Final report

April 2018

Innovating for Improvement

Live Well Coaches in Primary Care

Royal Borough of Greenwich/Greenwich CCG

The Health Foundation

NHS Greenwich Clinical Commissioning Group

ROYAL borough of GREENWICH

About the project

Project title:

Live Well Coaches in Primary Care

Lead organisation:

Greenwich CCG

Partner organisation(s):

Royal Borough of Greenwich; Charlton Athletic Community Trust, GP practices in the Riverview Network

Project lead(s):

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Part 1: Abstract

Live Well Coaches (LWCs) use Motivational Interviewing (MI) techniques to support individuals to set goals and take actions to address health or social needs. A network of LWCs was established as a strand of Live Well Greenwich (LWG), a whole systems approach to improve health and reduce demand on health services through embedding prevention at individual, community and population levels.

This pilot developed: a network of seven LWCs across primary care practices trained in MI, social prescribing and the wider social and economic needs of patients; a new four day training course for LWCs developed with and accredited by the Royal Society for Public Health; a criteria for eligible patients based on 'frequent attendance; a quantitative and qualitative evaluation framework; and preliminary data.

Frequent attenders of primary care often have significant unmet, non-healthcare needs (eg financial pressures, housing issues, social isolation). These wider factors directly impact on health and wellbeing, leaving frequent attenders vulnerable to physical and mental health issues and inequalities. Yet the system is not in place to support them and address wider needs in the holistic way required. In addition, the health professional's role, with limited time and capacity to navigate local health, social and voluntary services are barriers to connecting these attenders to the information and support they may require.
Six months was insufficient to evaluate patient and system impacts, but early data are promising. Those of the eligible cohort successfully contacted to be invited to meet an LWC (26%), 75% booked a first appointment with 58% attending, an average of 2 appointments per client and 80% attendance across all appointments. Attendees were broadly representative of the eligible cohort.

Outcomes data is available for 156 clients, with all at least in the early stages of change and the majority (62%) at the action stage. Qualitative data from clients and GP practices was very positive.

Enablers were identified at institutional and individual levels.

This pilot enabled prevention and LWCs to be embedded within the local system, with further resources committed from system partners to continue the programme.

Part 2: Progress and outcomes

Live Well Greenwich (LWG) is more than social prescribing; it is about system-wide change to embed prevention at individual, community and population levels. The ambition for LWG is an integrated, borough-wide and scaled-up approach to prevention that unites the efforts of all. The service, delivered across primary care and community settings and aligned with a strategic focus on prevention at community and population level, is unique. Innovation is driven by its focus on frequent attenders in primary care, telephone triage and its whole systems approach.

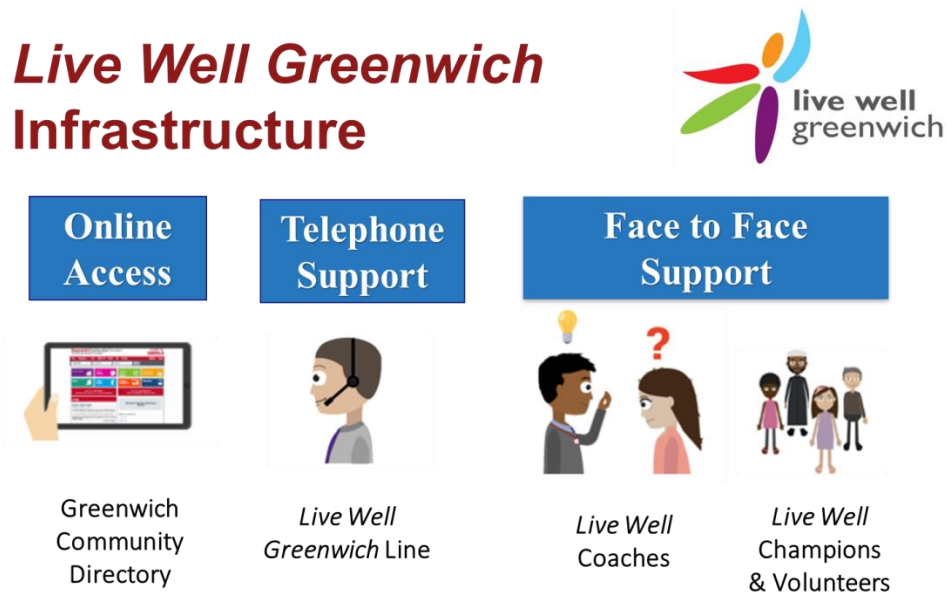
2.1 Live Well Greenwich approach

At an individual level, LWG operates at three levels (underpinned by Make Every Opportunity Count (MEOC) training for frontline staff and volunteers):

- universally available Greenwich Community Directory;
- universally available Live Well Line (1:1 telephone support services); and
- targeted 1:1 intensive Live Well Coach (LWC) intervention.

Health Foundation funding has supported the formative and process evaluation of a 'test and learn' pilot delivering Live Well Coaches (LWCs) in Primary Care, integrated with the broader LWG infrastructure in the 8-practice Riverview GP Network, one of four GP networks supporting a patient population of 71,944. Riverview Network was identified for the pilot because of the high levels of deprivation, historic community development activity in the area, and support from the GP Network for social prescribing. The *NHS GP Forward View* includes a focus on prevention as a core priority with a "*stronger focus on population health, prevention and supporting and mobilizing patients and communities"* including social prescribing[1]. This evaluation contributes to the evidence base for the role of social prescribing in the future of primary care.

