

GREATER MANCHESTER PUBLIC HEALTH NETWORK

DEVELOPING ASSET BASED APPROACHES  
TO PRIMARY CARE:  
Best Practice Guide

2016



# CONTENTS

1	INTRODUCTION
2	WHAT DO WE MEAN BY ASSET BASED?
5	CASE STUDIES
26	LESSONS FROM THE CASE STUDIES
28	HOW TO GET STARTED

# INTRODUCTION

The Greater Manchester devolution deal is an opportunity to re-envisage what health and wellbeing means - to rethink the role and relationship between public services and the communities and people they support.

We propose that a core part of this is an 'asset based' model of primary care. One that taps into the existing skills and resources in people and places to help people lead as independent and rich a life as possible. In doing so, reducing demand on primary and secondary health and care services.

This is a practical guide for getting started and growing asset based care at scale. It highlights examples of asset based approaches from both within Greater Manchester and beyond. Our research with commissioners, GPs, the community and voluntary sector, public health professionals, patients and the general population has helped us to better understand what it takes to make asset based primary care work in practice, and what it would take to adopt it, not just in isolated pockets but across a whole neighbourhood, system or region.

This guide is designed for primary care professionals in Greater Manchester. It details the background to asset based care, 10 case studies and recommendations for how to develop an asset-based primary care in a locality.



Innovation Unit  
[www.innovationunit.org](http://www.innovationunit.org)



Greater Manchester  
[www.gmphnetwork.org.uk](http://www.gmphnetwork.org.uk)

# WHAT DO WE MEAN BY ASSET BASED?

## What do we mean by assets?

Assets are the strengths that naturally exist in people and places. It may be someone who is passionate about gardening, a local reading group, a good neighbour or an unused building. They can be broadly grouped into:

- Personal assets e.g. the knowledge, skills, talents and aspirations of individuals.
- Social assets e.g. relationships and connections that people have with their friends, family and peers.
- Community assets e.g. voluntary sector organisations (VSO) associations, clubs and community groups.
- Neighbourhood assets e.g. physical places and buildings that contribute to health and wellbeing such as parks, libraries and leisure centres.

## What do we mean by asset based approaches?

Asset based approaches mobilise these assets to improve health and wellbeing and reduce pressure on services. They support people to lead the lives they want to lead; help people help themselves and mobilise the community. Asset based care is both a philosophy of how you provide care and a tangible set of interventions and approaches. It does not remove the need for high quality clinical care or health and social care professionals but identifies opportunities for people to help themselves and each other which ultimately reduces pressure on statutory health and social care services.

These can be broadly defined into five categories:

1. Holding asset based conversations with patients e.g. understanding motivations, care planning, coaching and shared decision making.
2. Connecting individuals to community assets e.g. peer support, social prescribing and link workers.
3. Mapping and growing community assets e.g. asset mapping, directories of community assets and seed funding for VSOs.
4. Mobilising place-based assets e.g. local neighbourhood networks.
5. Working with communities to develop local provision e.g. codesign and collaborative commissioning.

### Asset based conversations

All asset based approaches to primary care start with asset based conversations with patients. These conversations re-define the relationship between the primary care system and the public. They set expectations of staff and of patients and they shape behaviour. They help patients identify their own skills, strengths and agency, as well as the assets in their own family and community.

These asset based conversations can start with a patient's goals and aspirations and lead to a discussion about what needs to change, what the patient is able to do, and what the healthcare profession is able to do. There is a strong focus on outcomes, and on the agency of the patient.

These asset based conversations could be with any number of health care professionals: a GP, pharmacist, optometrist, dentist, practice nurse, healthcare assistant or therapist. However, these asset based conversations could equally be with non-clinical members of the primary care team, such as health trainers or link workers. These roles are important in the second step in asset based care: connecting individuals to community assets.

### Connecting individuals to community assets

There are a plethora of names given to people whose job it is to help connect individuals to community assets: health trainers, health navigators, community link workers, peer supporters, volunteers. One important part of their role is to understand the motivations and aspirations of the individual and produce a plan to them with the most suitable community assets. These could be an exercise group, a cooking and nutrition class, an arts and crafts club, the citizens advice bureau or a child minding circle. The options are limitless.

### Mapping and growing community assets

For these connections to work well, people in these roles have to be rooted in the local community, with strong networks and relationships and have access to some systematic map or directory of local assets. Moreover, there has to be some intentional investment in a thriving community and voluntary sector, which is normally achieved through effective infrastructure organisations, and access to small grant funding.

### Co-ordinating and mobilising assets in a place

Thriving community assets don't just rely on small grants for survival. They are part of a supportive network of public and private place-based assets, by which we mean: employers, shops, pubs, businesses; libraries, schools, day centres, village halls, bus services, social housing and parks to name a few. A place based approach provides spaces to meet, raises public awareness and promotes wellbeing across the whole community. It optimises all the assets and resources locally.

### Working with communities to develop local provision

Finally, the knowledge and the energy of patients, carers and the community are important assets in the design and delivery of local provision. Local people can play a role in the co-design, co-commissioning, co-delivery and co-evaluation of provision on behalf of other patients and future generations. Although this is many steps removed from the initial asset based conversations, our experience shows that when you involve people in developing local provision, the services and organisations are more closely connected with the needs and assets of the community and means they are shaped, led and owned by the local people.

## ABOUT ASSET BASED CARE

This definition of asset based primary care raises a number of questions for localities to consider:

- In our local population, which groups of patients would benefit most from an asset based approach to their care?
- Which patients should systematically take part in asset based conversations, and at what point on their care journey should these conversations happen?
- Which members of staff should be trained in asset based conversations and be responsible for holding these conversations with patients?
- Who is best placed to connect patients to local community assets? And who will provide them with the information to do this well?
- How are we ensuring we have a thriving set of community assets to connect people to?
- And how are we coordinating the public, private and community assets place by place?
- Finally, as our patients and community are our greatest asset, how are we involving them in the design and commissioning of future provision?

We explore some of the answers to these questions through case studies from across Greater Manchester and beyond.

## CASE STUDIES

The 10 case studies contained in this report were selected from a list of over 70 examples compiled from interviews with primary care professionals in Greater Manchester, experts in asset based care and online desk research. Our selection criteria was that case studies needed to: be part of a primary care system, have evidence of better outcomes for patients and take an asset based approach. We deliberately selected examples from Greater Manchester, the UK and around the world.

## MAKING CITIES WORK FOR THE OLDER POPULATION

### Age Friendly Manchester

Loneliness and social isolation in old age have a significant impact on health. Age Friendly Manchester is a multi-pronged approach that started over a decade ago to reduce barriers to participation for older people in civic, cultural, and everyday life. It is not a traditional top down change programme – they aim to seed change across the city and grow a social movement to create an Age Friendly City. The Age Friendly Manchester Board, which provides a critical ear to help drive the programme, is made up of older people from across Manchester, supported by council officers and three elected members. Its role is to make sure older people are taken into account in every policy decision.

The programme supports and seeds a number of initiatives designed to improve life for older people in Manchester. For example: working with arts and cultural organisations to run a 'culture champion' scheme alongside 80 older volunteers; supporting 10 neighbourhood networks and 15 Age-Friendly ambassadors; funding local initiatives with micro-grants; and is beginning work to develop the UK's first age-friendly hospital. The programme receives £50,000 budget from Manchester City Council annually and has been able to raise over £6.5 million additional funding through partnerships with leading research institutions including Age UK, University of Manchester, Manchester Metropolitan University and the World Health Organisation.

