120 years. The Glasgow Centre for Population Health has linked an additional 335,000 deaths to austerity in the five years before the pandemic - more than from the first 2 1/2 years of COVID-19…The cost-of-living crisis is plunging ever more people into poverty and making the lives of those already in poverty even more untenable.* [8. p.4]

These long-standing austerity-driven reductions in social security, public services and community social supports have been linked to worsening health inequalities in Scotland, with the most disadvantaged tending to experience the worst outcomes. [9,10,11]

In Scotland, a major review of health inequalities by the Health Foundation highlighted the following and is the second key report to highlight. This report noted;

> *The gap in healthy life expectancy has been widening. In 2019, there was a 24-year gap in healthy life expectancy between people living in the most and least socioeconomically deprived 10% of local areas in Scotland…. Since the mid-2010s the proportion of the population in both relative poverty and extreme poverty has been on a slow but persistent upward trend. [12 p.11]*

Today, increased demand for mental health support services in Scotland is unprecedented. The percentage of people reporting mental health conditions more than doubled between the 2011 and 2022 Scottish Censuses. [13] In their June 2025 report, *Awareness, action, accountability: Tackling Scotland's mental health emergency*, the Royal College of Psychiatrists (Scotland) reported;

> "*As Scotland recovers from the trauma of a world-changing pandemic and subsequent cost of living crisis, the population is in the grip of a mental health emergency - and the warning signs are everywhere. Record numbers of people are reaching out for help from an overwhelmed system. Yet too many are met with delays or care that comes too late. People are waiting months - and sometimes up to years - for support"* [13, p.3]
>
> *Some people are more likely to develop mental health problems because of unfair social determinants* [of health]. *But it also works the other way around -*

having a mental health condition can make those social challenges even harder. This creates a cycle where both problems feed into each other". [13. p.10]

The fourth report, from the Scottish Human Rights Commission (SHRC), *State of the Nation report*: *2025,* represent its annual assessment of how human rights are being realised across Scotland. [14] Launching the report in December 2025, Professor Angela O'Hagan, Chair of SHRC stated:

"*Economic, social and cultural rights are the foundations of a dignified life. But for many people in Scotland these rights remain out of reach. People are struggling to heat their homes, feed their families, or access basic services, and this is fuelling real frustration and tension across our communities*. [15]

The ongoing challenges highlighted in the above reports (and others) mean that CLWs across Scotland are increasingly managing the consequences of these pressures in their day-to-day work within GP practices.

It was against this backdrop of increased demands on GP practices and wider economic and social challenges that our research was undertaken.

3.0 Study Methods and Methodology

A qualitative design employing in-depth semi-structured interviews was used. Research participants were individuals actively involved in community link worker (CLW) activities. This involved: (i) service users aged 18 years and over receiving support from a CLW; (ii) individual CLWs; (iii) General Practice staff who referred service users to the CLWs; (iv) Third Sector Organisation (TSO) leads employing/hosting CLWs; (v) TSO leads not employing/hosting CLWs but supporting service users signposted to their community group by a CLW; and (vi) strategic leads working directly with CLWs services.

NIHR Study: Qualitative interviews in Lothian case study site

Local research participants	No. of interviews
Service users	**5**
Community Link Workers (CLWs)	**5**
Referring Professionals (RPs)	**5**
Third Sector Organisation (TSO) leads hosting CLWs	**3**
Third Sector Organisation (TSO) leads not hosting CLWs	**2**
Strategic Leads involved with CLW services	**2**
Total	**22**

Purposively sampling ensured diversity in service users age, gender, and deprivation and variation in individual stakeholder roles and responsibilities. Six separate interview topic guides were developed for each individual stakeholder group. Interviews for the Lothian case study site were conducted between February and May 2024. All research participants received a participant information sheet (PIS) and consent was recorded prior to each interview.

Interviews lasted between 45 and 60 minutes. All 22 interviews were transcribed verbatim and were analysed reflexively using inductive thematic analysis. Researchers familiarised themselves with transcripts, generated codes, and organised these into initial themes, which were discussed, reviewed, defined, and named by a core of experienced qualitative researchers involved in this study. A reflexive approach was maintained to acknowledge the researchers' active role in these interpretations.

Ethical approval for this study was granted by North East-York Research Ethics Committee. REC reference: 23/NE/0176.