[1] NHS England (2016) *General Practice Forward View*



2.2 Developing the infrastructure

What is a Live Well Coach

Health coaching, based on Motivational Interviewing techniques, supports people to set goals and take actions to address health or social needs. Key characteristics include: a focus on a person's goals rather than what professionals think they should do; empowering people to take ownership and responsibility for their health; and helping people plan and break down their goals into manageable steps. Our model is informed by the Rushika Model of Care[2], where a named person as part of a primary care team, can work with a patient to "do what it takes" to support access to health care or services that address social need and achieve behaviour change. Local insight has identified housing, financial concerns and social isolation as key patient issues.

Developing a local workforce

Seven existing Health Trainers were trained to become LWCs through a locally designed programme, focused on developing skills in social prescribing and the wider social and economic needs of clients. LWCs offer clients up to six 1:1 sessions and work with them to set goals for change to their lives, signposting into appropriate support (e.g. welfare benefits advice).

Building on this training, we have worked with the Royal Society for Public Heath (RSPH) to develop a four module course, covering the core role and specific skill set of a LWC including mental health awareness and motivational interviewing. Alongside a further two modules on the local prevention system and practising skills, this will be our training and development offer to 'grow' more LWCs and help deliver our ambition to mainstream the LWC service borough wide.

[2] http://www.iorahealth.com/model/

Building on our community development work we will develop our Live Well Champions (residents volunteers trained as community health promoters) to become LWCs. The first two cohorts of Champions are being trained. Following further validation by RSPH, our core four modules will be accredited and available nationally.

2.3 Establishing the evaluation framework

The evaluation has taken a mixed methodology approach to analyse the impact of the LWCs in primary care. The approach was based on our existing Public Health service evaluation framework and the social prescribing literature. Primary evaluation measures were changes in short form WEMWBS (Warwick-Edinburgh Mental Well Being Scale)[3] and outcome scores based on achieving goals set by the client with the LWC.

Primary data sources:

- Focus group with three LWCs based in primary care (20/03/18) to gather insight into the experience of working as an LWC; its challenges and benefits.
- Focus group with eight Live Well Line advisors based at Charlton Athletic Community Trust (26/03/18) to understand the service from the perspective of the first point of contact with the eligible cohort.
- Short survey of Riverview GPs via Survey Monkey in March 2018, four responses received, to understand levels of use and GP awareness of the service as well as opportunities for future development.
- Data extract from Live Well CRM (customer relationship management system) to understand and analyse outcomes data from the eligible cohort.

2.3 Identifying and inviting the cohort

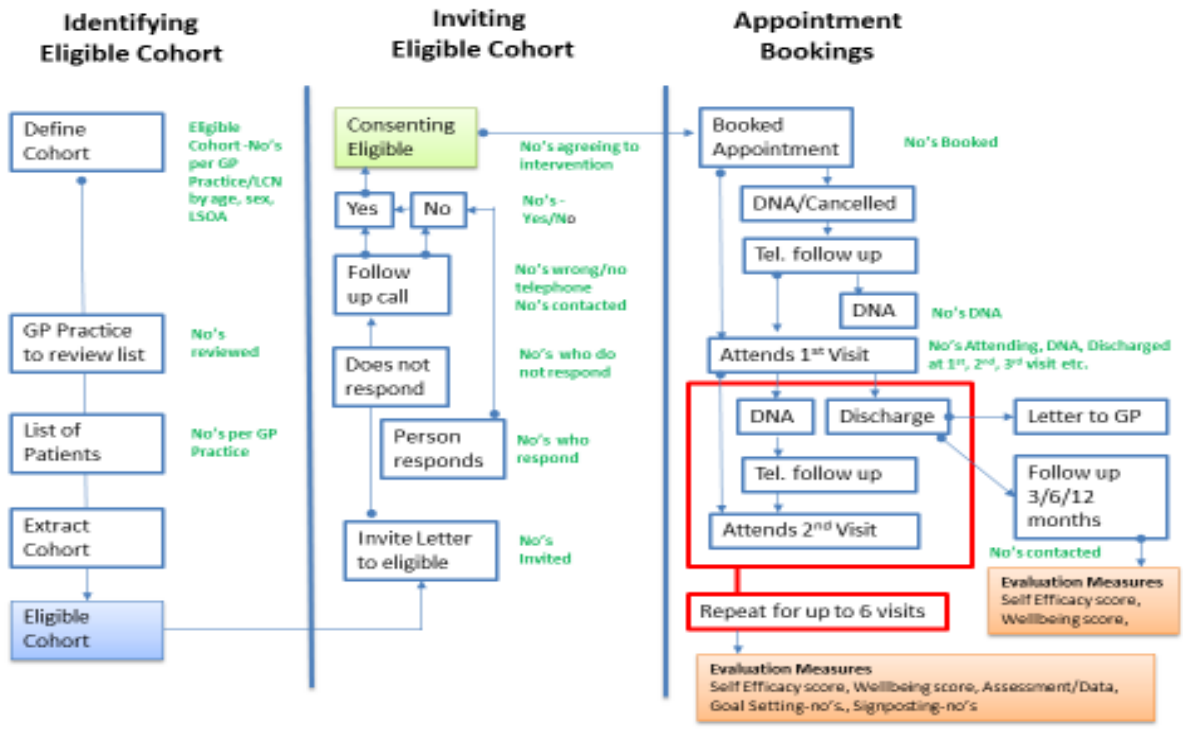
The cohort consisted of 2,748 GP frequent attenders identified from practice lists and flagged on GP records (12 or more GP appointments in previous 12 months with exclusions, e.g. end of life care, anti-coagulation). Rationale for cohort selection was local insight and evidence from elsewhere suggesting that patients attending most frequently may have unmet non-healthcare needs and that the benefits of social prescribing for this client group can be significant[4]. GPs wrote to patients advising