It can be a challenge to maintain the ongoing involvement of statutory services in the Age Friendly Manchester programme. When healthcare professionals have attended neighbourhood networking events they have been enthused about the potential of these community organisations. However, they have often not been able to continue their involvement. Where community organisations have found a practice manager who was able to champion their initiatives, these relationships have often been critical to building links with primary care providers.

“Taking older people into account in every policy we make.”

#### MODEL

A whole city approach to making the city Age Friendly. Age-Friendly Manchester is led by the programme team, part of Public Health Manchester.

#### WHO

Age-Friendly Manchester is led by the programme team, part of Public Health Manchester. The Board was established to oversee and provide a critical ear to our work and give a voice for older people in the city. Funding is received by the programme team and invested in the facilitation of the Board.

#### FOR

510,770+ older citizens across Manchester

#### FUNDING

£50,000 annually from Manchester Council and additional grant and research funding through partnerships and networks (£6.5 million to date).

#### IMPACT

Individual programmes such as the 'culture champions' have been independently evaluated, the approach as a whole is delivered in close working with the Manchester Institute for Collaborative Research on Ageing (MICRA).

#### What makes it work at scale?:

Global mandate and research partnerships: Age-Friendly Manchester is part of a network of 258 Age-Friendly cities worldwide and is the first UK city to be certified as 'Age-Friendly'. Engaging with global policy and research enables them to attract funding and committed partner

Citizen led: the board and local networks are led by older citizens who are actively supported to improve their communities from the bottom-up.

Positive: the aim is to start with what makes people happy and to inspire people to connect and do more (as opposed to a deficit approach which sees older people as a problem to solve).

#### Impact:

First UK city certified 'Age-Friendly' in 2010

Wide range of growing age-friendly community led networks and projects

80 volunteer 'culture champions' helped 168g older people access more arts and cultural events

Over 80% of 'culture champions' say their role has made them feel more confident, and more connected

#### Mini-story:

The North West Nomads were born out of one of the neighbourhood networks. A member of the community, also an Age-Friendly Manchester Board member, wanted a practical solution for tackling isolation and decided to try organising a day out. The group evolved from there. There are now over 430 members and they organise regular trips for older people to local cities, markets and the countryside. All of this is paid for by the members who contribute a small amount for activities.

#### Useful resources:

- Age-Friendly Manchester website: [www.manchester.gov.uk/olderpeople](http://www.manchester.gov.uk/olderpeople)
- [www.manchesterculturalpartnership.org/wp-content/files\\_mf/vopculturechampionsevaluation.pdf](http://www.manchesterculturalpartnership.org/wp-content/files_mf/vopculturechampionsevaluation.pdf)
- Age Friendly handbook for socially engaged practioners: [www.cpa.org.uk/cpa-lga-evidence/Manchester-Age\\_Friendly\\_](http://www.cpa.org.uk/cpa-lga-evidence/Manchester-Age_Friendly_)
- [Neighbourhoods/Handler\(2014\)-An\\_Alternative\\_Age-Friendly\\_Handbook-Large\\_print\\_version.pdf](http://Neighbourhoods/Handler(2014)-An_Alternative_Age-Friendly_Handbook-Large_print_version.pdf)



## Being Well Salford

(Greater Manchester)

Being Well, run by social enterprise the 'Big Life Group', offers one-to-one health coaching. Unlike other local services, such as Health Trainers, the Being Well service does not have strict referral criteria and can work with people for up to a year and across multiple health behaviour issues. Patients often come to them with complex web of life challenges which need to be tackled before they can think of starting to improve their physical health: from alcohol consumption to low self-confidence or housing issues. Clients are taught tools and techniques to keep themselves motivated, which they can also use to support friends and family. There is emerging evidence that the programme increases self-efficacy over time. For example, 43% of patients had reduced their alcohol intake at the end of their programme and this increased to 79% a year on, showing that patients felt empowered to sustain healthy behaviour.

**"It isn't that we make problems go away. But people learn to deal with them better, to be more resilient."**

21 Being Well coaches were recruited based on their values and beliefs rather than a specific skill sets. The recruitment process included making a video and tasks that tested their interpersonal skills. They trained for 12 months, including 8 weeks training in motivational interviewing at the University of Salford, and receive ongoing mentoring. Beyond case-work, their role also includes building relationships with local organisations from the health, statutory and voluntary and community sectors. Being Well provides volunteering opportunities and apprenticeships as part of their ongoing commitment to creating employment and training opportunities for the local population.

Their relationship with primary care is variable. One of the partners in Being Well is Salford Matters, a social enterprise which includes a GP practice, and many of their coaches are based in GP surgeries. However, they have found it generally difficult to engage GPs and other primary care professionals. GPs can find the landscape of public health services confusing – especially as some of the services overlap. They have found that smaller GP practices without locums are easier to engage and that talking directly to GPs and nurses is often more effective than going through practice managers.

The service has been commissioned until April 2017 and they are working with commissioners to explore how they might calculate and demonstrate value for money.

### MODEL

Health coaches working with patients who want to improve their health. 21 coaches, each looking after 120 patients per year.

### WHO

Being Well is managed by Big Life Centres who employ 21 coaches, 10 volunteers, 1 apprentice, 2 team coaches, 2 administrators, 1 volunteer coordinator and a service manager.

### FOR

No strict referral criteria - anyone in Salford who wants to address unhealthy behaviours and change their lives for the better can use the service.

### FUNDING

Commissioned by Salford City Council to support 1500 people a year.

### What makes it work at scale?:

Locally grounded: Being Well is delivered through a partnership of 8 local organisations (Langworthy Cornerstone, Salford Community Leisure, Salford Health Matters, Salford Unemployed and Community Resource Centre, Social adVentures, Unlimited Potential, YMCA, People's Voice Media). 73% of staff live in Salford and together they have a deep knowledge of the area's resources and population.

Cross-issue, client-led support: Clients are put in control of their journey towards a better life. This leads to better outcomes over the long-term as people feel genuinely invested in the process and gain confidence that they can solve their own problems.

### Impact:

1560 referrals from 87 different agencies in 2014.

Uncommonly for this type of service, 45% of clients are men, and there are a fair number of men-specific peer-support groups to keep them engaged.

A year on, 100% of those who had stopped smoking had not started again, 79% had continued to reduce their alcohol intake, and 64% continued to lose weight after they left the service.

### Mini-story:

"I felt listened to, and no other service has ever fulfilled this for me. You helped me identify the reasons behind my actions and why I felt fed up and low. I now feel more positive about my ability to do things and I am thankful that I have done this." Participant

### Useful resources:

Website: [www.beingwellsalford.com](http://www.beingwellsalford.com)

Annual report: [www.thebiglifegroup.com/wp-content/uploads/2014/12/Being-Well-Salford-annual-report-final-2.pdf](http://www.thebiglifegroup.com/wp-content/uploads/2014/12/Being-Well-Salford-annual-report-final-2.pdf)

## Bromley-by-Bow Centre

(London)

The Bromley by Bow Centre (BBBC) is healthy living centre owned and led by the local community, one of the most deprived in Britain. It grew out of a social regeneration project in 1984, led by the founder who spent months 'loitering with intent' to understand the community. It has evolved alongside the passions and needs of the community; initially establishing a community café, arts and dance spaces, a nursery. Through the next decade the Centre grew substantially building a comprehensive range of community services.

