GP Trainee Name: Edwina Akerele
Rotation: GP with Public health ITP (Aug 2017- Feb 2018)

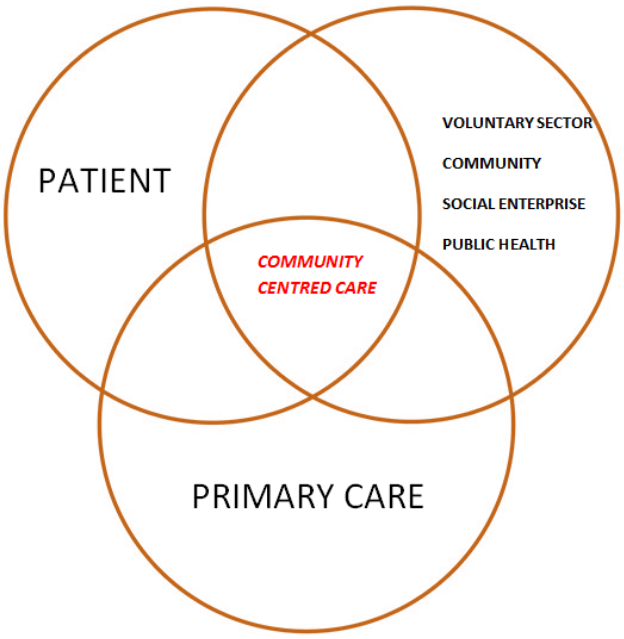
Supervisors
Public Health: Rachel Wells, Jeff Lake, Louisa Pavli
General Practice (GP): Anita Patel, Gill Parsons

Umbrella Project Title
"Demand Management in Primary Care"

Defining The New Models of Care

Contents

1. **Background**
2. **A summary of the existing definitions of different link workers and other new models of care.**
3. **Applicability of these new care models to current health and social care needs in Barnet Primary Care.**



Background

"Health is the ability to adapt and ***self-manage*** in the face of social, physical and emotional challenges" (Huber et al, BMJ, 2011).

The NHS Five Year Forward View asks us to imagine new models of care and "a future where fully engaged patients, carers and citizens play a greater role in their health and health care".

Increasingly, primary care and the NHS at large have to deliver high quality care to a complex, diverse, ageing population with fewer resources. Encouraging patients to self-manage and promoting a community that works together to improve health for all is beneficial to everyone.

In primary care there will be less demand from Gps for services that could be accessed by the patient in other ways. Ultimately this will increase Gp efficiency as they will be better able to focus their energies and time appropriately. This has the potential to increase cost savings through a reduced burden on services. Importantly, the patients and members of the community will be empowered in their own self-care and social capital will be generated increasing their sense of well-being.

NICE Guidance[1] on "Community Engagement" recommends recruiting community members to plan and deliver health promotion activities and help address the wider determinants of health. It highlights community champions as people that can inspire and motivate community members as well as advocate for change.

A Cochrane systematic review[2] found that community health workers educate their peers enabling them to effectively navigate and utilise community health resources. This improves the quality of life of the individuals they work with especially the vulnerable members of the community.

In primary care, this whole systems change is one in which ***community centred*** general practice is established. Patients, the community and health care professionals in primary care and better connected and community health and well-being becomes a shared responsibility. Patients get better outcomes and are more likely to access services appropriately.

---

[1]NICE (2008) Community Engagement to Improve Health, in NICE public health guidance 9. NICE: London
[2]Lewin SA et. al (2005) Lay health workers in primary and community health care. Cochrane Database Systematic Reviews CD004015.

Titles for people who have a linking role (referred to as link workers in social prescribing schemes) continue to grow, and include: health advisor, health coordinator, health facilitator, health trainer, community connector, community navigator, social prescribing coordinator, support broker, health broker, community broker; wellbeing coordinator, voluntary, community and social enterprise sector advisor.`[1]

Other titles commonly used in theory and/or practice include health champions, health coaches and care navigator.