[3] https://warwick.ac.uk/fac/med/research/platform/wemwbs/

[4] Cawston, P 2011 Social Prescribing in very deprived areas. *British Journal of General Medical Practice,* 61:350 Smits FT et al, BMC Public Health, 2009 Jan 'Epidemiology of frequent attenders: a 3-year historic cohort study comparing attendance, morbidity and prescriptions of one- year and persistent frequent attenders'

them that a LWC service may be of benefit to them and followed up by telephone contact from CACT to offer a LWC appointment. GPs could also directly refer patients to the service.

Process for identifying Live Well clients



LWCs were based in eight Riverview Network practices. LWC sessions were offered on seven different days and times of the week. Each client was offered up to six sessions 1:1 for up to 45 minutes.

2.4 Results

The intervention phase reported is September 2017-March 2018 due to delays in project initiation including accessing cohort data. A total of 1076 appointments were delivered by the LWCs during the intervention phase with an average of 2 appointments per client.

Holt-Lunstad et al., 2010 (A systematic review finding the effects of social isolation to the health detriment comparable to the harm caused by smoking 15 cigarettes a day.)
Windle, K et al., 2011. Preventing Loneliness and Social Isolation; interventions and outcomes *Social Care Institute of Excellence*

2.4.1 Uptake

Of those successfully contacted by the Live Well Line (26% of cohort), 75% booked a first appointment and of those 58% attended their first appointment. DNA/cancellation rate across all appointments was 30%; further investigation is required to understand this figure. The opportunity to have 1:1 face to face support for up to 45 minutes was highly valued by clients.[5] We will do further investigation as to why only 725 were successfully contacted, this might be due to data quality issues or due to high numbers not answering the telephone when an unknown number called.

Total eligible cohort	2748 people
Successfully contacted by LWL	725
Took up appointment	511
Declined service	180[6]

Examples of client responses to the call reported by Live Well Line advisors:

'Thank God you called me' (cancer patient behind on bills)

'What can you do for me?'

'Can I keep your number and call you back' (many clients on phoning back found to have high levels of additional need)

'Feel they've been heard/been listened to – ask for the [advisor] name at the end of call'

(Focus group with Live Well Line)

2.4.2 Demographic summary

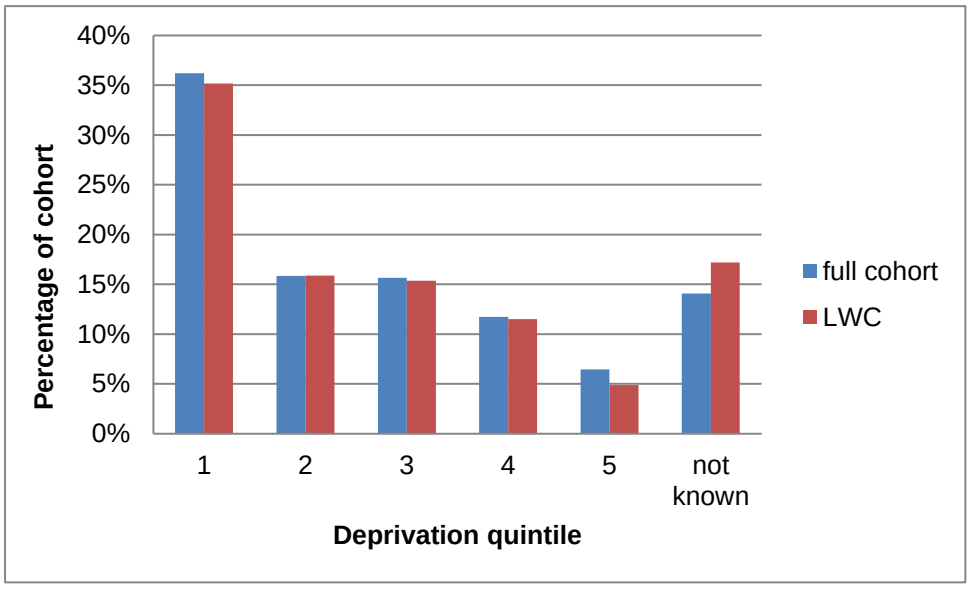
Comparing the demographic profile of clients taking up a LWC appointment and the eligible cohort suggests that the cohort is broadly representative.