In 1997, the community saw the need for better medical services, so developed a Healthy Living Centre, building and integrating the first community owned health centre in Britain and finding a group of like-minded GPs. The Centre is driven by strong values: compassion, friendliness, and 'assume it's possible'. Emphasising values has both ensured continuity and allowed BBBC to evolve and change - a local person may see different professionals but they will receive the same response and experience. The space and design of the building and surrounding park also reinforce the values and community ownership - there are no NHS signs and local artwork is displayed throughout the centre.

"Everyone has something to contribute: services, staff, users. Everybody's treated the same."

The charity aspect of the centre's funding allows for free and organic development of community-led initiatives, with only 27% going towards medical activities. These include: art and gardening groups; award-winning holistic life-planning services for adults with learning disabilities; various preventative programmes; debt, benefit and legal advice; help into work and entrepreneurship support; and park, café and exhibition spaces. Embedded in the centre is a social prescribing service that is referred to by the centre's GPs and five other neighbouring practices. 700 referrals were handled in the past year, many making use of other resources at the centre. BBBC have also incubated over 60 local social enterprises.

BBBC has developed over many years alongside the community and has been built on relationships and shared culture, rather than rigid structures or protocols. BBBC does employ a few methods to reinforce their vision. For example, Trustees of the charity include local champions and most of the employees live in the area and have used the services. Staff working at BBBC share their kitchen and cafe with the community and attend regular Ideas Labs to develop new ideas for the centre. CommuniTea workshops are run regularly with the community to evolve and respond to the local population.

### MODEL

Healthy Living Centre based in BBBC (including one onsite GP practice). Social prescribing link workers connect with the Centre's activities (work support, art, cooking, gardening, adult learning disability and mental health life planning, entrepreneurship support etc) as well as to over 40 other organisations.

### WHO

BBBC: 150 staff. Health Centre: 22 staff.

### FOR

2000 people a month with 7000 registered patients. 700 social prescribing referrals handled a year with 6 GP practices referring for social prescribing.

### FUNDING

BBBC receives statutory, trust and corporate funding. The Health Centre has an Alternative Provider Medical Services (APMS) NHS contract. Social Prescribing - half funded by the CCG, half by the Primary Care Network of Participating Practices.

### What makes it work at scale?:

Service integration built through human relationships: co-location works here because all services buy into the vision, and people know and trust each other across the centre. For example, all staff and users share the same cafe.

Demand-led service development: any staff or user can propose and be supported to develop new services for local people. This enables the BBBC to stay relevant to evolving population needs and wants.

### Impact:

700 social prescribing referrals a year from 6 GP practices (including BBBC) to over 40 organisations

95% of health professional respondents surveyed report they see a benefit to their patients following social prescription including: increased WEMWBS scores; improved confidence and autonomy; improved access to services from socially isolated people and those with mental health problems; and decreasing repeat GP visits.

### Mini-story:

"Thanks to the Bromley by Bow Centre, I've been having a great time getting fit. I'm learning lots about nutrition and the exercise is helping my arthritis. I never thought I'd be taking Zumba classes at 63." Janet Hajithemistou – weight management programme participant

### Resources:

Bromley by Bow website: <http://www.bbbc.org.uk/>

BBBC also offer tours and social prescribing seminars which can be booked via: <http://www.bbbc.org.uk/book-a-tour>

# USING DIGITAL TECHNOLOGY TO CREATE SUSTAINABLE SUPPORT NETWORKS FOR ISOLATED PEOPLE BASED AROUND THEIR INTERESTS AND PASSIONS

## Connect and Do

(London, UK)

The nature of mental health can mean that services are heavily focused on patient safety and risk management; and can foster dependency on services. Lambeth Council in London worked with Certitude, a London-based learning disability and mental health charity, to design a service that would reconnect isolated patients to the communities in which they live. They co-designed a new service called Connect & Do with patients and staff.

Connect and Do is an online platform which allows users (introduced by services or self-registered) to get recommendations of local courses and activities that they can do based on their interests. Trained volunteer Community Connectors provide 12 weeks coaching to help patients overcome social fears and form sustainable relationships around these interests. Originally, Connect and Do was designed like a personalised directory, but it was relaunched last year as a fully-fledged social networking site, where members can interact with each other, comment, talk, and host personal blogs.

"The last thing we wanted was to exacerbate the stigma around mental illness by segregating people into their own 'club', so the platform is open to anybody."

The service did have early teething problems in the pilot, for example, there was initially concern amongst staff and volunteers that more vulnerable patients were not suitable for support from Community Connectors and were therefore hesitant to refer into the programme. For this reason, some staff felt resistant to refer people into the programme. The initial cohort of volunteers also needed extensive support which required a large amount of resources.

Importantly, Connect and Do is open to anyone, and lists all types of mainstream activities, from choirs and football to reading groups at the local library. Certitude has recently introduced the service to six more London boroughs and it now operates across Lambeth, Brent, Bromley, Ealing, Hounslow, Lewisham and Southwark.

### MODEL

An online and offline peer support and community connecting service run by the charity Certitude

### WHO

Certitude employs paid Connect and Do platform managers in each of the boroughs, and recruits volunteer Community Connectors who are trained to coach others to overcome barriers to full social participation.

### FOR

Anyone living in the boroughs of Lambeth, Brent, Bromley, Ealing, Hounslow, Lewisham and Southwark. It is particularly aimed at patients who are socially isolated or have mental health problems.

### What makes it work at scale?:

User-created content: the online platform lets users add activities and create groups themselves, so activities stay relevant to the user base and the platform grows organically.

Powered by peers: now the online platform is built, it only needs proactive Connect and Do managers to get it going in new places by training local volunteer Community Connectors and recruiting new users.

Builds patients' digital skills: not everyone is familiar or comfortable with online technology, so Connect and Do runs monthly courses to help patients make the most of the online platform.

### Impact:

An evaluation of the initial pilot in Lambeth found that 142 people used the service during its first three months, of these 52 were actively engaged. The results of this initial evaluation found that:

80% felt more supported

87% were more independent

73% felt they could better deal with crisis

Users' average validated WEMWEBS scores increased from 17.4 to 23.6.

### Mini-story:

"Working with the Community Connectors Team was like getting back on a bike after a long time. By being outdoors with my coach, walking and talking, I felt as though I was reacclimatising [.] I was so happy to be able to achieve my year-long goal of attending the gym independently, with just the support of a telephone call." User

### Resources:

Summary leaflet: [http://lambethcollaborative.org.uk/wp-content/uploads/2014/09/Community-Connecting-through-Connect-Do-brochure\\_final\\_for-sign-off-1-1.pdf](http://lambethcollaborative.org.uk/wp-content/uploads/2014/09/Community-Connecting-through-Connect-Do-brochure_final_for-sign-off-1-1.pdf)

Website: <http://www.connectanddo.org/>



# TRAINING HEALTHCARE STAFF TO SUPPORT PATIENT BEHAVIOUR CHANGE

## Health Coaching for behaviour change

(East of England)

Patients with long-term conditions account for 50% of all GP appointments and 70% of overall NHS spend. 50% of patients leave primary care not understanding what the doctor told them, and only half of patients take their prescribed medications as recommended [1]. Health Coaching tackles these problems head on, by giving clinicians new skills and techniques in behaviour change, shifting mind-sets and enabling them to have conversations with their patients that are empowering and shared. This means that patients with long term conditions become better able to manage their own health and care, adopt healthy behaviours and improve their quality of life. This in turn reduces the number of visits, improves compliance with treatment, and thus cuts costs and waste in the NHS.

