Year One Review
Full report

December 2014

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EXECUTIVE SUMMARY

Being Well Salford (BWS), launched in May 2013, is a partnership managed by The Big Life group, with seven other third sector providers; Langworthy Cornerstone, Salford Community Leisure, Salford Health Matters, Salford Unemployed and Community Resource Centre, Social adventures, Unlimited Potential, YMCA, who help to deliver the service and Salford University, People's Voice Media and Pennine Care NHS Foundation Trust who support the delivery through training, evaluation activities and clinical supervision.

The service offers free support to local people who have multiple health-related lifestyle issues, to make changes to improve their health and wellbeing. It employs Being Well Coaches to work with people on a one-to-one or group setting. Coaches are employed either by a partner organisation or The Big Life group. By year end (March 2014), the service had received 933 referrals from 83 different referrers, leading to 577 assessments. On average just under six out of ten people referred went on to access the service. In the 2nd year of delivery, the service is targeted to work with 3000 participants.

A key aim of Being Well Salford is to Capture learning and identify further refinement to inform on-going service development. This is a review of the first year findings.

The model

- A partnership model involving a range of third sector organisations and community enterprises established in the local community across Salford, with a concern to develop the capacity of smaller organisations to deliver services under the umbrella of the partnership, but with formal relationships between partners based on sub-contracting and performance management
- A recruitment process which takes account of the skills and values of staff in relation to work, rather than formal qualifications ,and a comprehensive competency development framework
- A dispersed geographical approach prioritising individuals and communities who are most in need, within a centralised service and management framework to ensure consistency and opportunities for working as a team
- A coaching process which is person-centred, linking to the persons' starting point and other key determinants, which uses tools and techniques that research has shown to get results, particularly motivational interviewing
- A case management approach, which puts clients in control of their own action plans and concentrates on building their skills and self-efficacy to manage their own behaviours and make sustainable changes.

Partnership approach

The BWS partnership and delivery model was developed through a period of collaborative development by the partnership during the initial start-up period up to April 2013, and subsequently through service development in the delivery phase. The partners came together to collectively provide a service which would not be possible through organisations acting individually, reaching a wide geography and engaging people who find it easier to access non statutory services. The Big Life group supported local organisations to establish robust operational arrangements where needed and provided the case management system.

The BWS approach fits within the spirit of the Social Value Act, which seeks to support contracting of statutory services to the third sector, with a view to boosting community

engagement and changing the way that other providers work through more effective and ethical public expenditure, on a 'not for profit' model.

Recruitment

The BWS team has 12 coaches, 2 Team Coaches, 2 Administrators, a Volunteer Co-ordinator and Service Manager. Coaches are employed by partner organisations or The Big Life group. Some partner organisations host but do not employ coaches. There have been two rounds of recruitment for Coaches who have all been assigned to neighbourhood areas and have built up strong local links and understanding of the communities in which they work.

Volunteering opportunities and apprenticeships are part of the approach, with a view to enhancing capacity and creating further jobs and training opportunities for local people. There are 2 apprentices and 14 active volunteers so far. 2 volunteers have gone into jobs locally in the health sector.

The approach to recruiting coaches to deliver the service, and to developing their competencies, was a key area of innovation. The person specification did not include any specific qualifications, but focused on the person's values, skills and qualities. The recruitment process included video applications (rather than application forms) and assessment days. After almost 200 applications across two waves, the service employed 12 coaches. 80% of the staff team live in Salford.

All coaches work within a competency framework and train for 12 months before qualifying as a Being Well Coach. The first cohort of coaches qualified in January and the 2nd cohort of coaches will qualify in July 2014. Training for coaches includes;

- Formal training delivered by University of Salford
- Informal training activities: shadowing and knowledge sharing
- Partnership activities drawing on expertise of related services and agencies in Salford
- Ad hoc courses – for example, courses focussing on risk management, matters and credit unions

Geographical approach

BWS aimed to engage with those in the most disadvantaged areas with the poorest health outcomes. Targets for the neighbourhoods were identified based on the extent of relative deprivation and population levels in the different parts of Salford. Coaches were assigned to each neighbourhood and developed neighborhood health profiles , engaging with key local organisations and services to understand the local need, promote the service and develop referral pathways.