	Demographic summary	**Full cohort**	**Had LWC appointment**
Gender	Female	69%	71%

[5] Focus groups coaches and LWL operators
[6] Primary reasons to decline the service – not interested (75%); Medical Reasons (6%)

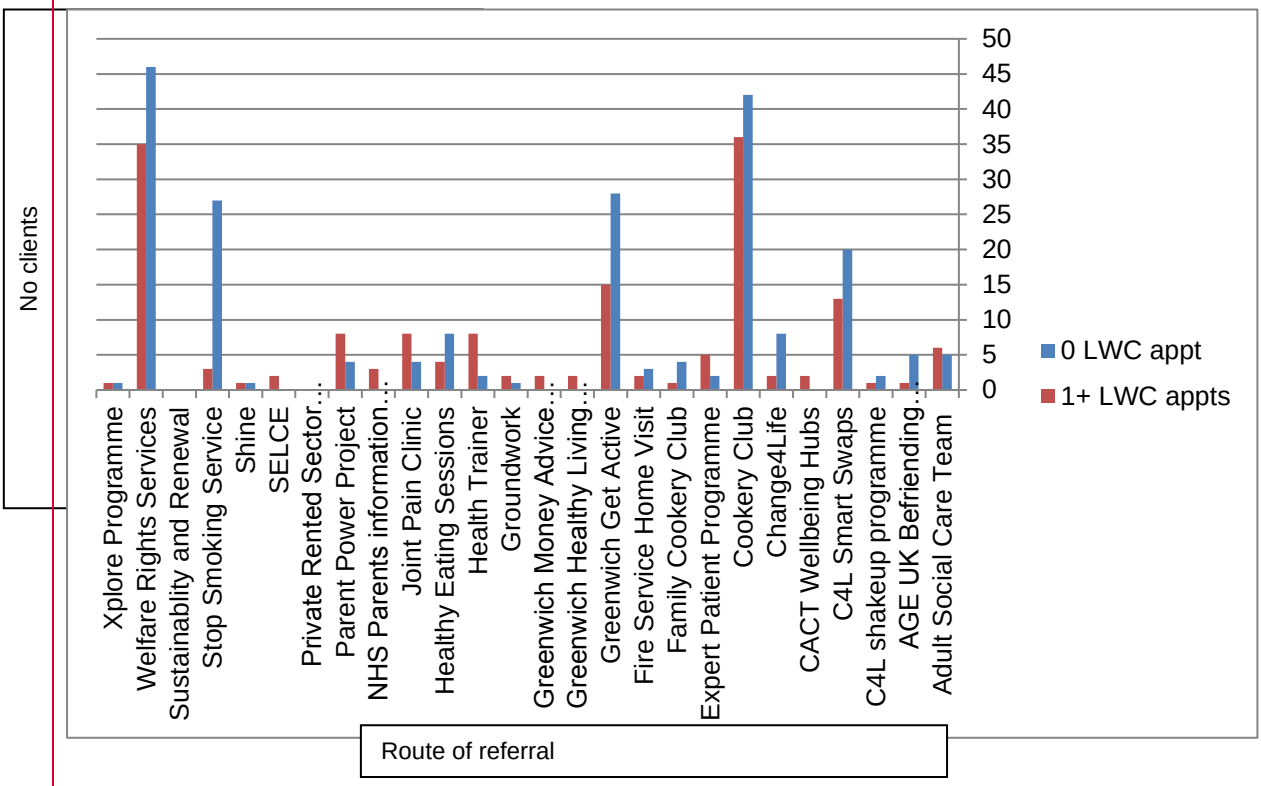
	Male	31%	29%
Age	<18	22 (1%)	0 (0%)
	18-40	712 (30%)	123 (24%)
	41-64	1085 (46%)	276 (54%)
	65+	555 (23%)	111 (20%)
Ethnicity	Asian or Asian British	10%	13%
	Black or Black British	15%	27%
	Chinese	0%	1%
	Declined	25%	14%
	Mixed	1%	2%
	Other	17%	8%
	White	31%	35%
Disability	Yes	91%	72%
	No	9%	28%
Smoker	Yes	98%	89%
	No	2%	11%
Housing status	Not known	88%	72%
	Other	1%	3%
	Owned outright	1%	4%
	Owned with mortgage	1%	3%
	Refused/don't know	2%	4%
	Rented from housing association/privately	5%	12%
	Rented from housing	2%	4%

Comparison of full cohort and LWC appointment group by deprivation



2.3.3 Referrals

376 referrals to services were made by the Live Well Line across the eligible cohort for 229 clients, an average of 1.6 per client (range of one to seven unique referrals). 213 (57%) referrals were made for clients who did not take up the opportunity of a LWC appointment, reflecting the value of both the LWCs and Live Well Line. Referrals were widely spread across services with the majority of referrals to Cookery Clubs, Greenwich Get Active, smoking cessation and Welfare Rights Service.