The training was first developed and piloted by Drs Newman and McDowell in 2010 with practice nurses. In 2013, two day training programmes were commissioned by Health Education East of England for nearly 800 clinicians (doctors, nurses and allied professionals) in 45 acute, mental health primary care and community settings. The two day training costs ~ £400 per participant. Health coach training gives staff simple tools and techniques that can be used during 10 minute appointments to listen, build rapport, challenge and motivate patients. This helps patients to maintain positive health behaviour changes to meet their self-determined goals. Following the training, clinicians are able to use these skills in leadership roles, and some go

onto become trainers themselves (through a 10 day accredited training) and to champion and train in their own organisations.

*"We're trained to be fixers but actually a lot of the time now you can't fix it. You want to support people to fix themselves"*

Dr Penny Newman, founder

It has been particularly hard to engage clinicians working in general practice as professionals have less time for training. The training works best with multidisciplinary teams as certain professions, such as nurses and allied health professionals, are particularly receptive to learn from each other, and relationships are built across organisational boundaries. It is also important that the training is linked into, and aligns with, other initiatives for people with long term conditions and that there is a culture of innovation and learning within the organisation.

Health Coaching has been selected as part of the NHS Innovation Accelerator, a fellowship programme that aims to deliver on the commitment detailed within the Five Year Forward View, to scale innovations of proven benefit. As part of this programme, Dr Newman and others are building a social movement for health coaching and developing a set of resources that will make it easy for organisations to adopt health coaching across a range of applications.

ACHIEVING EFFICIENCY  
SAVING TIME AND MONEY



ACHIEVING SCALE  
SYSTEM WIDE IMPLEMENTATION



### MODEL

Health Coaching training to change the types of conversation held between healthcare professionals and patients. Train the trainer model: 8 day programme for clinicians championing the practice from within their organisation, or to a range of organisation in their area.

### WHO

Training developed by Health Education East of England (HEEoE).

### FOR

A range of patients across settings - particularly those with long term conditions.

### FUNDING

Costs £400 per participant for the two day training, funded by Health Education East of England.

### What makes it work at scale?:

**Train the trainer model:** The programme is designed to build a self-sustaining culture of health coaching, with a further 8 day training programme available to clinicians championing the practice.

**Culture change in health settings:** Coaching enables clinicians to have more empowering conversations, not only with patients but also with colleagues i.e. through appraisals. Trainers also become champions for this approach and catalysts in their own organisation for culture change.

### Impact:

800 clinicians in 31 organisations trained to date.

72% of patients report measurable benefits to their patients.

A pre and post evaluation found a 63% indicative cost saving from reduced clinical time, giving a potential annual saving of £12,438 per full time physiotherapist. When implemented on an acute rehabilitation ward in Wessex, savings of ~£5,000 were achieved per patient.

### Mini-story:

"I have a patient with COPD who smokes. Usually I would say "you really should stop smoking". This time I asked "what do you think would make your chest better" and the patient immediately identified stopping smoking. She set the goal to stop realistically after her birthday in 2 weeks' time, looked at her options and decided to go to a level 3 group as she wants to go to a class. She will see me a week after the class for coaching. She is delighted and so am I as the idea came from her not me." Practice Nurse / Respiratory Nurse

### Resources:

[1] Summary of health coaching: [https://eoeleadership.hee.nhs.uk/Find\\_out\\_more\\_about\\_health\\_coaching](https://eoeleadership.hee.nhs.uk/Find_out_more_about_health_coaching)

East of England leadership resources:

<https://eoeleadership.hee.nhs.uk/healthcoaching>

<https://eoeleadership.hee.nhs.uk/sites/default/files/Does%20health%20coaching%20work%20-%20summary.pdf> does health coaching work? lit review

[https://eoeleadership.hee.nhs.uk/sites/default/files/1404813191\\_LmkH\\_health\\_coaching\\_interim\\_progress\\_report.pdf](https://eoeleadership.hee.nhs.uk/sites/default/files/1404813191_LmkH_health_coaching_interim_progress_report.pdf)

[https://eoeleadership.hee.nhs.uk/Evaluation\\_evaluation\\_HEEC](https://eoeleadership.hee.nhs.uk/Evaluation_evaluation_HEEC)

# PROMOTING SELF MANAGEMENT THROUGH PHONE BASED HEALTH COACHING

## Proactive Health Coaching

(Sweden and the UK)

Approximately 1% of the population accounts for 35% of unplanned admissions to hospital, these trips can be distressing for the patient, costly for the NHS and many can be prevented[1]. Faced with this challenge in Sweden, Health Navigator developed a model of support which taps into the assets that patients and their families have – Proactive Health Coaching (PHC). This service aims to improve the quality of life for people with long term conditions, promote self-management and build up patients' confidence and skills. In doing so, it has dramatically reduced unplanned admissions in Sweden. The service runs across 17 hospitals and 450 primary care centres across Sweden, providing coaching for over 30,000 people. Recently, PHC, has expanded to their first site within the UK with the Vale of York CCG and the evaluation being supported by the Nuffield Trust.

The model of health coaching is phone-based, delivered by nurses and is made up of three main stages – invitation to the programme, coaching and on-going monitoring. Patients who are suitable for the programme and at high risk of an unplanned admission are identified through algorithms which analyse population level data. Once invited to the programme, the patient and health coach meet in person to develop a tailored plan and a set of goals. The intensive coaching is then provided over the phone giving patients advice about their condition, building their confidence to self-manage and helping them to draw on their personal strengths and resources around them. To continuously improve the care and monitor the impact of the service, on-going iterative feedback to the nurse coaches is central to the service. On a weekly basis, health coaches are provided with feedback to help them improve their skills.

Rather than replacing clinical care and requiring significant organisational changes to primary and secondary care services, the model of coaching sits alongside and complements existing pathways and care. The health coaches' link directly to primary care, keeping GPs informed of the progress and plan of the patients. This information helps GPs keep track of potential risks and develop an informed plan to prevent deterioration. By helping patients to self-manage and tap into informal care and support, PHC helps patients make the most of clinical care.

"The health coach has been a constant throughout my ordeal – the other health care contacts have changed consistently."

### MODEL

Phone-based health coaching. Patients at high risk of an unplanned admission to hospital are invited onto an intensive period of health coaching – helping them to self-manage and stay well.

### WHO

Delivered by qualified nurses who are employed and trained by Health Navigator.

### FOR

PHC has provided care for over 30,000 patients in Sweden who are at high risk of an unplanned hospital admission, typically the patients are older patients who are suffering from multiple long term conditions.

### FUNDING

Proactive Health coaching is delivered by the Swedish organisation Health Navigator AB and in the UK is commissioned by CCGs.

What makes it work at scale?:

**Care that is targeted:** Health Navigator uses algorithms to identify the patients who would benefit most and nurses are supported with a smart backend system to help them identify the patients within their caseload who most need attention.