This paper reports on the qualitative findings from the case study site in Lothian in one city-wide HSCP.

4.0 Results

Following our data analysis, the following themes, drawn from interviews with CLWs, service users (SU), referring professionals (RP), and third sector organisation leads (TSOs) and strategic leads (SL) provide a snapshot of how systemic, everyday challenges manifest themselves in their daily work in the context of CLW services, GP practices and TSOs in this city.

Six key themes and a number of sub-themes emerged from the city-wide data;

Theme 1: Benefits of CLWs- service user perspectives
Theme 2: Empathy, time, and trust - CLWs therapeutic encounter with service users
Theme 3: Changing role of CLWs: Growing social determinants of health needs
Theme 4: Referring professionals on the key role of CLWs in general practice
Theme 5: TSO leads reflecting on impact of CLWs
Theme 6: The future sustainability of CLW services

4.1 Theme 1: Benefits of CLWs- service user perspectives

We asked CLWs to ask service users to consider being interviewed for our study. We stressed to CLWs that we wanted a range of service users, with a range of physical health, mental health and social problems. It was also important that we spoke with service users who were initially sceptical about seeing a CLW or who needed to be pushed to consider attending community groups.

Demographic characteristics of service users

Service User	Age Range (years)	Gender	Ethnicity	Deprivation status (Based on SIMD)	Employment status	Lives alone	Multi-morbidity*	No. of meetings with CLW
SU1	50-65	Male	White	High deprivation	Unemployed	Yes	Yes	4
SU2	65+	Female	White	Medium/low deprivation	Retired	Yes	Yes	4
SU3	50-65	Female	White	Low deprivation	Unemployed	No	No	4
SU4	65+	Female	White	High deprivation	Retired	No	Yes	4
SU5	30-49	Male	White	High deprivation	Full-time carer	No	Yes	4

The following case study highlights the impact a community link worker had on one service user who was a full-time carer who was struggling to cope.

Individual service user case study SU5

David (not his real name) is a full-time carer for a sibling with high neurodivergent support needs. Referred by his GP to a community link worker (CLW) for help with his mental wellbeing and isolation, he described feeling "*broken*". Years of caring had left him exhausted and struggling with anxiety and depression. Post-COVID, he found it hard to build a relationship with a GP because appointments were brief, rarely with the same GP, and usually by telephone, but he stressed "*it's not their fault, they're just too stretched*."

After in-depth discussions, the CLW linked David with a carers' organisation that arranged free counselling within six weeks, which he found "*massively beneficial*." He couldn't afford the gym, so the CLW organised a free CAP card so he could return to exercising, which he described as "*a godsend*." The CLW also accompanied him to a local cooking class (he wouldn't have attended by himself), helping him reconnect socially, build confidence, and gain new skills and friends.

David's most transformative step came when the CLW secured charity funding for a short holiday in England while his family member was in respite care. It was his first real break in years, giving him space to rest, reflect, and begin making future plans for himself again.

David described his sessions with the CLW as a "*monumenta*l" turning point, valuing having someone he could "*offload*" to without feeling judged. The consistent community support helped him regain purpose and provided hope and direction that clinical care alone could not.

Another service user said the CLWs time, encouragement, and guidance helped him understand his issues, build confidence, and access local community resources. He especially valued the opportunity to express himself fully and being listened to.

> *The extra time with the link worker meant you could talk things through… Without their encouragement, I doubt I would've visited the Men's Shed or the community arts centre. They helped me be more open, less nervous around people. They really listened a lot.***SU1**

The service user described how the CLW brought hope during a very low period, and helped her join a local green community group—first accompanying her, then enabling her to attend independently.

> *What did the link worker give me? Confidence. Positivity… I was in a poor state of mind. But after we met, there was that little bit of hope. When you're in a really difficult place, you need hope. She certainly gave it. I got involved with an outdoor community group, and after first accompanying me, she gave me the confidence to go on my own.* **SU3**

This service user sought help for long-standing anxiety and depression and, although initially reluctant, through the CLW, was persuaded to join an exercise group which improved her mobility and reduced her isolation.