The service has promoted itself through a launch, roadshows, media and has worked alongside local agencies and organisations to identify people who can benefit from the support of the coaches.

- 87% heard about the service from other agencies (of which 26% were GPs).
- 7% were informed through BWS media (posters, website, leaflets etc.)
- 7% word of mouth

The centralised approach to referrals aims to get potential participants through triage within 5 days of referral and assessed within 10 days. It is important for BWS to see participants as

close to them making a decision to access the service as possible to capture their motivation. We measure both attempted contacts and successful contacts. 97% of participants are attempted to be contacted within 5 days for triage and 91% within 10 days for assessment. However, successful contacts are lower as it has proved harder to make contact than anticipated, 54% of participants are triaged within 5 days and 32% are assessed within 10 days

From a profile of participants accessing the service so far 63% were from areas in Salford classified as within the 20% worst deprived nationally on the Index of Deprivation. 54% are female 46% Male. The average participant age is 46 and 90% of participants are White. 95% of participants present with low mood, 77% suffer ill health, 63% had bereavement and 40% have experienced job loss.

Coaching

When participants first contact the service, motivation to change is measured. 20% of participants think they need to consider making changes, **49**% of participants think they should make changes but feel they are not ready to and 21% of participants are starting to think about making changes. **67% of participants** feel that their health is at risk from lifestyle behaviors with **73% of participants** stating they know what to do to be healthier. However, there is a disconnect between having the knowledge and putting it into practice. Coaches report that there are many mistaken health beliefs and under half of participants are not confident in making changes. One coaches reports

...the participants say they know what they should be doing but say its hard to fit it into their lives, or they are influenced by mood which knocks them off course, emotional eating for example …

In a sample of participants, 40% reported three detrimental health behaviours and almost 30% had four. The most common combination, were

- Lack of exercise and unhealthy drinking and smoking and low mood - 20%;
- Unhealthy BMI and lack of exercise and low mood - 20%;
- Lack of exercise and smoking and low mood - 14%;
- Unhealthy BMI and smoking and low mood - 8%.

Coaches supported participants through both **1:1 and group work**, with 53 people accessing 10 behaviour change groups.

Coaches used the following tools to support participants to identify smaller steps to achieve their main health related objectives:

- Motivational interviewing (MI), a person-centred collaborative approach that focuses on people making their own choices. MI has been shown to work well with people who are ambivalent about behaviour change, including those who may have attempted to change their behaviour in the past but were unsuccessful and now doubt their ability to follow through on any changes.
- Health screening tools, as appropriate to the individual for example BMI calculators for those interested in weight issues or use of Audit-C profiling for drinking issues.
- Health information, drawing on various sources, especially the knowledge of the coaches developed through training but supporting the participant to research their own health information using internet sources and other sources.

- Use of tools which support self-assessment and positive lifestyle changes as appropriate to the individual, such as ‘bubble sheets’, ‘eat well plates’, and the ‘balance wheel’.
- Sign-posting to other sources of support and information. This includes helping participants to look up information online or find things out for themselves.

Outcomes

There are 26 Participants who have left the service.

An Analyses of participants still in the service highlights that:

- 78% of participants are making good progress on goals
- 50% of participants achieved 3 goals in 4 sessions
- 52% of people who recorded alcohol as an issue reduced alcohol intake, 23% had not drank at all since last session
- 50% of people had increased exercise since last session
- 35% of people had reduced weight with 1 in 10 people reducing weight by more than 5% of starting weight
- 37% of participants quit smoking since last session, a further 19% reduced smoking by more than 5 cigarettes per day and a further 7% reduced cigarette by between 1 and 4 per day
- There is a marked increase in mental wellbeing from people attending 10 sessions, with 70% of people increasing mental wellbeing. 37% of people have increased mental wellbeing with between 4-10 sessions
- Some participants disengage after a few sessions and there are issues with a high DNA rate in the service, as high as 40% of booked appointments in some neighbourhoods

INTRODUCTION

A key aim of the specification for the Being Well Salford Service was to "Capture learning and identify further refinement to inform on-going service model"[1]. This report aims to make a contribution to identifying the key lessons so far.