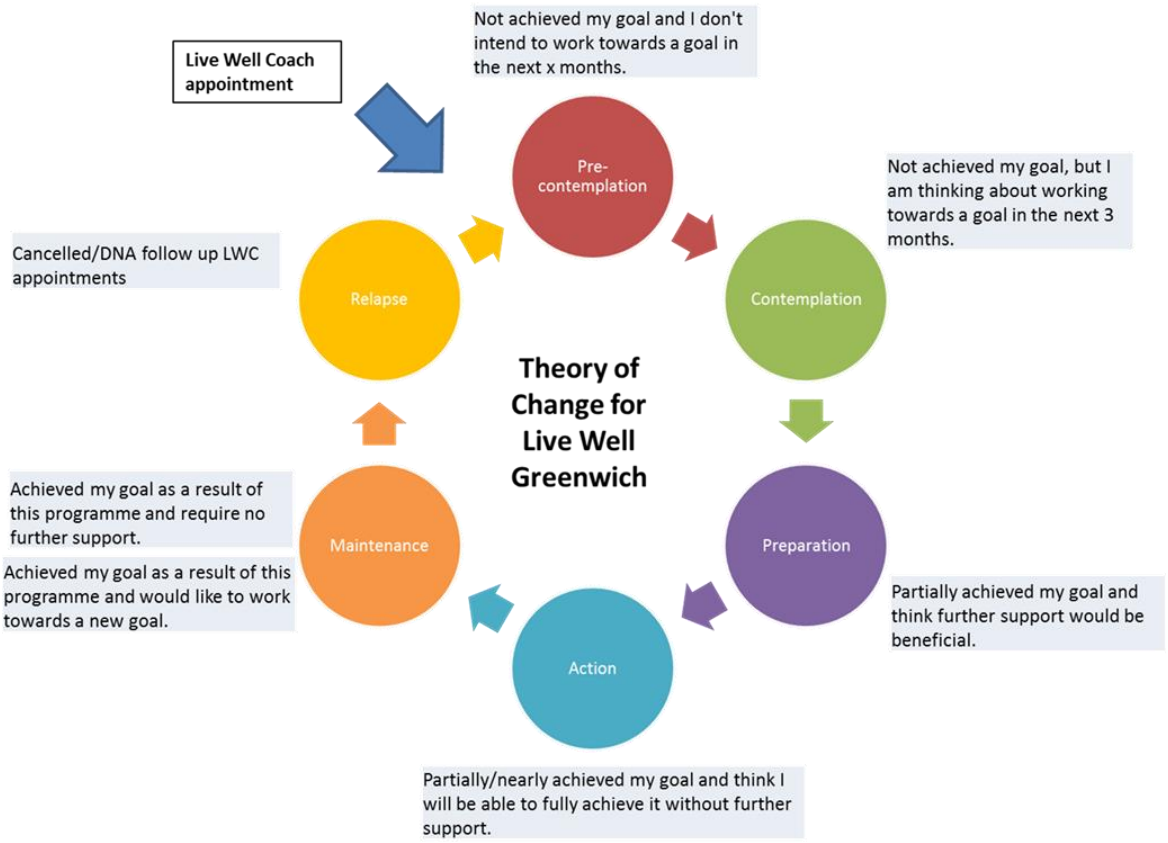


2.4.4 Outcomes data

Outcomes data is available for 156 clients. For the remaining clients who had at least one appointment, the lack of outcomes data is either because the client is still participating in the intervention, they did not attend follow up appointments, or is a reflection of early data collection issues. Average number of appointments per client is two. Further research will consider long term outcomes of the project including any change to GP attendances.

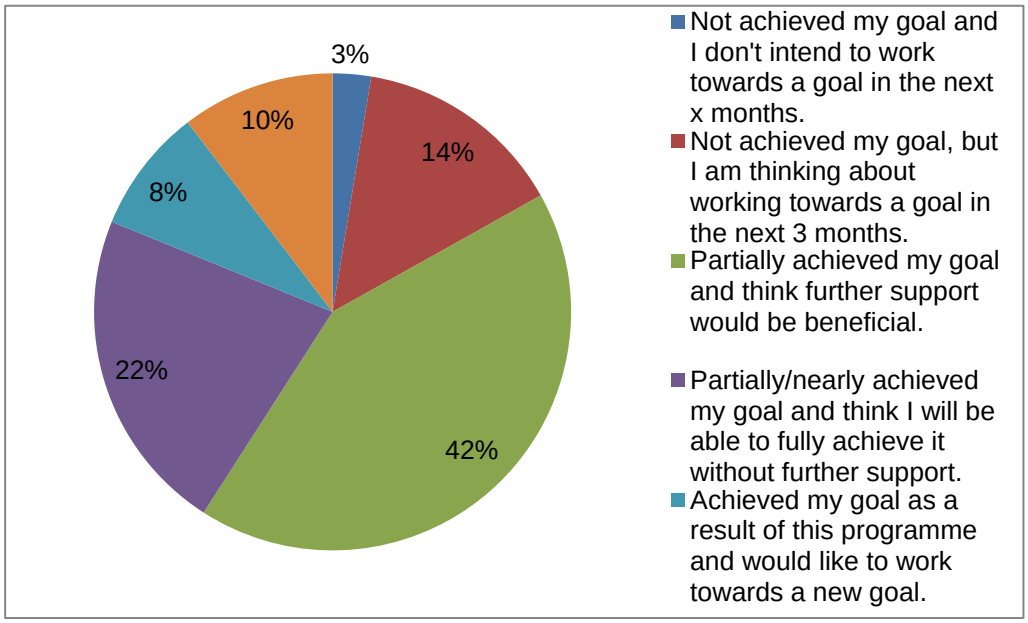
Outcomes data has been mapped to the change cycle for the programme.

Cycle of change for Live Well Greenwich



When client outcomes for the completed client group are considered we see that almost all clients are at least at the early stages of change and the majority are at 'action' stage, suggesting that the right client group is accessing the LWCs.