> *I've had depression for many years… The GP referred me. First meeting with the link worker we spoke for an hour. It was good to get everything off my chest- even the horrible things we spoke about… She gave me relaxation exercises – I was really anxious. She told me about a*

community exercise class; I didn't want to go… She said it would be good for me. She was right – 16 weeks – I'm still going. Brilliant. **SU4**

This service user was grieving the loss of her husband who she had been married to for decades, and was experiencing poor health, low mood, and social isolation. She frequently visited the GP. Talking at length with the CLW "*was such a relief*" and they welcomed the practical support received.

Meeting the link worker was best thing that happened to me because I didn't know where to turn. I felt so lonely. So isolated. Where do I start? She really listened to me. Now I've got the two groups I go to… I only cry occasionally now. I got good practical help with attendance allowance and a blue badge. The link worker was absolutely tremendous for me. **SU2**

4.2 Theme 2: Empathy, time, and trust - the therapeutic encounter with service users

As noted earlier, rising waiting lists for mental health services highlight the increasingly important role of CLWs in providing listening support and continuity while individuals wait for specialist care. Across our case study sites, our findings matched those of Westlake et al. [16] whose research on link workers in England highlighted that '*holding*' emerged as a key but often overlooked aspect of the CLW role. This involves supporting service users while they wait for services such as mental health care, sustaining them through periods of uncertainty, reducing pressure on primary care, and bearing witness to distress through active listening. This work however can add to the emotional burden of the CLW role.

Interviewed CLWs emphasised the importance of having sufficient time with service users, particularly those with complex psychosocial needs, to '*unpeel the layers'*. Longer sessions help to build trust, allow deeper issues to surface, and provide relief for individuals who can often felt unseen and unheard.

While many service users require straightforward signposting (e.g., to a walking group or weight management support), others need support for long-term social isolation, enduring mental health problems, low confidence, and past trauma, all of which can hinder trust and engagement. For these individuals, empathetic engagement - underpinned by strong listening skills - is crucial. Empathy, defined as the ability to understand and share another person's feelings, involves recognising a service user's situation, communicating that understanding, and responding in a supportive and therapeutic way [17].

Consistent, non-judgemental listening helped service users feel safe, heard, and hopeful, making empathetic, listening support an important part of the CLW service.

*We are dealing with people with all sorts of trauma…regular conversations about suicide, abuse, historical abuse. Primary care is a trusted environment, so people share and find that helpful. People come in with the weight of the world and leave saying, '*I feel seen, I feel heard, I feel better*'.* **CLW4**

As these CLWs noted, active listening is central to building trust and creating a safe, non-judgemental space where people feel genuinely heard.

*Firstly, having really strong active listening skills is very important… Not being judgemental, giving them space to explore. The amount of service users who say, '*nobody's ever actually sat and listened to me like that before*'. Now that is sad, but it's validating for people to know it's okay to come in and talk.* **CLW3**

I think as link workers we do quite well with establishing that initial rapport with people. Making them feel safe to chat about something they don't have time to chat about with the GP. Sometimes you might not have linked somebody to services, but they've sat and chatted and they feel so much better. **CLW2**

Sub-theme: The importance of CLWs establishing boundaries around their role
Whilst CLWs provide valuable listening support and a safe, non-judgemental space for service users, all CLWs stressed that maintaining clear boundaries was essential. They are not there to be therapists or counsellors, but professionals offering time, space, and validation within their defined role and remit, which was something that needs explained to service users.

*It's usually an hour for the first meeting. Most referrals have got mental health issues…Service users say, thank you so much for giving me all this time- "*can I come back for another chat*". I make it clear that I'm not a counsellor or a trained therapist. People are looking for free counselling or therapy but there's long waiting lists. I explain again what my remit is.* **CLW5**

As one CLW noted, some service users need direct support from formal mental health services, highlighting the need for emphasising clear boundaries.

I'll always have an hour with somebody. You need time to get to know them. It's emotional and hard for many people to share. First, you've got to build trust. Sometimes it's clear-housing, a gym pass. Other times it's past trauma. Often, they should be engaging with proper mental health services… so I often have to explain that I'm not a clinical worker. **CLW1**

As these CLWs noted, their role requires balancing empathy with clear boundaries-offering space for people to offload during long waits for mental health or other support services while avoiding becoming a long-term source of dependency.