**Continuous evaluation:** through continuous monitoring and evaluation Health Navigator is able to demonstrate its impact and help nurses to develop their skills and care.

**Working alongside existing services:** as the service is designed to complement existing pathways and care, the implementation of the service is relatively straightforward as it does not require significant organisational changes to primary or secondary care.

Impact:

Twelve randomised control trials have demonstrated a positive impact on patients' quality of life and reduction in unplanned hospital admissions:

- A study with over 30,000 patients found a reduction of non elective admissions by up to 40%.
- A before and after evaluation demonstrated that 54% of the patients experience an increase in quality of life.

Resources:

[1] NHS IQ case study: [http://www.nhs.uk/media/2740572/case\\_study\\_proactive\\_health\\_coaching\\_in\\_the\\_vale\\_of\\_york\\_ccg.pdf](http://www.nhs.uk/media/2740572/case_study_proactive_health_coaching_in_the_vale_of_york_ccg.pdf)

Health Navigator website: <http://health-navigator.co.uk/>

## CUSTOMER-OWNED DEVOLUTION OF ALL HEALTHCARE SERVICES

### Nuka (Alaska, USA)

The devolution of health budgets in 1982 in Alaska, not just to local authorities but directly to the Alaskan indigenous population, was an opportunity to radically rethink healthcare. Together with the non-profit Southcentral Foundation, the new 'customer-owners' chose to reorganise healthcare around the values of the community; focusing on both shared responsibility for keeping well and on relationships between individuals and families. Through this focus on holistic, integrated, preventative and primary care, Nuka have reduced demand and spending on secondary and tertiary care by over 50%.

Every detail of care is designed to reinforce the values of shared ownership, strong relationships and family health. The 'customer-owners' chose to redesign healthcare environments to be welcoming, comfortable, and largely de-medicalised. Consultation rooms, for example, have enough space for whole families. Consultations are collaborative problem-solving conversations, with the explicit goal of empowering people and families to look after themselves.

**"Give customers options,  
not orders."**

Shared ownership by the community has been sustained through extensive opportunities for feedback and engagement. These include locality-based advisory groups, surveys, focus groups and a telephone hotline for suggestions. Response rates are over 95%. As well as drawing on the insights and participation of the local population, Nuka works closely with local and national partners who can complement the care they provide and respond to gaps in services.

Building trusting relationships and providing excellent care is made possible by the extraordinary commitment and motivation of staff. Southcentral, run by native Alaskans, believes in providing good jobs for local people. They invest heavily in staff development, knowledge sharing and training with a focus on soft skills, relationship building and knowledge sharing across a different specialities. As a result they boast very high staff retention rates.

Most of the population have shared values which means that Southcentral can provide care that is appropriate for the majority of the population's needs. Engagement activities are largely representative of the entire community. This approach may not be possible in a more

#### MODEL

Nuka is built on a partnership between Southcentral Foundation and the Alaska Native community. The non-profit Foundation includes a hospital, primary care clinics, dentistry provision, complementary medicine, home-based services and over 65 preventative and public health education programmes. Southcentral Foundation provides the majority of the population's health services on a prepaid basis.

#### WHO

1,600 employees serving 64,000 native Alaskan customer-owners

#### FUNDING

\$227 million operating budget (2013)

#### MEASURES

Outcome and process measures are continuously evaluated and improved alongside customer-owners. The Foundation gives regular updates on progress, even when things don't work out.

#### What makes it work at scale?:

Radical new agreement of what a health system is for: responsibility for staying well lies with individuals, families and communities, with clinical staff in a supportive role.

Customer-led preventative services: Nuka 'customer-owners' themselves decide on the preventative priorities for their area through locality-based advisory groups.

Intentional whole-system design: Southcentral provides care which ranges from preventative programmes to tertiary care. They aim to

maximise coordination and minimise duplication.

Investing in staff to reduce turnover and increase customer satisfaction: Nuka recruits staff for the long-term, providing regular training opportunities and mentoring. Staff turnover was down by 75% in the last 5 years, while satisfaction rates for both staff and

customer is over 90%.

#### Impact:

Since 1999:

- access to primary care has increased from 35% to 95%.
- hospital admissions have decreased by 75%.
- 42% reduction in urgent and emergency care services, 58% reduction of tertiary care.
- same-day routine appointments available (down from 4 week average wait)

#### Resources:

Website: [www.southcentralfoundation.com/nuka/learn-about-nuka/](http://www.southcentralfoundation.com/nuka/learn-about-nuka/)

Kings Fund report: [www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska](http://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska)



## USING DATA TO PRE-EMPT OLDER PATIENTS' NEEDS

### Staying Well Bolton

(Greater Manchester)

diverse population with differing values, cultures and needs.

By 2030, there will be over 60,000 people over 65 in Bolton, an increase of 37%. To improve wellbeing for the older population, the Bolton Public Health Team leveraged the asset of the GP register and existing 'health check' programme to develop the Staying Well Service. Using a sophisticated risk stratification tool, Staying Well proactively identifies people at risk of future need, preventing demand before it arises.

Using the GP register, Coordinators work alongside the GP practice to identify patients who are over 65 and at risk in order to arrange an initial 1-2 hour assessment with a coordinator using visual tools to guide the conversation. Coordinators are responsible for monitoring, maintaining and improving the wellbeing of the patient. It may range from: spending an hour to help connect the patient to a local community organisation; building confidence for managing self care; or offering longer term support to motivate behaviour change. Coordinators have different backgrounds and expertise but are joined by a common purpose - "a passion to help people to help themselves and an appreciation of the strengths and skills of older people". The service offers an opportunity for the older person to talk through anything that might be worrying them as well as focusing on the strengths of the individual. Allowing time to build trust and meeting the person in their own home has been an important part of providing a user-centered service as it builds trust and helps coordinators to understand the person's environment .

"Proactively identifying people with potential care needs, now and in the near future."

Collaboration with partners has enabled the success of the service. Coordinators work within GP practices and align their work to practice protocols in order to both build important relationships and to improve information sharing. 'Service champions' (including housing, social care and acute care) have been appointed to support the service and provide training to Coordinators. In return, 'Service Champions' benefit from the local level intelligence gathered by the service. For example, Coordinators found that lots of patients left their hearing aid in their drawers as the battery had run out so the audiology department now provides additional batteries.

There have been challenges along the way. For example, there is some overlap with the Integrated Neighbourhood Team which provides support to older patients at risk using a different risk stratification tool. Staying Well have needed to work closely with the team to avoid unnecessary or confusing duplication. As individuals receive a personalised service makes it difficult to predict costs and the outcomes can be long term or intangible. This makes it difficult to justify the service to commissioners. Fortunately, funding from the Better Care Fund has given the service the time and space

#### MODEL

A sophisticated risk stratification tool is used to identify older patients at risk on GP registers. Coordinators make an appointment to identify both assets and needs, providing support to signpost, refer to VCS (e.g. Age UK, Citizen Advice Bureau, Bowel and Bladder team, Bolton Care & Repair, private home support agencies) or support behaviour change. Intelligence gathered is fed back to improve services and care.

#### WHO

17 council-based staff, 3 based in local neighbourhood teams. Currently 11 practices run the service, the aim is to spread to all 50 general practices by 2017.

#### FOR

Patients over 65, registered with Bolton GP practices and identified as having a 50% higher likelihood of a hospital admission.