Summary of patient outcomes



When WEMWBS data is included, it suggests that change in WEMWBS is less likely where the goal has not been achieved. It is also likely that the WEMWSB is not sufficiently sensitive to demonstrate change over a short intervention phase and this will form part of future project development.

"Anne" is a 63 year old woman isolated in the community. Stated I am happy to join groups to feel less isolated, talks of resistance came through I asked if she would like me to take her to first session she replied yes, and I did. She now goes to Clockhouse [community centre] strong and steady exercise sessions as much as she can.

"Joanne" had rent arrears and other benefit issues. In four weeks we have been able to sort out free school meals for children, housing and council tax benefit sorted through phone calls and set task performed by Joanne. On week four she shed tears and told me I was "an angel sent to her". She has reduced anxiety and has taken up regular walking as exercise.

Part 3: Cost impact

3.1 Programme funding

The Heath Foundation funding supported: programme management; training for LWCs; development of the IT framework; and project communications, including the Live Well launch.

The supporting infrastructure (in particular the Live Well Line and the Greenwich Community Directory) and additional activity from the RBG Welfare Rights Service was funded through existing local authority resources.

3.2 Economic case

Economic modelling of the business case for borough-wide social prescribing suggested that every £1 spent on social prescribing in Greenwich would realise an average return on investment of £5.34 (95% confidence intervals: £3.35-£7.11). Economic evaluation of similar schemes elsewhere suggests a return on investment of between £2.90[7] and £4[8] for every pound invested. Greenwich Public Health team is committed to a Social Return on Investment (SROI) approach to project evaluation. The SROI of our Smoking Cessation services indicates a net return on investment of £7.64 for every £1 invested[9].

The current project is working with primary care to identify the impact on GP workload associated with the LWC intervention. This requires additional longitudinal data. Future data linking at 12 months will allow the project to explore the impact of the intervention on primary care usage. Anecdotally, GPs suggest the existence of the Live Well Service has given them a valid and timely alternative route for support.

Research[10] found that very frequent attenders (patients who continue to be long term frequent attenders beyond a year) have high levels of physical and mental ill health, consulted primary care five times as often as the norm, received five times as many prescriptions and are referred to hospitals five times as often. It concluded that if the average consulting rate could be reduced by just one consultation per year, it would represent an overall reduction of 1% in the GPs practice workload for this group. Local evidence suggests that a focus on frequent attenders in A&E can reduce attendances by 20% (1 in 5).

[7] Kimberlee, R (2016) *What is the value of Social Prescribing?*
[8] ibid
[9] Greenwich Public Health (2014) *Social Return on Investment – Smoking Cessation Services*
[10] An assessment of the attributes of frequent attenders to general practice, Heywood PL et al

The additional activity commissioned from RBG Welfare Rights Service has accessed over £700,000 of additional payments across 514 clients and this is likely to increase. WRS directly intervened in 308 cases to provide targeted support for clients less able to resolve problems by themselves.

Case study: Welfare Rights Service
The Live Well Line referred Mr and Mrs A to WRS. They are European nationals with a one-year-old baby, he works full time and she works part time. They had previously been told that they did not have any entitlement to benefit (it is unclear who told them this) possibly due to their nationality, due to their earnings, or both. The family were struggling to pay their rent and to meet basic living costs. WRS were able to advise them on their entitlement to tax credits and Housing Benefit and stayed in touch with the couple during the claims process – as a result of this advice the couple were better off by £105 per week.

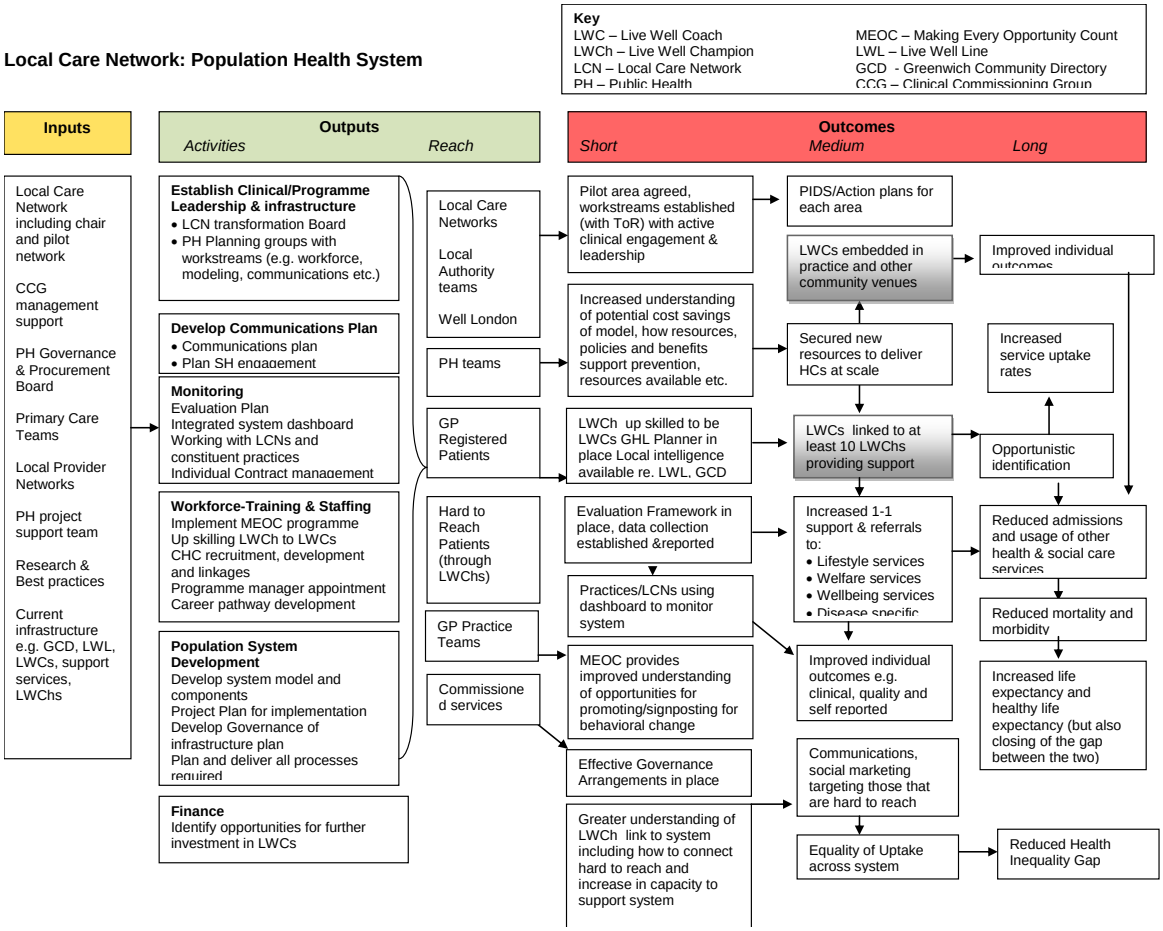
3.3 Future investment and future sustainability