Introduction

April 2014 marks the first year of operation of the Being Well Salford (BWS) service. BWS is a partnership managed by Big Life group and involving seven other third sector providers[2], People's Voice Media, Pennine Care NHS Foundation Trust and Salford University. The service offers free level 2[3] support to local people who have multiple health-related lifestyle issues to make changes to improve their health and wellbeing. The service is made up of Being Well Coaches who are trained through the University of Salford and support behaviour change using advanced motivational interviewing and other techniques. The team of coaches work with people on a one-to-one, telephone and group basis.

The BWS service was commissioned by the Clinical Commissioning Group/Salford City Council[4], through a competitive process, as part of a major review and restructure of Level 2 health and well-being provision in the City. This report provides a review of the service development and achievements, drawing out learning points and key messages for the partners, commissioner and other stakeholders. The report is based on analysis of quantitative data and qualitative information within the framework of the Being Well evaluation plan. Annex 1 lists the key information sources for the report, which include quantitative and qualitative information collected from participants, and through discussions with key stakeholders, analysis of key documents and meeting notes. The report also draws on references to evidence based practices in the wider literature.

Background to the service

Salford context

Estimates of the numbers of Salford people who have unhealthy lifestyle behaviours suggest that the situation is worse in Salford compared to the national average for England. Some 30% of Salford residents smoke (8 percentage points above the average for England); and people in Salford drink above the national average , with 44% classed as hazardous drinkers. Estimates show rates of obesity at 24% for both Salford and England.[5] Tobacco smoking is considered the leading cause of ill health and premature death in Salford.[6] Levels of health and wellbeing vary considerably across Salford and are mainly affected by socio-economic circumstances and lifestyle along with other factors such as education, employment, access to health and other services, environment, community networks, transport

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[1] NHS Salford, Way to Wellbeing Level 2 Service Specification, p. 15

[2] The partners are Langworthy Cornerstone; Salford Community Leisure; Salford Health Matters; Salford Unemployed and Community Resource Centre; Social adventures; Unlimited Potential; YMCA.

[3] Nationally there are four levels of emotional health and well being need: universal, targeted, complex and acute/chronic. These are used to identify, prioritise and develop a range of support or interventions matched to a person's needs and strengths.

[4] At the time of transition Public Health commissioning process began in CCG.

[5] AHPO (2012),

[6] Salford City Council (2011), Joint Strategic Needs Assessment

and housing. Life expectancy represents the cumulate effect of the prevalence of risk factors and interventions and is 12.1 years lower for men and 8.2 years lower for women in the most deprived areas of Salford than in the least deprived areas.[7] Health behaviours and socio-economic factors are together estimated to account for about 80% of the differences in mortality rates, with physical environment and health interventions contributing most to the remaining gap.[8]

A key policy priority is linking behaviour change interventions more closely to inequalities policy, in order to focus the attention on improving the health of people in the poorest communities. The proportion of the English population that engages in three or four unhealthy behaviours (including lack of exercise) has declined over time (from 33% in 2003 to 5% in 2008), but the benefits have not been evenly distributed: in 2008 people from lower socio-economic group categories and with least education (no qualifications) were found to be at least five times more likely as those with higher education to engage in all four behaviours.[9] A worsening from three times as likely in 2003. Mapping the Salford data on the proportion of adults with unhealthy behaviours (smoking, drinking and obesity) to deprivation data shows in general the greater the deprivation level the higher the prevalence of unhealthy behaviours.[10] A key issue for health and wellbeing strategy in Salford is the prevalence of negative health beliefs whereby residents see unhealthy behaviour as a regular part of life or not possible to change.

The service specification and response

The specification for the service was set out in Salford City Council's commissioning document:

- A three year programme (to 2016) of level 2 support for people with multiple health behaviours – drinking, smoking and weight issues;
- Engage with 3000 people a year;
- Deliver sustained changes in health behaviours – reductions in drinking, smoking quits, significant weight loss changes and improvements in exercise - with a view to addressing health inequalities in the City;
- Other benefits including employment of local people and volunteering/training opportunities.