#### FUNDING

Commissioned by Bolton council with additional funding through the Better Care Fund. The service is commissioned based on improvements in the reported well being of the client. This means that the support provided is dependent on the needs and goals of the client.

#### What makes it work at scale?:

**Data as an asset:** Drawing on an extensive literature review, local GP data, geodemographic modelling and existing risk stratification tools, the public health intelligence team developed an Index of Potential Care Needs which combine both health and social risk factors. The team have also formalised data sharing agreements across parties

**Real-time data-modelling systems:** the team worked extensively with other providers to formalise data sharing agreements and guarantee the interoperability of the digital tools. This was used to develop a comprehensive list of patients at risk that is accessible, in real time, to health and social care professionals. 98% patients were happy for data to be shared across parties.

**Aligning with national priorities:** the Care Act and Better Care Fund has given the team greater credibility and authority, this has helped to get health and social care partners on board.

**Visual tools:** Staying Well's package of materials, tools, service specifications and job descriptions are freely available and have been codesign with clinicians and service users. Organisations across the UK have already started to use these tools to develop their own services.

#### Impact:

Local Government Chronicle Awards 2015: 'highly commended' by the judges.

Anecdotal evidence suggests high levels of satisfaction for both users and GPs. It also appears to reduce demand on GP time and repeat visits.

#### Mini-story:

One patient had not been completing their diabetes treatment for years and the GP had nearly lost hope so they referred them to a Coordinator. After some time, the patient grew to trust the Coordinator and revealed that she was illiterate. This marked a huge turning point in that person's health and wellbeing as the health plan was able to be communicated in a way that was accessible to her.

#### Resources:

Tools developed by Staying Well Bolton:

[www.boltonshhealthmatters.org/category/tags/people-and-places/staying-well](http://www.boltonshhealthmatters.org/category/tags/people-and-places/staying-well)

[www.boltonshhealthmatters.org/content/potential-care-needs-index](http://www.boltonshhealthmatters.org/content/potential-care-needs-index)

## SOCIAL PRESCRIBING FOR LONG-TERM CONDITIONS

### Ways to Wellness (West Newcastle)

to demonstrate their impact.

West Newcastle has some of the most deprived wards and poorest population health and wellbeing outcomes in England. For over a decade there have been social prescribing schemes in this area and, since April 2015, social prescribing has been delivered at scale through the Ways to Wellness programme. Ways to Wellness is the UK's first pay-by-outcome social prescribing service and has implemented a unique prime contractor model - contracting with four service providers to deliver the social prescribing service. During their seven year contract with Newcastle West CCG, they will only be paid if they can demonstrate quantifiable improvements in wellbeing for their patient cohort, and reductions in use of secondary services.

17 GP practices are referring patients suffering from specific long-term conditions (COPD, asthma, diabetes, heart disease, epilepsy, osteoporosis, and any of the above suffering from anxiety or depression) to link workers from a collaborative of four community providers who are paid through Ways to Wellness. These link workers are trained in behaviour change coaching for long-term conditions which means they work with patients to identify health and wellness goals that are meaningful to them, and help them work towards them. Typically, this will include a mix of physical activity, healthy eating/cooking, increased social activity, welfare information and positive relationship advice. They also connect people to community and voluntary groups and other resources in their area.

"It's nice to be told: 'We want you to do these activities because we know you can'.  
Drugs are telling you,  
'You are ill' ... but activities are telling you 'You can do things'."

One of the key tools to measure outcomes is using the 'Wellbeing Star'. It is used to measure patient's progress every six months on a range of categories including symptom-management, mood, social connectedness, housing and financial situation. The tool is completed jointly by the support worker and patient to provide a fair picture of progress made. Outcome-based payments kick in from over 0.5 improvement points in the Wellbeing Star for the whole cohort, with maximum payment of £492.50 per person made for a cohort average improvement of 1.4 point.

While referrals have been higher than expected, referral rates from individual practices and health professionals have varied significantly and some link workers appear to be more successful than others in generating

#### MODEL

Social prescribing by link workers embedded in primary care. Ways to Wellness contracts 4 service providers who deliver the service.

#### WHO

16 link workers from four community-sector providers. They are City and Guild Health Trainer qualified with extra training in long-term conditions and mental health.

#### FOR

Patients with COPD, asthma, diabetes type 1 and 2, heart disease, epilepsy, osteoporosis, and any of the above suffering from anxiety or depression. The project specifically targets the most deprived wards and will reach about 1 in 4 patients with long term conditions in West Newcastle.

#### FUNDING

Investment from Bridges Ventures (£1.65m) for set-up and development costs (this will be repaid if base level outcomes are met with no guaranteed repayments), a seven year Social Impact Bond contract with the CCG, top up payments from the Big Lottery Fund (£2m) and the Cabinet Office's 'Social Outcomes Fund' (£1m).

#### MEASURES

1) Standardised measurement using the Wellbeing Star 2) Management information system to compare performance across providers and evaluate what makes interventions most successful 3) reduction in hospital attendance compared to a control population in neighbouring wards

#### What makes it work at scale?:

Long-term investment at low risk to CCG: £4.65m investment over the life of this project, using a social finance and outcome-based commissioning contract to share the cost and risks of new ventures.

Standardised measuring tools: individual progress becomes quantifiable across a range of health and wellbeing outcomes in line with CCG priorities.

Shared data-management system (HSCIC N3 compliant): shared notes across traditional healthcare and the four voluntary sector services allows for safe, coordinated care and quality management across all providers.

#### Impact:

Aims to support 25% of people with long-term conditions in West Newcastle (8500) over 6 years. This means up to 3600 at any one time, each for an average of 18 months. They are already exceeding referral targets with only 3% drop-out rate.

Expected savings of £10.8m from a reduction in use of secondary care, measured against neighbouring area with similar socio-demographic features and the same cost baseline for LTCs

#### Mini-story:

Linda, 61, was overweight, suffered from shortness of breath and joint pains and was socially isolated. Together with a link worker, Linda set goals and chose to go to gym sessions and pilates. She was shown breathing exercises that she could do at home and designed a healthy eating plan. After seven months, Linda had lost 1 stone 4lbs, and had reduced her use of an inhaler. She also made new friends in class and feels happier.

#### Resources

Website: [www.waystoellness.org.uk](http://www.waystoellness.org.uk)

#### Case study reports:

[www.biglotteryfund.org.uk/~/\\_/link.aspx?id=38B25B895A86492AAA548D4737DFE302&\\_z=z](http://www.biglotteryfund.org.uk/~/_/link.aspx?id=38B25B895A86492AAA548D4737DFE302&_z=z) (Deep dive SIB case-study)  
[www.nhscc.org/wp-content/uploads/2015/09/NHSCC-core-cities-WEB.pdf](http://www.nhscc.org/wp-content/uploads/2015/09/NHSCC-core-cities-WEB.pdf) 'Transforming healthcare in England's core cities' NHS clinical commissioners, sept 2015 (Ways to Wellness featured)



## ADDRESSING NON-MEDICAL DEMAND IN THE NHS

### Wigan Primary Care Community Link workers

(Greater Manchester)

referrals. For the Ways to Wellness team, having an information system that allows them to see, discuss and address these variations is critical.