Additional investment to expand social prescribing is currently being sought through a Voluntary and Community Sector led bid to the Department of Health and Social Care. RBG has secured CCG GP resilience funding for Care Navigation. This will enable us to develop and train and embed a new cohort of LWCs within primary care and in community settings. It is expected that the programme will become cost saving over time; however investment will be required to scale-up the programme. Economies of scale will be realised with a borough-wide programme and an explicit recognition of the benefits of having the tiered service model.

Part 4: Learning from your project

4.1 Logic Model

Reflecting on the last 18 months of the project delivery and on the logic model set out at the beginning of the process, we are confident that we have in place the key infrastructure to deliver the LWCs at scale. The time it takes to demonstrate change cannot be underestimated at system and indeed individual level. System change requires capabilities; opportunities and motivation all in place to make change.



It has proved challenging to demonstrate the impact of the project on patient outcomes during the funding period. We have needed to review and fine-tune the interventions during the course of the research; staff development has been key and has taken time.

The key elements for our overall approach are in now place:

- governance structures

- training programmes; and
- on-going service development including changes to the data collection methodology.

The pilot has not been operating long enough to enable individual and system impacts to be demonstrated in full, aligning with the evidence on social prescribing and behaviour change programmes. The intervention period of the pilot was only six months. Nonetheless, from qualitative feedback, LWG is firmly established as a key driver of prevention in the borough; the scope and opportunity for the programme to deliver is well recognised and the demand for LWCs across primary care and beyond is high. GPs report high awareness of the service and regular referrals/sign posts to LWG[11].

4.2 Key enablers

In order to establish a sustainable system and intervention the key enablers are:

Institutional

- CCG and RBG programme sponsorship and leadership
- RBG Public Health programme management; commissioner of core services; development and delivery of core training programmes
- Individual GP practices host LWCs; GPs a key referral source and their relationship with LWCs is critical
- A strong and ongoing relationship between primary care and public health has been critical as has the support of key GPs.
- Providers (notably CACT and Greenwich Health Ltd, the new GP Federation) commissioned to deliver the Live Well Line and new Live Well Hubs (having a comprehensive CRM system is essential to enable delivery
- Wider stakeholders – to deliver the wider Live Well agenda requires buy in from across the sector and communities, this was evidenced through the Live Well launch

[11] GP Survey March 2018

Individual

- Health Trainers trained to become LWCs – the LWC role has proved to be a challenging job and has required lots of new skills and knowledge and support. “you can’t help everyone”; “don’t take it personally”; “you could be the best thing that has happed to the person all week” (LWC focus group)

- Senior Public Health Manager, Long Term Conditions Coordinator/ Head of Live Well instrumental in getting the services of the ground.

- Live Well Line advisors who contacted clients to invite them to LWC appointments and who operated effectively as LWCs on the telephone; 57% of referrals were made for client who did not take up a LWC appointment, but the value of offering face to face appointments should not be underestimated.

4.3 Qualitative evidence

Response to the pilot from stakeholders has been positive, including surprise that this is not more widely available. As a project team, we feel that we have achieved more than we set out to, and the pilot has evolved significantly over the last year, exceeding expectations. The response from patients has been particularly satisfying.

Practice feedback has been very positive, with the timeliness of the programme during a period in which primary care is extremely stretched and the LWC service being able to relieve some of that pressure by providing support of wider economic and social issues that general practice has neither the time nor ability to deliver. Anecdotal feedback has confirmed the existence of social prescribing has enabled broader conversations between GPs with patients because there is a support route for non-clinical issues. The impact on future service delivery as the service is expanded across the borough is significant; and we will be seeking to identify the impact of LWG on NHS service use.