We are supposed to work to a 4-6 sessions model. At the outset we say, I'm a short-term intervention. I'm here to help you find the right support in the community. We need to be very clear about the role, manage the expectations, setting the boundary - that it's a short-term service. **CLW4**

I'm always wary my role is not seen as long-term support worker. But it's not simple signposting either. It's getting the balance between establishing a relationship, working out what's needed, helping them connect with others, then having an ending - without creating dependency. **CLW2**

The importance of CLWs having clear boundaries around their specific roles and remit was also commented on by TSO leads that hosted/employed CLWs.

We get people who aren't remotely ready for change. You get people far too mentally unwell to be referred to a link worker. We should only be getting people on the mild to moderate end of the mental health spectrum. If they're too unwell, you bounce that back to a mental health service. You get people in crisis. We're not a crisis service.
TSO2 _Hosting CLWs

I think when people are referred to us in a point of crisis, that can be very difficult for the link workers to navigate. Also, I think an attachment can often be formed with the link worker, good and bad. So, it can often be people that are maybe a little bit vulnerable and will share that with the

link workers. They are then left holding that person - that can often be difficult to manage. **TSO3 _Hosting CLWs**

Sub-theme: CLWs on the importance of supervision given demands of the job

Community link workers reported that their role can be emotionally demanding, with service users often sharing experiences of trauma, past or ongoing abuse, and poverty-related stress. As primary care is a trusted space, CLWs carry a significant emotional burden, making regular, high-quality supervision essential. They valued support from clinical psychologists, third-sector supervisors, CLW network leads, and peer networks, particularly given the isolation some may experience within GP practices. Many felt fortunate to have strong support systems in place, emphasising that robust supervision is critical for resilience and safe practice.

I find the clinical psychologist really beneficial actually. Especially to be able to speak confidentially about some cases and how it has impacted on me. **CLW5**

It is a lot of emotional stuff. Very robust support and supervision is absolutely essential for our wellbeing. We are dealing with people who come with all sorts of trauma… regular conversations about suicide, abuse, historical abuse, and all of the things that come with living in poverty. **CLW4**

We receive clinical supervision roughly every month with a psychologist. Our third sector organisation also provides supervision every six weeks. There's also informal peer supervision, which some people use a lot if they feel a bit isolated. **CLW2**

We have a clinical psychologist who does group sessions. I appreciate we're in a really fortunate position that we have a lot of support and that is a really important strand of that support. **CLW3**

4.3 Theme 3: Changing role of CLWs addressing growing social determinants

Community link workers interviewed for this study highlighted the realities of supporting individuals and communities facing multiple, overlapping challenges. Working in contexts of social deprivation, reduced voluntary-sector capacity, and statutory systems struggling to meet rising demand, they reported increasing levels of financial hardship, housing problems, food and fuel insecurity, and social isolation among service users. Their accounts point to the systemic nature of these issues and the emotional and practical pressures of responding to unmet need within constrained statutory and voluntary sector provision.

As one CLW observed, deepening social hardship and increasingly complex needs now coincide with services that are difficult to access and reduced community capacity, creating a landscape in which CLWs have become a critical- and often last- source of support.

Where I am working, it's deprived, so there's financial stress. The top issues- mental health, social isolation, cost-of-living crisis- fuel and food poverty. And housing. The council housing service is just woefully inadequate. The biggest barrier for us is absolutely lack of services. The third sector has been cut.…It's systemic… Essentially, we're downstream, hauling people out. But there's only so much we can do. I'd hate to think what would happen to people if we weren't there. **CLW3**

Another CLW described how escalating social needs, coupled with the increasing challenges associated with accessing statutory services like housing, benefits, and mental health services have impacted significantly on the nature of CLWs daily work.

> *We get a lot of benefit requests; where people are often digitally excluded or don't know how to access the benefits system or help for carers. Food banks, a lot of food poverty. Housing - quality of housing. There's a lot of tardiness in these systems. People don't get called back or they feel dismissed. A lot of advocacy work, where patients feel that* (statutory) *systems are not listening to them or responding to them.* **CLW2**

For this CLW, the socioeconomic and consequent mental health challenges are reflected in the demographics of those seeking help:

> *Nearly all the people that we see they're living on a very low income, or they're living on benefits. They're a young population as well. Nearly everybody that we see is, maybe 30 to 50. Yes, there are people either side of that- but that's quite a young population to be coming for help. And I would say everybody has got a mental health aspect to their care needs.* **CLW1**

Other CLWs reflected on the lasting impact of the COVID-19 pandemic on community capacities:

> *I came into this role just as the pandemic ended. I wasn't really aware until I started seeing people face-to-face when they started telling me- I used to do X, Y and Z in the community, but that's closed now because of COVID. I started to hear a lot of that. There's more pressure on organisations that are open. Waiting lists are bigger now because there's not as many.* **CLW5**

One link worker described the stark reality of supporting people whose needs exceed what local services can offer, highlighting both the challenges and the hope their role provides.