There are subtle differences between these roles but generally they are voluntary, unpaid roles. The individuals who take up these roles are members of the community that have been identified as able to proactively and independently support patients to improve their health and well-being.

A short elevator pitch definition amalgamating the core components of these titles can be proposed as: "a trained person who gives their time, skill and knowledge to promote the health and well-being of their local community using a patient-centred, peer to peer approach".

Patient/care navigators

These are individuals who provide an interface between healthcare professionals, community services and service users. They are not necessarily clinical and help to facilitate the patient journey. They provide help and direct patients to the most appropriate services, supporting patients and families on their health and wellbeing journey. The can also provide treatment planning and offer referrals (signposting).

Expert patient

A popular term for a UK patient with a chronic disease whose knowledge and experience about it empowers him/her to play a part in its management, and whose advice the NHS may seek to improve various processes in managing that particular disease[2].

In a paper by Richardson G et al, the cost-effectiveness of the Expert Patients Programme (EPP) compared with usual care, in people with long-term conditions was assessed. Over a 12-month period, the mean QALYs gained in the EPP group were 0.276 and in the control group they were 0.258, which was an additional 0.018 (95% confidence interval, CI: -0.004 to 0.041). Adjusting for age, sex, medical condition, and baseline EQ-5D score, the difference in mean QALYs gained was 0.020 (95% CI: 0.007 to 0.034).

The results of the cost-effectiveness acceptability curve (CEAC) showed that, at a willingness to pay threshold of £20,000 per QALY, the EPP had a 94% probability of being cost-effective.

---

[1] Making Sense of Social Prescribing. University of Westminster

[2] Segen's Medical Dictionary. © 2012 Farlex, Inc. All rights reserved

Patient navigators. NHS England. Gail King. Head of EPRR. Sept 2016

Richardson G, Kennedy A, Reeves D, Bower P, Lee V, Middleton E, Gardner C, Gately C, Rogers A. Cost effectiveness of the Expert Patients Programme (EPP) for patients with chronic conditions. Journal of Epidemiology and Community Health 2008; 62(4): 361-367

Health Champions

The "Altogether Programme", an NHS national network organisation defines Health Champions as people who, *with training and support*, **voluntarily bring their ability** to relate to people and their own life experience to transform health and well-being in their communities. A **peer to peer**, "someone like me" approach is used to facilitate behavioural change in patients and the wider community. There are different types of health champions as highlighted below:
Practice Health Champions
Emergency Department Health Champions
Community champions
Youth champions
Pregnancy and Early years Champions
Senior Health Champions

Here, practice health champions are recruited and trained from the local community. They reflect the needs and aspirations of the community that the GP Practices serve. The work of the practice champion varies, depending on their interests, experience, the needs of the practice and the local community's health priorities. The champions themselves decide their level of involvement.

Hounslow and Richmond Community Healthcare similarly, define Health Champions as ***volunteers*** who work in their local communities to motivate, empower and help people lead healthier lives by raising awareness of local Health Services and encouraging people to make healthy lifestyle choices[1].

Of note, one of the key actions under Barnet's Child Oral Health Improvement Strategic Plan (2014/16) was identifying and supporting oral health champions in Children's Centers to meet their oral health standards[2].

Another area in which the term health champion is being used is in ***healthy living pharmacies*** where pharmacy staff pro-actively support and promote behaviour change, improving health, wellbeing and self-care.[3] In this situation however the ***pharmacy staff are commissioned to carry out health champion related activities***.