The BWS partnership supports the objectives of the Partners in Salford City Partnership which is designed to support the development of joint strategies and activities, working together, sharing resources and reducing duplication. Involving and promoting joint delivery and resourcing, improving community engagement are key aims of the Salford City Partnership.

In their response to the specification, the Being Well Salford partners set out their vision for the development of the provision:

- A partnership model involving a range of third sector organisations and community enterprises established in the local community across Salford, and

[7] Health Profile, 2012

[8] Herne (2010),

[9] Buck and Frosini, Kings Fund, (2012). www.kingsfund.org/publications/clustering-unhealthy-behaviours-over-time

[10] Being Well Salford (2012), Neighbourhood briefing local area review

with a concern to develop the capacity of smaller organisations to deliver services under the umbrella of the partnership;

- Work with defined target populations and within suitability criteria, with delivery from multiple community locations supporting proportionate universalism (targeting identified communities where access needs to be supported);
- Offering an access point with supported self-assessment process and screening for risk, and use of evidence based tools for self-assessment and behaviour change support;
- A menu of support and sign-posting to access services across the well-being offer including access at a range of level 2 groups (by setting up new groups and working with existing groups);
- Use of validated tools, reviewed at points, to measure changes in people's health-behaviours and well-being factors underpinning these.
- A case management approach, which puts clients in control of their own action plans and concentrates on building the skills and self-efficacy to manage their own behaviours and make sustainable changes.

There was consensus that the service needed to look different to existing provision. A development session in the early stages identified a vision as follows:

"Not another service going over all your problems

and what needs sorting out"

"Energizing" "Exciting" "Fun"

"Fun, collective, risk, social: Why do people go to Bingo?"

"A club – with benefits, incentives, offers a menu of support options"

"Doing something collectively, together, focused on a street,

an activity, a group".

Report structure

The report is structured as follows:

- Section 2 sets out how the service and model underpinning it was developed, the 'theory of change' approach on which the service was based, systems and processes and key features of the provision.
- Section 3 describes the operation of the service in practice, reflecting on the assumptions underlying the model and the evidence regarding how far these assumptions have played out in practice. It presents evidence relating to participants situations, readiness to change, the starting points and other determinants.
- Section 4 presents evidence on how the service has been delivered to participants and who has taken part in it. It explores take-up and flow through of participants.
- Service 5 summarises the service achievements so far, including the effect on health behaviour change and well-being outcomes recorded for participants, and explores underlying factors that can be considered achievement.
- Section 6 gives some overall findings and conclusions, and provides recommendations, based on the preceding discussion.

ESTABLISHING THE MODEL

This section shows how the approach is based on co-production and working as a partnership within the third sector. The service process is delivered centrally through The Big Life group but the service provision is based within partner agencies and community venues in Salford. This model was developed to work within communities to deliver health behaviour change and create added social through the partnership.

Partners, underpinning systems and processes

The BWS partnership and delivery arrangements were developed through a period of collaborative development within the partnership during the initial start-up period up to April 2013, and subsequently through service developments in the delivery phase.

The Big Life group and seven third sector organisations deliver the service - Langworthy Cornerstone; Salford Community Leisure; Salford Health Matters; Salford Unemployed and Community Resource Centre; Social adventures; Unlimited Potential; YMCA. Salford University, Peoples Voice Media and Pennine Care NHS Foundation Trust support the delivery through training, evaluation activities and clinical supervision. The Big Life group is the lead contractor for Being Well Salford and reports to the Commissioner. Coaches are employed either by a partner organisation or The Big Life group .

The partners came together to collectively provide a service offer which would not be possible through organisations acting individually. The Big Life group has built local capacity by supporting the organisational development of the partner organisations, and other aspects of the service such as through supporting volunteering and apprenticeships.

Social Value
The BWS approach fits within the spirit of the Social Value Act, with a view to boosting community engagement and changing the way that other providers work through more effective and ethical public expenditure, on a 'not for profit' model[11]. Social Value is defined as "additional benefit to the community from commissioning/procurement process over and above the direct purchasing of goods, services and outcomes'[12].