> *One chap on my caseload has been referred many times over the years. We've not found the right support for him. It doesn't exist. Social Work is broken. He needs long-term support- which doesn't exist. Things are really bleak out there at times. As a link worker you are in the business of hope. Peoples' lives are hard. But you can offer a little nugget of hope, and practical support.* **CLW4**

Other interviewees, such as this TSO lead that hosts CLWs, also highlighted growing demands for basic social determinants to be addressed by their CLWs.

> *I would say that there are a greater number of people presenting with these issues- cost of living crisis, food poverty, energy poverty- and that is resulting in maybe a slightly longer wait to have them resolved.*
> **TSO3 _Hosting CLWs**

4.4 Theme 4: Referring professionals' views on CLWs in general practice

Referring professionals consistently emphasised the growing importance of CLWs in primary care, describing them as essential partners in addressing the widening social challenges that service users bring to GP consultations. With rising pressures such as growing poverty, housing problems, and the cost-of-living crisis shaping service users' health, referring professionals reported that much of these need falls beyond their clinical capacity, and limited appointment times to address them. CLWs, they noted, bridge a gap that provides the social support, knowledge, and time that clinicians cannot, preventing significant unmet need developing and enabling more holistic, manageable support for service users.

Some referring professionals in GP practices observed that contemporary general practice increasingly serves as a point of contact for complex social and economic challenges that extend well beyond the traditional remit of the NHS of addressing physical and mental health.

> *People nowadays don't just come to the GP with something physically or mentally wrong with them. They have a variety of other issues that probably the NHS wasn't initially set up to deal with. So, we in the clinical side definitely need somebody not clinical to help with the patient caseload that we can't do/give/provide regarding the social issues. Link workers fill that space. We need more link workers actually.* **RP3**

Referring professionals, especially experienced GPs interviewed, highlighted the essential role of CLWs, emphasising how their expertise bridges a growing cross-over between health and social care needs that general practice clinicians can no longer meet alone.

> *If there wasn't a link worker service here, there would be massive unmet need. You can't unpack the social side of life from peoples' health. They are interconnected. But I don't have the knowledge or the time to address those social issues. Our knowledge is not the same as our link workers. I also think that historically, things that might have been done by Social Work services are now picked up by link workers.* **RP4**

These referring professionals highlighted that escalating socioeconomic pressures are intensifying service users' support needs, underscoring the growing strategic importance of CLWs in alleviating demands that exceed the scope of standard clinical care.

> *Link workers are enormously important because of the level of social pressures on peoples' lives now. Cost of living. Housing issues. People need more social support. If it weren't for us having a link worker, I'm sure we as GPs would be having many more very long, more complex, appointments with people. The link worker is better at addressing their social issues than we are.* **RP2**

This experienced GP stressed that worsening socioeconomic conditions and rising vulnerability among service users in socially deprived areas are amplifying the non-clinical determinants of health, reinforcing the critical role of CLWs.

> *Patients' circumstances are getting worse with austerity. We know how much health is determined by non-clinical things. We have highly vulnerable patients struggling to manage long-term conditions, and mental health. But we as GPs have very short appointments. I deeply regret we have so little time. And it's difficult for us to keep up with community groups and services -they're changing all the time. That's why link workers are so incredibly important.* **RP5**

Sub-theme: CLWs and their integration in GP practices

As noted in the background section, compared with other professional groups, CLWs are a relatively new phenomenon in primary care. Across the UK, policy initiatives to ease pressure on primary care have introduced a range of additional MDT professionals into GP practices, yet research shows that fully embedding these roles takes time. Research on integrating new and additional MDT roles into GP practice teams highlights the importance of shared expectations around roles and responsibilities, relationship building, recognised impact, and supportive infrastructure. [18,19.20]

Overall, CLWs in this case study site reported feeling increasingly valued, noting that GP practice staff now have a much clearer understanding of the CLW role than when it was first introduced. As staff observed the CLW role in practice, support generally increased. Some exceptions remain, most often where clinicians adopted a more medicalised approach to care. As a relatively new professional group within primary care, the integration of CLWs continues to depend on relationship-building, visibility within practices, and- crucially-the culture of individual settings, with more holistic orientated GP practices more readily embracing the CLW role than those operating within a traditional medical model.