Nationally, one fifth of GPs' time is taken up by non-medical demands. Anecdotally, the figure is much higher, as much as 30%<sup>[1]</sup>. Wigan's link workers were developed to free up clinical staff time by looking after the broader determinants of poor health. This work originally began as a six month pilot with 11 GP practices from across the borough - now nearly all practices are signed up (63 practices). Any member of staff in a practice can refer someone they think needs more than medical attention. Link workers each look after clusters of five to six practices and are usually able to meet patients within the week. This is particularly valuable to both doctors and patients, as waiting lists for low level social issues or mental health needs can be long, and timely support helps to prevent crises before they arise. Support provided is focused on the whole person and the goals, skills and resources the patient has around them. Link workers can also refer directly to specialist help when needed. There is no limit on the length or number of appointments, though the majority of patients do not need more than one meeting.

"[Our link worker] does things for people that I can't,

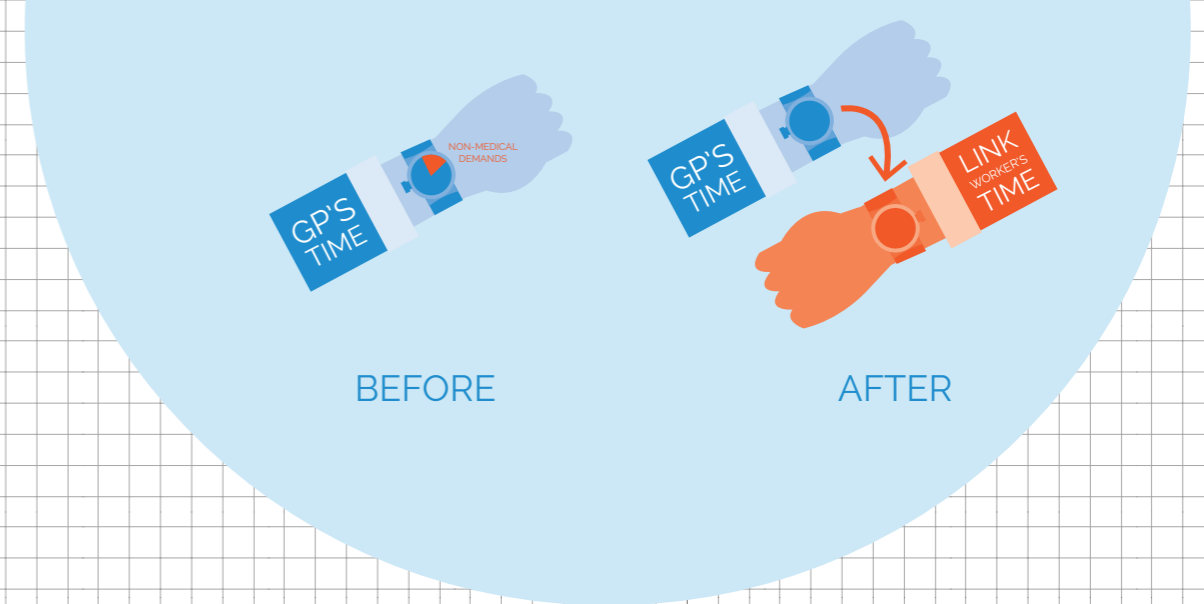
and couldn't do."

Dr Weems, GP

Community capacity building has been an important success factor of the link worker role. One of the original link workers knows over 200 community and voluntary sector organisations and invests his time building relationships and learning what is out there and meeting the organisations in person. Intelligence gathered through building relationships is fed back to commissioners and GP practices which is helping to create a map of services and an understanding of gaps in provision. Capacity building developed through the link worker model has been complemented with existing peer support programmes. This means that the support provided by link workers is more likely to be sustained - link workers can't, for example, attend rugby matches with someone all the time but they can find someone who can.

The strength of relationships with providers, GP managers and partners have enabled the quick uptake of the approach. Wigan Borough CCG opted to work with a known and trusted provider to innovate flexibly and adapt the model. In addition, the implementation of the link worker role was facilitated through existing relationships with GP.

Wigan Borough CCG and Wigan Council are also developing other pathways - through adult social care, acute care. They are also considering other referral pathways, for example embedding link workers within new services for frail and elderly and early intervention services for mental health.



**MODEL**  
Wigan CCG + Wigan council + NHS England City Healthcare Partnership CIC link workers looking after 5-6 GP practices

**WHO**  
12 community link workers who were recruited for their ability to have asset based conversations with clients and build relationships with hundreds of community and voluntary sector organisations and clinical staff.

**FOR**  
Any patient registered with a Wigan GP with more than clinical needs.

**USING**  
Deep knowledge of community and voluntary resources.

**FUNDING**  
6 months pilot and subsequent roll-out funded jointly by the council, CCG. Local voluntary and community organisations are also partners of the pilot.

**IMPACT**  
The pilot's independent evaluation will be used to segment the patient cohort, evaluate effectiveness in more or less deprived areas, and tweak operational features of the model.

#### What makes it work at scale? :

Established relationships between Wigan council and the CCG: the CCG based Locality Team has established close working relationships with practices over three years. Practice managers were therefore happy to try the new approach and knew their feedback would be listened to.

Link worker embedded in GP practice team: link workers are not an 'add-on', but part of the team. They build personal relationships with practice staff at all level, and log their notes in the same IT systems. This makes the GP practice team more likely to refer patients to the service. Being based within a GP practice also means patients feel their problems are taken seriously.

#### Impact:

All 63 GP practices in Wigan signed up to the October 2015 roll-out

1800 people to benefit (equivalent to 18.5% of Wigan's chronically ill population)

Very positive feedback from staff - patients referred are healthier and happier and visit GP's less.

#### Mini-story:

There are many stories captured that demonstrate the benefits of the link worker model. Here is one: Daniel, 43, is a military veteran who is recently divorced and has no contact with children. He works full time as a warehouse manager and feels that life is boring with a routine of work/sleep/work. He drinks an average of 15 cans a day and is aware that this is a problem. Meeting with the Link Worker, Daniel agreed to curb his drinking and showed interested in learning new skills through volunteering, so that he could change his job in future. He also wanted to get fitter and lose weight. He was given details of the Veterans' Council and information about volunteering opportunities. Daniel now attends weekly Health Walks run by his practice's Patient Participation Group (PPG) and has joined a local Ramblers group. He is meeting more people, improving his fitness, and using time at weekends more productively.

#### Resources

<sup>[1]</sup> Report on the use of GP time by Citizens Advice: [www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice\\_AVeryGeneralPractice\\_May2015.pdf](http://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf)

## LESSONS FROM THE CASE STUDIES

These case studies showcase places and organisations that have implemented and developed asset-based approaches at scale. Achieving scale hasn't been easy - these organisations have had to iteratively test and develop new ways of working over years, and in some cases, decades - in order to sustainably improve outcomes. We have highlighted some of these key lessons below:

Asset based conversations between professionals and patients. What works:

Introduce structured approaches to support professionals to have different conversations for example motivational interviewing, care planning or solution focused practice.

- These structured approaches can help professionals have different types of conversations
- However, at their core they are all about empathy, active listening and a patient-led conversation about what matters to them

[See Health Coaching](#)

Train staff to ensure they have not only the skills but also the right beliefs and attitudes

- The best training helps people to model and experience what asset based conversations really look and feel like

[See Staying Well Bolton](#)

Change the organisational conditions

- Longer appointments for coaching or care planning can save time in the long run if they are preventative
- Implementing information systems that capture people's goals and progress towards these goals supports professionals to do this systematically

[See Health Coaching and Ways to Wellbeing](#)

Connect individuals to community assets e.g. peer support, social prescribing and link workers. What works:

Have clear referral criteria and monitor who is using your service.