The champions themselves develop new skills and experiences by volunteering their time and/or skills which support their own growth and personal development.
The connection with general practice strengthens their status as community leaders, increasing their effectiveness in their community[4]

With health champions, many examples of the ripple effect have been seen where people who have been reached by the champions become more active themselves.[5]

---

[1] **http://www.richmond.gov.uk/media/3684/ph_healthy_lifestyle_0815.pdf**
[2] https://barnet.gov.uk/jsna-home/health.html
[3] **http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/**
[4] http://www.altogetherbetter.org.uk/SharedFiles/Download.aspx?pageid=36&mid=57&fileid=99
[5] J South, J White & G Raine (2010) Community health champions: Evidence review

Health Coaches

Health coaching can be defined as helping patients gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their ***self-identified*** health goals.[1]
In the above paper, five principal roles of health coaches are outlined: 1) providing self-management support, 2) bridging the gap between clinician and patient, 3) helping patients navigate the health care system, 4) offering emotional support and 5) serving as a continuity figure

Health coaches can be nurses, social workers, medical assistants, community health workers, health educators or even other patients if given appropriate training and support[2]

In South Somerset, The Symphony programme uses a 3 tier approach integrated care model that uses health coaches in tier 3. Tier three is enhanced primary care which supports practices to take a much more preventative and proactive approach to their patient list by expanding the practice team and introducing health coaches.[3] In this program, health coaches;

- Work with patients to help them develop the confidence to manage their health conditions.
- Ensure any liaison with other services is effective and coordinated.
- Can be contacted by the patients directly and can see patients freeing up time for GPs.

Health Trainers

"Health trainers provide local people with motivation and practical support to improve health and are either drawn from their local communities, or are knowledgeable about those communities. They will identify, or have referred to them, appropriate "clients" drawn from hard to reach, disadvantaged groups. In addition, clients can self-refer. Health trainers will work with these clients on a one-to-one basis to support them to decide what aspects of their lifestyles and wellbeing they want to address, to set goals, agree action plans and provide individual support focusing on behavior change"[4]

The Health Trainer workforce in England developed from 2005 through a unique collaboration between the national team at the Department of Health (which operated until 2010/11), regional teams and local services.
Levels of pay vary, according to local circumstances and a few health trainers work on an unpaid basis.[4]

---

[1]Heather D. Bennett et al. Health Coaching for Patients With Chronic Illness. *Fam Pract Manag.* 2010 Sep-Oct;17(5):24-29.
[2]Holland SK, Greenberg J, Tidwell L, Newcomer R. Preventing disability through community-based health coaching. *J Am Geriatr Soc*. 2003;51:265–269.
[3]https://www.england.nhs.uk/gp/case-studies/symphony-programme/
[4]http://healthtrainersengland.com/about-health-trainers

Applicability of link workers to current health and social care needs in Barnet

These individuals are an effective bridge between the community and primary care health professionals. Practice Champions can also enrich decision making in local practices as their passion for and understanding of the local community means they are well informed about the community's needs. Champions also support service delivery in many different ways for example increasing the numbers of people attending Saturday flu clinic[1]

In Barnet specifically, the community itself is a valuable resource and can be deployed as a means to engage patients especially in isolated communities and difficult to reach areas.
The ***Barnet Joint Strategic Needs Assessment*** website highlights that:
Barnet is the largest Borough in London by population and is continuing to grow.
The over-65 population is forecast to grow three times faster than the overall population between 2015 and 2030.
The Borough will become increasingly diverse, driven predominantly by growth within the existing population.

Two strategic issues (to be addressed over the next five years) also outlined are

1. In adult social care and health, **increased community care to reduce the need for services by meeting people's daily needs**, as well as providing activities which reduce isolation and have other preventative benefits.
2. **Working with voluntary and community (VCS) groups to target areas with higher levels of social isolation**, to encourage greater social contact and develop new volunteering opportunities.

However,[2]

Barnet has a strong foundation for an asset-based approach with 88% of residents satisfied with their local area and high levels of local capacity.

90% of residents agree that they help their neighbors out when needed and 28% volunteer regularly (weekly or monthly).

In a recent data collection survey, 30% of residents say that they volunteer regularly and 42% say that they have given unpaid help to an organization in the last 12 months[3] highlighting that Barnet residents are a valuable asset.

In terms of both health and disability-related charitable activities, less than 20% of Barnet based charities (225) identify their charitable purpose as the advancement of health[4]. The new models of care are perfectly suited means to prioritise health and wellbeing within VCS groups.