One experienced CLW described how understanding of the role has changed over time and how experiences vary across practices:

> *Link workers are not such a novelty now. Practice staff understand the role better. It's changing all the time. In 2017 when we started, I would have given a very different answer – we had to justify our presence and were at the bottom of the pecking order…… I'm lucky I'm now treated as an equal in my practice. Staff there recognise that there's a lot of patients they can't help - but I can. I've learned GP practices are incredibly different. Some have a more holistic understanding of health. Others are more traditionally medical.* **CLW3**

Another link worker described the ongoing effort required to build visibility and trust within GP practices.

> *Doing social prescribing within a medical setting, you have to work hard - be visible, establish rapport, prove yourself. But the atmosphere is now conducive and supportive of social prescribing. I think there's real respect and value in the breadth and creativity of our role. It's taken time. Time needed to educate staff. It's an ongoing process given staff turnover. But practice staff welcome the benefits of the role.* **CLW2**

Another link worker described the mixed levels of engagement among some GPs and the importance of ongoing relationship-building.

> *The GPs that use the link worker service love it. But there's GPs that won't take on anything new. We've got a great relationship with the psychiatric nurses - they refer a lot. There's much more appreciation of what we do since we gave a PLT talk at the practice. I don't think people realised how much we can help with. It's also about building relationships, being noticed.* **CLW1**

This link worker highlighted strong practice support and improvements in referral quality over time as staff became more familiar with the role and remit of link workers.

> *Both the practices I'm in very much value the link worker role. They very much get it and are very supportive of social prescribing and what my role can bring to the team. Initially it took time to get the right referrals to me. But for the last few years everything has been appropriate and it's often fed back to me how valued our role is.* **CLW4**

This link worker highlighted the challenges of being the only person in the role within a busy clinical environment.

> *When I first started, I was shadowing link workers. I heard from other link workers that it can be isolating role particularly when you're the only link worker in the practice.* **CLW5**

Sub-theme: CLWs and their integration in GP practices - the TSO view

TSO leads noted that, in 2017, early integration of CLWs into GP practices was challenging, particularly due to limited GP buy-in in some practices, system access issues, and new employment structures, although these have improved over time. However, for some TSO leads GP engagement still varies, resulting in inconsistent integration. Regular feedback meetings and access to dedicated space within practices were seen as key to fostering collaboration. While some TSO leads described strong integration-highlighting examples such as dedicated rooms, structured referral slots, and clear systems-others reported more variable engagement, with some GP leads proactive in their involvement and others relying on CLWs to initiate communication.

One TSO lead reflected on the early challenges of integrating link workers into GP practices

> *When the national link worker programme started, we weren't quite sure how we'd fit with GP practices, and it took a change in staff for it to work properly… I've been to practice meetings, so I can chat with practice managers or the lead GP. Some link workers have to go and find them and say, I need to talk to you… Other GP leads are more proactive and meet every six weeks.* **TSO2_Hosting CLWs**

One TSO lead employing/hosting CLWs reflected on the difficulties encountered during the initial rollout of the programme, explaining

> *We were early adopters in 2017. It was a challenge. Some practices were sceptical. Another obstacle was access to systems and the line between being GP practice staff but employed elsewhere. There was a lot of paperwork and red tape. Some GPs refer more and some don't. Within practices, some GPs are keen to support the link worker role and others just don't.* **TSO3 _Hosting CLWs**

One TSO lead employing/hosting CLWs reflected on the progress made since 2017 in terms of link worker acceptance and integration in GP practices

> *The vast majority are now embedded in the GP practice fairly well. The one that is attached to a single practice has her own room and that works really well. She's got referral slots booked at particular times of the day so it's really regimented. I think the concept of link working's well established. I think that reinforces and reinvigorates the role.* **TSO1 _Hosting CLWs**

Sub-theme: The importance of rooms for CLWs in GP practices

Link workers emphasised that having a room in the practice/s the covered was essential for confidential conversations with service users and for feeling an accepted part of the practice team. However, experiences varied: some had a designated room, others relied on ad-hoc allocations, and some struggled to secure suitable space. Limited access sometimes forced meetings into public settings or time- consuming home visits which reduced their visibility within the practice. With more than 5,000 new MDT staff being introduced to Scottish primary care following the 2018 Scottish GP contract [1], the need for office space has intensified, making consistent room space harder to secure.