- Ensure that your referral criteria fit the vision you have for your service.
- Monitor who is using the service - and adapt your service and referral process based on these insights

[See Proactive Health Coaching and Being Well Salford](#)

Define the link worker role clearly

- Link workers need to provide both direct support and be able to signpost patients towards suitable community organisations and activities. They should complement not replace clinical care
- They should also have a strong link with primary care - embedding link workers in GP practice help to build these relationships
- They should work closely with the community and voluntary sector to understand and grow community activities available

[See Community Link Workers and Ways to Wellbeing](#)

Continual feedback

- GPs and secondary services trust link workers more if they hear about how their patients are doing - therefore communication flows are key
- Draw on the intelligence from link workers to improve services and enhance the commissioning of future services

[See Proactive Health Coaching and Staying Well Bolton](#)

Map and grow community assets e.g. asset mapping, directories of community assets and seed funding for VSOs. What works:

Ensure it is community and citizen-led

Use and work with people and organisations who already understand the landscape such as the community and voluntary sector

[See Bromley by Bow](#)

Keep mapping live and dynamic

- Assets are changing and subjective, make any directories interactive and iterative to ensure that they capture this
- Crowdsourcing platforms or wikis are one way to do this but it can also be the role of link workers or community champions

[See Connect and Do and Ways to Wellbeing](#)

Use seed funding to grow community assets

- Be clear about what you want this funding to achieve - to stimulate new provision where gaps exist or to grow or sustain existing provision
- Consider and measure wider social outcomes such as employment or social connectivity that might be influenced by investing in and increasing community capacity

[See Bromley by Bow](#)

Work with communities to develop local provision e.g. co-design and collaborative commissioning.

Include local people in the governance and running of the service

In Manchester City, the Age Friendly Board ensures that all policies take account of Manchester's older people.

Draw on local knowledge and ensure community ownership by recruiting local people or existing users of the service

[See Age Friendly Manchester](#)

Create multiple channels for people to get involved

Provide as many routes to get involved as possible. Nuka have developed a range of options for participation including joining locality-based advisory groups, surveys, focus groups, and a telephone hotline for feedback.

[See Nuka](#)

The design of spaces should reinforce community ownership

Bromley by Bow Centre has no NHS signs and all the artwork is by local people

[See Bromley by Bow](#)

Place-based approaches to mobilising assets e.g. local neighbourhood networks.

Develop hubs where people already go

Creating a new community hub or wellbeing centre from scratch can be difficult. Build hubs where people already go, for example as part of or near existing community centres

[See Age Friendly Manchester and Bromley by Bow](#)

# HOW TO GET STARTED

There is no "right" way to get started - it will depend on your local context. In the section below we describe one way to develop an asset based approach within an 'integrated neighbourhood primary care team'. This is intended for local leaders and commissioners who are getting started.

## 1. Setting up a team to lead the work:

Bromley by Bow, Nuka and Ways to Wellness all began with a mixed group of community leaders, and healthcare professionals, passionate about improving outcomes in their community. Build a team that combines health and care professionals, and people who know the local community such as VCS organisations and local people. They all have to believe in the vision of asset based care. Commissioners should support and convene the group but the leadership should come from the community, clinicians and council together.

Questions to consider:

- Is there a shared vision for primary care in your local area?
- How will you involve local people and VCS in building the vision and values?
- Who will carry out the research and implementation?

## 2. Understand which patients to focus on

Many asset based approaches have a broad referral criteria which means care is not targeted and professionals are unsure when to refer. Data should be collected to understand who would benefit most to define the focus population groups. Analysis should consider all social determinants of health and draw on as much local level data as possible. For example, Bolton analysed data from local GP practices and developed a risk stratification tool that looked at both social and health factors.

Questions to consider:

- What data sources can you draw on locally to understand both health and social risk factors?
- Who are the frequent attenders in GP practices/emergency care?
- What national data can you use to compare the local area against?

## 3. Understand and map the user journey

There are different stages of a user journey where an asset based conversation can take place: before a problem arises, at first contact with services, during recovery etc. Having defined the focus population, a typical user journey should be mapped to identify where asset based conversations will have most benefit and to collect outcome measures that matter to those individuals.

Questions to consider:

- At what stage of care should an asset based conversation take place?
- Which staff should hold asset based conversations?
- What workforce and organisational changes are needed to embed asset based care as part of the user journey (e.g. training, accountability, appointments, test results)?
- What are the outcome measures that are important to the focus population group along their journey?

## 4. Understand which approach will work best in your community

There is no single approach that will work for all communities. The approach(es) should be tailored to the gaps and opportunities of existing provision, considering both formal and informal services. To do this effectively requires an in-depth review of current provision.

Questions to consider:

- What asset based approaches are currently running in your local area? How effective are they?
- What are the levels of volunteering in your local area?
- Do you have a map or database of community assets?
- Which local services and leaders should you engage with to build a richer understanding of opportunities and gaps in your local area?

## 5. Create a development plan for your neighbourhood team

There are a range of different approaches that could be developed to grow asset based care and almost always a combination of these approaches are needed to achieve the desired effect on patient outcomes e.g. care planning and social prescribing. Such a plan is likely to include the following:

### a. Develop the roles that connect individuals to assets in the community

If the links between individuals and assets in the community are limited, new connector roles such as a link worker or social prescriber should be developed. These individuals are often accountable for providing asset based care, building community capacity and gathering local level intelligence.

Questions to consider:

- What are the values and skills you will recruit for?

### b. Invest in a small grants fund to grow community capacity

If there are limited resources in the community and the VCS the development of a fund will allow local assets to flourish and will support existing link roles. For example, Bromley by Bow Centre have incubated 60 social enterprises locally which complement their social prescribing programme.

Questions to consider:

- What funding criteria will ensure the target population benefit most?

### c. Develop the workforce to have asset based conversations

If professionals don't yet have the skills and tools to hold asset based conversations the leadership team should focus on workforce development. Training and support should be provided to the individuals who have been identified as being accountable for providing asset based care, this may be GPs, link workers or pharmacists.

Questions to consider:

- Which organisations should you engage with to consider training options? (Health Education England North West etc)
- Do you have decision aids and tools to support professionals to hold new conversations?

## 6. Implement and evaluate your plan

Success will require ongoing learning, evaluation and adaptation. The new service will need clear outcomes including both clinical and patient reported. Staying Well and Ways to Wellness are both commissioned on self reported health and wellbeing outcome measures before/after service use.

Questions to consider:

- Who will collect both qualitative and quantitative data?
- What forums will be used for practitioners and leaders to share lessons?
- How will you share data across different systems?

## 7. Plan for sustainability

Once the approach is established and there is evidence to demonstrate the impact, ongoing stakeholder engagement is needed and alternative funding routes may be considered. The most sustainable forms of asset based care ensure have alternative funding streams other than typical commissioning routes. For example, Ways to Wellness secured £1.64 million social finance from Bridges Venture and payments from the Big Lottery Fund and the Cabinet Office.

- Do you have a financial, moral and business case for the new approach(es)?
- How will you engage with and understand the motivations and interests of potential investors?
- How will you continue to engage stakeholders?