The service development process was managed through a series of working groups that met regularly to discuss and agree the frameworks and processes to be put in place. Annex 4 sets out the work streams. Getting and maintaining a common core service framework was especially vital given that coaches would be sitting in different environments and employed by different partners.

[11] The Public Services (Social Value Act) was passed in March 2012 and was implemented from January 2013, and requires public bodies to consider how the services they commission and produce might improve the economic, social and environmental well-being of the area. Social Enterprise UK (2012), The Social Value Guide
[12] Social Enterprise UK (2012), The Social Value Guide, p.11

The frameworks which underpin the Being Well Salford model are:

The Pathway Model	Setting out the participant 'journey' through the service. Includes referral, triage, self-assessment, assessment, goal setting and review, planned exit and follow-up
The theory of change	Conceptual framework underpinning the model setting out how participants benefit at different stages of the pathway and the anticipated participant outcomes. Provides the basis for the development of the pathway, progress monitoring and evaluation of outcomes and impacts.
Operational model	The partnership structure which supports the delivery and the management and governance arrangements. The partnership includes the different organisations providing and supporting the service, with decision making through a Board supported by task working groups.
Partners sub-contractual specification	The working relationships are established between the partners based on the contractual specification of roles and responsibilities and a performance management approach.
Neighbourhood model	The model of delivery is based on local neighbourhood areas each with a local plan detailing the services being provided and the outputs which might be expected in each case, tailored to local circumstances particularly population and deprivation factors.
Capacity planning approach	The work of the coaches was planned and organised in order to maximise capacity around a sessional based delivery model and work with participants in appointments face to face, in groups and by telephone. Use of volunteers and trainees supports the capacity planning approach.
Coaching model	Coaches work with individuals to help them self-management of their health-behaviours, taking account of their beliefs, values, priorities, culture and life situation. The coach-participant relationship is through a collaborative process, grounded in the participant's own agenda, which seeks to build the person's self-efficacy. The coaches' practices are based on skills and values: evidenced based interventions, empathy, compassion, health and well-being knowledge.
Coach competency framework	The coach competence framework is the underpinning framework for building the competencies of the coaching staff in terms of the required skills and knowledge to work effectively with clients and to manage workload etc. The framework is relevant to formal training through

	Salford University, other training on an ad hoc basis and other types of soft skills development including teamwork/team building.
Caseload management	The arrangements for supervision of the coaches' work with participants includes internal supervision and external clinical supervision through Pennine Care.

Staffing arrangements and staff development

The team coaches are employed by partner organisations and The Big Life group to deliver from different locations in the community. Some partner organisations host but do not employ (in some cases due to systems/capacity issues, or due to pension/tenure issues). There have been two rounds of recruitment and the coaching staff team currently stands at 15. Coaches have been assigned to neighbourhood areas and have built up strong local links and understanding of the communities in which they work.

Volunteering opportunities and apprenticeships are part of the approach, with a view to enhancing capacity and creating further jobs and training opportunities for local people. There has been 1 apprentice and 14 active volunteers in the first year. Two volunteers have gone into jobs locally in the health sector. Formalisation of the volunteer role as part of the service delivery is planned from summer 2014.

Recruitment

The approach to recruiting coaches to deliver the service, and to developing their competencies, was a key area of innovation. The person specification did not include any specific qualifications, but focused on the person's values, skills and qualities. The recruitment process included a series of events at community venues to promote the opportunities, video applications (rather than application forms) and assessment days. The first wave secured 120 applications, and eight coaches were recruited with a mixture of ages, gender and backgrounds. 80% of the core staff team live locally.

The training programme, and the competency framework for coaches, was developed by a training task group involving the partners which met up to December 2012. There have been several strands to developing the competencies of coaches:

- **Formal training** (2 rounds from January 2013) delivered by University of Salford: an eight week course was developed followed by return to university 1 day per month. There is the option of working towards academic credit within the university's work-based learning framework (at a level which reflects previous learning at HE level 4-7).
- **Informal training** activities: taken forward internally within the service through team work activities, facilitation of sharing of experiences, resources and tools within the team;
- **Partnership activities** drawing on expertise of related services and agencies in Salford, for example, joint working with Salford Drug and Alcohol Service;
- **Ad hoc courses** for staff and volunteers, for example, Strive for Five training;
- **Individual staff development** within the framework of the coaches' staff appraisal system and CPD.