“Currently monthly (signpost to Live Well Line) but I would expect this to increase now I have more knowledge of what can be offered” (GP partner)

4.4 Challenges

As with any innovation there have been challenges to project delivery during the funding period. In particular:

- Significant time delays getting practice cohort lists defined, requiring additional resource from the PH team so reduced patient numbers seen within

pilot period.

- Underestimated the training and development needs of the Health Trainers into LWCs, and LWCs felt that the implementation required further support and training.

- Underestimated the expectation that patients had of the service and what is was able to achieve with them. The service is primarily focused on working with patients using MI approaches to help them to work towards goals to improve their health and wellbeing. Some patients expected that the LWC could sort out of all of their problems, and the LWCs could feel overwhelmed. With the ongoing programme, there is need for communications to be very clear about what the LWC can offer to a patient. Nonetheless, the LWCs felt that the majority of patients felt good about the service they received and this is reflected in the outcomes data. Some patients in conversation with the coach recognised their own health needs and took action themselves without further support. *"High proportion of clients leave feeling pleased with the session"* (LWC focus group)

- Systems to ensure that the data collection processes are correctly in place were essential and required significant and ongoing development work. There remains an issue of incomplete data.

- Initial set up of the model did not include appointments easily accessible for the working population; this was addressed through telephone support and including evening appointments at one site, and offering weekend appointments.

- Demand for the service was so high that it was expanded beyond the Riverview Network. A small community services delivered by CACT to meet demand from GPs. This meant more patient choice - not all wanted an appointment in their own GP surgery. Some patients were concerned about what and how the feedback to their GP might be, particularly where issues around employment and mental health were involved.

4.4 Sharing innovation

Our journey started years ago and LWG is a product of Public Health, CCG and other programmes coming together to build a systematic approach to prevention. To work across a local authority and a CCG, with primary care to deliver a complex innovation takes time and requires key enablers within the system, along with system infrastructure and core governance. It takes time to get the intervention work and the LWG model is constantly developing and adapting (on a plan, do, study, act approach). It has been important to capture the learning as the project develops. Complex problems often require complex solutions to address high levels of need;

LWG offers this through operating at individual, community and population levels; with service delivery at universal; targeted and person specific. We are still working to ensure that LWCs are embedded within practices, learning from the Rushika model.

Part 5: Sustainability and spread

Live Well Greenwich is the product of a number of Public Health developments across multiple work streams over a number of years. It puts prevention at the heart of all we do. Better co-ordination across all parts of the system will improve navigation, access and uptake of information, and will make best use of resources and services that are available to residents and communities. From a public perspective, this co-ordination is realised as our staff and volunteers within Greenwich organisations signpost residents to the one-stop shop resources. These resources represent a LWG gateway into information and support across a whole range of life issues known to impact on health and wellbeing, including debt and finance, work and training, housing, social isolation and healthy lifestyle changes. LWCs in primary care provide the top tier of this intervention working 1:1 with patients in greatest need.

During the pilot funding period, the Live Well brand and service has been established across Greenwich. The programme was launched at Charlton Athletic Football Club on 2/11/17 and attracted 80 stakeholders. The launch achieved the largest Twitter presence Public Health has experienced, and stakeholders left pledging to engage further with the programme. We had initially planned to deliver the pilot in one LCN, but demand has been such that we rolled out a community-based LWC service to the rest of the borough through CACT. For evaluation purposes, the pilot data has been kept separate but as the programme develops we will evaluate across all elements of the system.

We have worked with the RSPH to develop a new four module course which covers the core LWC role to train future cohorts of LWCs locally, but accredited for national use. The community engagement element of LWG is essential to maximise programme reach as well as ensure the programme is rooted in our local communities. The next cohort of LWCs, recruited from Live Well Champions, have just completed the first stage of their training which will contribute to meeting growing demand for LWCs within primary care.

Sustaining the project

The CCG remains committed to LWG and has committed £50,000 to extend and embed the LWC programme within primary care. This development will focus on primary care staff and will aim to train 90 people over the next 18 months on the RSPH four module programme. CACT and Metro GAVS are through to the final stage of bidding to the DoHSC to increase social prescribing local capacity.

This evaluation will inform the re-procurement of the Live Well Greenwich Line to secure the service for the next five years. Findings from this evaluation have demonstrated the core role of the line as well as the critical importance of ensuring that the right monitoring process and systems are in place from the outset. The new contract will be in place from April 2019.

In the course of the funding period, the LWG programme has been established within the borough and seen to address the prevention challenge. Prevention and Living Well have been identified by the CCG as key priorities for their Clinical Commissioning Strategy due to be published in September 2018. We will continue to embed LWG within the borough, as well as regionally as part of the Sustainability and Transformation Plan process. Nationally, we have or intend to submit a number of abstracts for conference presentations and Live Well was invited to provide information to inform the Mayor of London's Health Inequalities Strategy.

Future milestones:

LWG is one of the core Public Health department priorities. Key milestones include:

- Develop and embed a future cohort of LWCs across a range of community and primary care settings.
- Secure future funding arrangements, including fit for purpose re-commissioning
- Develop the Live Well programme infrastructure at scale
- Maximise the opportunities to engage local residents within Live Well through the community development programme.
- Embed the Live Well approach to prevention across the wider system