Rooms for meeting service users… that's a real problem for us. I can't always get a room… Getting a consulting room is difficult. I can only be guaranteed a room one day a week… I just can't see people on those days and can only do phone appointments. **CLW1**

I'm really lucky in my current surgery that I've got a dedicated room that's got my name on the door and I'm really seen as part of the team, so I don't have to worry. However, in the other surgeries that I've worked, that hasn't been the case. **CLW3**

I'm lucky that I am always allocated a room, but not my own personal room. I think that that would be the dream - your own room your own noticeboard and all your own bits of information, but I don't have that. That is just because there is more staff now in primary care. **CLW4**

I have the luxury of official room space, but some of my colleagues don't. That can really impede respect, visibility, and understanding of the role… There have been times I've had to room switch, and even a period with no room. So, I was doing a lot of home visits-which takes time and doesn't go down well with the network. **CLW2**

It wasn't only CLWs who stressed the importance of dedicated rooms in GP practices. Most TSO leads hosting/employing CLWs also highlighted that having office space is crucial for integrating CLWs into GP practice teams. Dedicated space increases visibility, supports informal relationship-building, and can boost referrals to the service.

The link workers say they can still do their job out-with the practice, but they miss being in the GP surgeries. That's a huge bit of building the team element and being seen by practice staff. We noticed a dip in referrals in two surgeries because the link worker couldn't find office space - out of sight- out of mind- I guess. So yes, office space is really important.
TSO3 _Hosting CLWs

4.5 Theme 5: TSO leads on the impact of CLWs

TSO leads that hosted and employed CLWs emphasised the importance of the trusted relationships CLWs build with service users - something increasingly difficult for time-pressured GPs. Longer appointment times allowed CLWs to provide deeper, more consistent support and address underlying social needs, complementing service users clinical care. Many TSO leads noted that CLWs' backgrounds in social work, community roles, or homelessness services helped them understand wider community issues, navigate complex systems, and tackle core social determinants, offering supports for essential needs.

One TSO lead that hosted/employed CLWs highlighted the growing scale of unmet social needs that link workers were increasingly facing

The main thing that the link workers are dealing with now are financial difficulties, food insecurity, inadequate housing, and poor mental health. There's big poverty. More people would be in hospital and there would be more homelessness, but for link workers. That's before they can actually start to work with somebody around changing things for the better in their lives in terms of traditional social prescribing activities. **TSO3 _Hosting CLWs**

This TSO lead explained how limited GP appointment times make the link worker role essential

> *I often use the example of how little time clinical staff, especially GPs, have… Appointments can be ten minutes. The link worker has the luxury of more time to delve into social issues… complementing clinical care and allowing the GP to focus on health issues. GPs don't have time. The link workers do.* **TSO1_Hosting CLWs**

Another TSO lead explained how link workers offer in-depth relational continuity over a number of sessions that GPs frequently cannot due to time pressures.

> *I think the listening time is a main one… With the GP it could be a different GP every time and you're repeating your story, but with the link worker it's the same person from start to finish. That rapport is vital. GPs rarely have more than 8 to 12 minutes… The link worker takes pressure off the system and really unpicks what's going on.*
> **TSO2_Hosting CLWs**

4.6 Theme 6: The future sustainability of CLW services

Concerns were raised about the long-term funding of CLW services, with ongoing uncertainty about future financial support and its implications for sustainability. Reliance on short-term or annual funding cycles was seen to limit long-term planning, and create instability for staff. Participants also highlighted increasing demand and growing complexity of need, raising questions about the capacity of current models to remain sustainable. In addition, limited career progression opportunities and workforce development were identified as challenges for retaining experienced staff.