The community health champion model was highlighted as best practice in the Marmot Review and the Public Health White Paper and the approach can give a positive return on investment of up to £112.42 for every £1 invested (York Health Economics Consortium)

This provides support for a financial benefit to investing in health champions. Importantly, through the health champion model, strong community links and relationships are established with the potential to take the pressure off general practitioners. The fact that 90% of residents help their neighbours in some way or another already suggests relationships that can be strengthened and utilised to improve the health and wellbeing of the community.

[1]http://www.altogetherbetter.org.uk/SharedFiles/Download.aspx?pageid=36&mid=57&fileid=128
[2,4] https://barnet.gov.uk/jsna-home/
[3] Resident Perceptions Survey, Spring 2017

There is a paucity of cost effectiveness data on practice health champion evaluations as it is a very new model of care across the NHS. In Barnet, there is on-going work to evaluate the impact of health champions in the practices who are using health champions.

The social return on investment and economic impacts are more likely to be seen in the long term rather than the short term. However case studies in the literature consistently highlight that user satisfaction is high with both patients and general practice staff.

What we can comment on now is that using the health champion model, practices can facilitate engagement between community members and patients to improve the overall health and well-being of the community via a patient orientated, peer to peer approach. Patients as well as the champions are happier and feel better supported. A welcome secondary effect being the reduction in demand on primary care staff.

Signposting in healthcare

There was widespread acknowledgement that there are a lot of good activities and initiatives happening across the country but a lack of awareness by professionals and individuals was a barrier to people being made aware of them or referred to them.
National Conversation blog (January 2016)

Sign posting bridges this gap and in health and social care is

1. providing quality and reliable information on services and options and
2. referring on…delivering someone "safely"–i.e. knowing the product is the right one

Signposting helps patients and service users understand, access and navigate community-based services that will improve their health. It is a means of championing self-care and improving health literacy. Anyone can signpost; from receptionists to community pharmacists as long as they are suitably trained and have a good knowledge of local resources

When successful signposting occurs, community engagement is strengthened and community facing care is realised. There is a social gradient in health and the lower a person's social position, the worse his or her health (The Marmot review. Strategic Review of Health inequalities in England post 2010).

Unfortunately the most socio-economically deprived are also the least likely to know of and access services that can assist in addressing their social, health and wellbeing needs. Health care professionals not only have a responsibility but are suitably positioned to signpost individuals to community/local services.

Making every contact count

Making Every Contact Count (MECC) is about supporting organisations and their staff to maximise on the opportunity they have with the public in promoting health and enabling them to make changes to improve their health and well-being[1].

MECC was mainly interpreted as training staff to deliver brief advice or a brief intervention as described within Behavioural change: individual approaches (NICE, 2014)[2]
Brief advice and brief interventions are part of the same approach to providing opportunistic health advice with key distinctions being the amount of time spent with a person and the expertise of the individual delivering the intervention[3]

Brief Advice

The term brief advice usually refers to a short intervention (usually from 30 seconds to 3 minutes) which may include verbal advice, discussion, negotiation or encouragement, with or without written or other support or follow-up. It is mainly about giving people information or directing them where to go for further help[4].

Brief Intervention[5]

The term brief intervention is used in this document to mean an intervention lasting longer than 3 minutes (usually 5- 10 minutes but can be between 30-60 minutes for extended brief interventions). It involves making the most of an opportunity to raise awareness, share knowledge and get a person thinking about making changes to improve their health and behaviours and usually includes:

- Giving simple opportunistic advice to change
- Assessing a person's commitment to change
- Supplying self-help materials or resources
- Providing specialist support (if suitably trained) or refer or signpost to specialist support
- Offering a follow-up appointment if appropriate
- Recording the outcome of discussion

MECC plus is usually a broader definition of the MECC approach and may include conversations to help people think about wider determinants such as debt management, housing and welfare rights advice and directing them to services that can provide support.[6]

---

[1]Public Health England, NHS England, Health Education England et al, Making Every Contact Count (MECC): consensus statement:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/515949/Making_Every_Contact_Count_Consensus_Statement.pdf