Overall, while CLW services are highly valued, their future sustainability was viewed as uncertain without more stable funding and stronger strategic support.

> *It would be a huge step backwards. it would be a betrayal really of everything that's been achieved if we don't maintain the service. I hope across the political spectrum that there's enough evidence now with lifestyle medicine, that this work is essential. It isn't optional anymore. You need to invest in communities and this is a good way of doing it. Stable, longer-term funding to support sustainability is vital.* **SL2**

Sub-theme: CLW concerns over variation in terms and conditions

Some CLWs highlighted concerns over variation in salaries and broader terms, and conditions amongst link workers. Several workers remarked that people doing the same role can be on noticeably different pay or benefits, sometimes even within the same organisation. These reflections indicate that variation in terms and conditions is an issue within the workforce.

> *There are loads of variation in terms and conditions. There have been issues around that and there are probably ongoing. What can you say? If somebody else is getting paid more than me, what can I do about that? Some are paid drastically lower than what I'm on.* **CLW2**

> *We're all employed by third sector, but on different salaries depending on who employs you. The guidance is to be band 5, but third sector pay is less than that. I didn't realise everyone would be on different salaries… these differences make it very difficult. Knowing somebody else could be on maybe £5000 more for exactly the same job.* **CLW1**

> *We are all on different terms and conditions. We all have different pay grades. We all have different holidays… I am on my terms and*

conditions which I have carried from my original employer. One link worker I know has different holidays than me, different pay than me. Even though we are employed by the same organization. **CLW4**

Sub-theme: The importance of a sustainable TSO sector

Third sector organisations were seen as a critical part of the community link worker model: they provide many of the community supports service users are referred to, and effective link working relies on strong partnerships between GP practices, CLWs, and third sector providers. Secure long-term funding for TSOs was seen by many interviewed stakeholders in this study as playing a vital role across the city in supporting the communities they service but additionally were also seen as crucial to supporting the development of social prescribing link workers in primary care.

A number of interviewees highlighted the growing challenges facing TSOs and why community link working needs a strong TSO sector.

I've been working in the voluntary sector for over 30 years and the situation that we find ourselves in is not unusual. It's just becoming more and more difficult. **TSO2_Not hosting CLWs**

A strong link worker service needs a strong and stable voluntary sector, they both need sustainable support.
TSO3_Hosting CLWs

5.0 Conclusions

This Lothian case study highlights the important role CLWs play in supporting service users across a continuum of needs, from straightforward signposting to community-based activities such as a walking group to more intensive, empathetic support addressing complex psycho-social needs and practical challenges of addressing key everyday social determinants of health needs.

Service users consistently valued the time, empathy, and encouragement provided by CLWs, which helped build confidence, reduce isolation, and support engagement with community resources. Referring professionals also emphasised the value of the CLW role within primary care, noting that CLWs help address the social determinants of health that clinicians often lack the time or limited knowledge of local resources to effectively address.

The findings show that CLWs are increasingly supporting people facing financial hardship, housing issues, food and fuel insecurity, and mental health challenges, often within overstretched statutory systems with long waiting times, especially mental health services. While their therapeutic listening support was valued by service users, clear role boundaries are important in establishing what CLWs can and cannot do. Given that service users can present with past and ongoing trauma, access to appropriate supervision and supportive working conditions, remain essential.

Across this and the other eight NIHR case study sites, CLWs were widely recognised as a key component of holistic primary care, particularly in areas of deprivation. However, concerns were forthcoming about their long-term sustainability which remains uncertain, largely due to reliance on short-term or annual funding arrangements. Similar concerns were also highlighted in Voluntary Health Scotland's *Essential Connections* report [21], which explored the range and scope of CLW programmes across Scotland and emphasised the need for more stable funding structures and clearer career pathways to support the continued development and sustainability of CLWs as a core professional group within primary care.

As the recent 2025 Scottish Government report *Socioeconomic inequality and barriers to primary care in Scotland* [22] noted

> *The location of primary care at the heart of the community presents valuable opportunities for intervention. Creating links between primary care and communities, for example through community link workers, can be a powerful tool to enhance health literacy, and to ensure that care delivery is rooted within lived experience. This approach should continue to be supported within primary care reform, to deliver on its aim of providing holistic and person-centred care for physical and mental health* [22.p34]

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