[2] NICE (2014) Behaviour change: individual approaches PH 49 Available from: https://www.nice.org.uk/guidance/ph49

[3]Wills J & Ion V (2014) Implementing 'Making Every Contact Count': A Scoping Review

[4]NICE National Institute for Health and Care Excellence. NICE guidance 2016. Available from:
https://www.nice.org.uk/guidance/ph49

[5]NICE (2006). NICE guidance. Lifestyle and wellbeing. Smoking and tobacco Available from
https://www.nice.org.uk/guidance/ph1/chapter/1-Recommendations

[6]Public Health England, NHS England, Health Education England et al, Making Every Contact Count (MECC): consensus statement.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/515949/Making_Every_Contact_Count_Consensus_Statement.pdf

Self care

Self-care is all about individuals taking responsibility for their own health and well-being. This includes: staying fit and healthy, both physically and mentally; taking action to prevent illness and accidents; the better use of medicines; treatment of minor ailments and better care of long term conditions[1]

Social Prescribing

It is estimated that around 20% of patients consult their general practitioner (GP) for what is primarily a social problem (Low Commission, 2015).

Social prescribing was highlighted in the General Practice Forward View as a mechanism to support increased integration of primary care with wider health and care systems to reduce demand on stretched primary care services[1]. In turn, this would make improvements in the social and economic determinants of health. It is one of the ten high impact actions in the General Practice Forward View[2,3].

Social Prescribing shares the values that underpin the wider 'personalisation' movement in health and social care (DH, 2008)[4].

The *Social Prescribing Network Conference Report 2016* defines social prescribing as "A **means of enabling GPs and other frontline healthcare professionals** to **refer patients** to a **link worker** to provide them with a face to face conversation during which they can learn about the possibilities and **design their own personalised solutions** i.e. **co-produce** their 'social prescription'- so that people with social, emotional or practical needs are **empowered to find solutions** which will improve their health and well-being, often using services provided by the **voluntary, community and social enterprise sector**."[5]

As this is a lengthy definition, the key words have been highlighted to emphasise the core components of a social prescribing scheme. It involves collaborative working between different sectors and the patient to deliver patient-designed, holistic, patient focused solutions that address medical problems alongside the wider determinants of the individual's health.

---

[1] Department of Health (2006) Supporting people with Long Term conditions to self care- A guide to developing local strategies and good practice. Department of Health, London.

[2,3]NHS England (2016) General Practice Forward View

[4]Department of Health (2008) Transforming Social Care. Local Authority Circular (DH). Department of Health, London

[3]Social Prescribing Network Conference Report 2016

Below are some examples of outcome improvements in general practice from the introduction of social prescribing models and new care models.

Social prescribing at Thornton Medical Centre, Leeds

The practice formed a partnership with their local community centre to help address demand on GP appointments. Patients can now access a new range of non-medical advice and support, direct via the reception or on referral by a clinician in the practice. The daily 'urgent appointment' list has fallen from 80-100 per day to about 10 per day in this practice.[1] This has improved access and reduced pressures on the practice.

Seven papers looking at the effect on demand for General Practice, reported an average 28% reduction (range 2% to 70%) in demand for GP services following referral to social prescribing[2] as highlighted in a systematic review by Polley. M et al.

According to Nesta, voluntary contributions to public services in England can be currently costed at an estimated £34 billion per annum[3]

Kimberlee et al, (2016) showed that the mean Social Return on Investment (SROI) was £2.3 per £1 invested in the first year for social prescribing[4].

---

[1]https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/messageboard/8-use-social-prescribing/170585295?b_start=0#487867950

[2]Polley, M. et al. (2017) A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. University of Westminster

[3] http://www.nesta.org.uk/publications/people-helping-people-future-public-services

[4]Kimberlee, R. (2016) Gloucestershire Clinical Commissioning Group Social Prescribing Service: Evaluation Report, University of the West of England, Bristol