A review of the approach to developing the competencies of the coach to deliver their role is currently underway and will be reported separately. Some initial observations suggest the following:

Key strengths of the approach	Areas for ongoing development
• Collaborative model of learning to university level. Focus on working with different health beliefs. • Training on evidence-based approaches to an advanced level (Advanced MI training). • Theoretical grounding in health, which helps to supports the coach role at local policy and strategy level. • Set within framework of ongoing assessment of training needs within service evaluation framework and at individual level.	• Applied learning and practical skills to deliver health behaviour change tools such as screening tools and e.g. 'balance wheel'. • Building coach time management and case load management skills. • Further understanding of key health issues/clinical observations and implications/risk factors, knowledge on information and behaviour change messages. • Opportunity for specialisation within the team.

Developing the pathway

The pathway drew heavily on a 'theory of change' which saw participants as engaging with the service over time and which linked interventions to immediate, intermediate and longer term outcomes. The pathway is based on the stages and defined outcomes below (*see Annex 3 for the theory of change model*):

Stage	Outcome(s)
Referral and triage	Suitability assessed
Initial self-assessment (and base lining)	Increased understanding of health behaviours and risk factors
A first appointment, face to face up to 1.5 hours. Identification of health behaviour change goals and the development and agreement of an individual action plan.	Commitment to specific health behaviour change goal(s) relevant to each individual.
Ongoing face to face, group or telephone support (up to 1 hour for face to face contact up to 30 minutes for telephone, group work via BWS course or participation as part of existing groups)	Increased self-efficacy and well-being. Progress to individual goals and positive changes in health behaviour
Planned exit and the offer to re-engage if needed	Goal achievement and health behaviour change
Follow-up at 12 months to assess whether changes were sustained.	Sustained behaviour change

Behaviour change tools and techniques

Figure 2.1: *Tools used to build skills and understanding which support positive behaviour change*

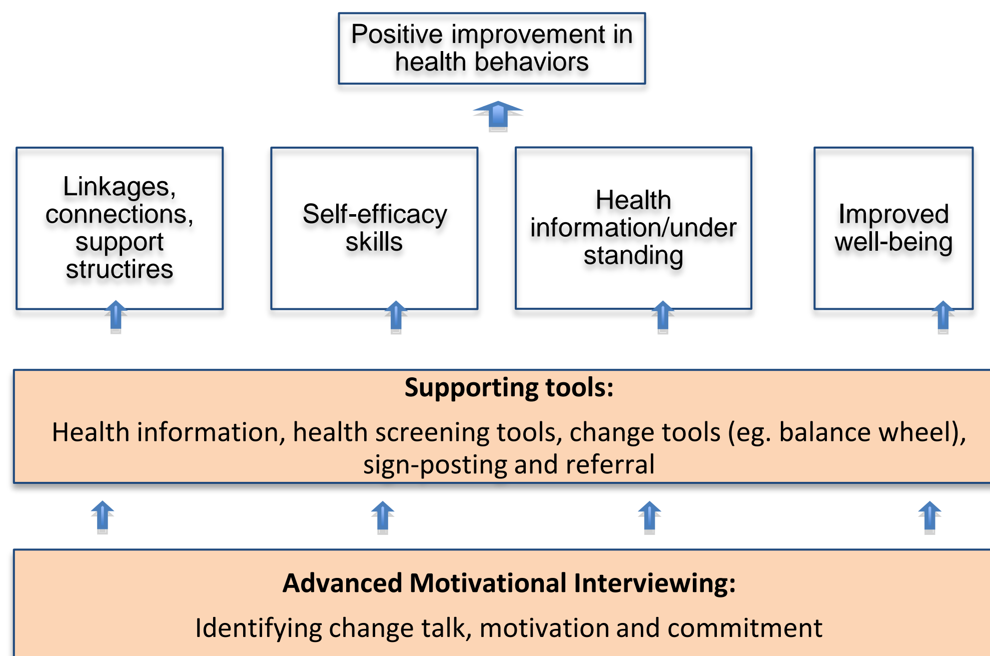


Figure 2.1 summarises in brief the BWS conceptual approach. The work with participants was designed to draw on evidence-based tools that have been demonstrated to generate change:

- **Motivational interviewing (MI)**, which is a person-centred collaborative approach that focuses on people making their own choices. The purpose of MI is to evoke and strengthen personal motivation for change. MI applies specific skills to help people, including prescribed use of techniques.[13] MI is non-confrontational and puts the focus on identifying and strengthening 'change talk', and in this way is guided by the persons' language and motivation. MI is goal orientated, with a focus on negotiating a plan of action and getting commitment to it. MI has been shown to work well with people who are ambivalent about behaviour change, including those who may have attempted to change their behaviour in the past but were unsuccessful and now doubt their ability to follow through on any changes.

- Supporting tools, particularly:
  - Provision of **health information**, drawing on various sources, especially the knowledge of the coaches developed through training but supporting the participant to research their own health information using internet sources and other sources;

[13] Particularly the use of open end questions, affirmations, reflections and summaries (OARS).

- Health **screening** tools, as appropriate to the individual for example BMI calculators for those interested in weight issues or use of Audit-C profiling for drinking issues;
- Use of **tools** which support self-assessment and positive lifestyle changes as appropriate to the individual, such as ‘bubble sheets’, ‘eat well plates’, and the ‘balance wheel’;
- **Sign-posting** to other sources and support and information. This includes helping participants to look up information online or find things out for themselves.

These tools are used throughout a process of collaborative goal setting and review. Such an approach has been shown to enhance people’s self-efficacy skills. A key skill required of coaches is in the managing of the conversation with clients that remains goal focused and identifies a realistic action plan for each individual.

In addition, the coaches use validated tools to collect data and work with clients and monitor their progress. The measures are based on collection of data from participants including self-declared measures for drinking (AUDIT-C short form), smoking, weight change and exercise. The WEMWBS wellbeing measurement tool and the health training self-efficacy measurement tool are used to track changes in well-being and self-efficacy. These tools are used in the framework of the pathway described above as part of the collaborative conversation between coaches and participants.

The Big Life group client management system (CMS) is used to record comprehensive information on participants to track their progress through the service and to record outcomes. Initially it was also hoped that the client management system would include a web-based front-end through which participants could input data and assess their own progress, and other resources such as the facility to text updates to participants. However, the CMS system is still being implemented across Big Life group businesses and services and currently, the databases is a closed system which is populated online by the coaches during or soon after the sessions with participants. The CMS system will continue to be developed in line with the participant and service need.

Approach to targeting

In broad terms BWS set out to target people who could benefit most from the service – especially those groups experiencing reduce life expectancy due to unhealthy lifestyle issues. Discussion in the early stages of the development gave consideration to how the people who might benefit could be described to potential referrers and there was a particular focus on those people who other services (including health practitioners) feel they can’t help, and people who are not coping in their day to day lives.

BWS understands that people experiencing socio-economic deprivation are more likely to have poor health and lower life expectancy, than people in more affluent areas.

In order for the service to engage with those in the most disadvantaged areas with the poorest health outcomes, a model to assess how the service was reaching priority groups was developed. This captured neighbourhood data (i.e. population size, geography and deprivation index) and risky behaviours plus low mood/primary mental health issues and life situation.

Targets for the neighbourhoods were identified based on the extent of relative deprivation and population levels in the different parts of Salford. Table 1 shows the breakdown by neighbourhood (taking account of the need for some 'smoothing' to ensure good coverage across the City). At the same time an Equality Impact Assessment undertaken in the development phase also identified actions to engage protected characteristic groups (see below for review of take-up).

Table 1: Share of participation target by neighbourhood

	Resident population	Level of deprivation (% of population living in the 20% most deprived neighbourhoods)	Share of target
Little Hulton and Walkden	34,400	57%	17%
Swinton	34,300	31%	10%
East Salford	44,300	74%	29%
Worsley and Boothstown	20,200		2%
Irlam and Cadishead	20,000	15%	3%
Eccles	33,600	52%	16%
Claremont and Weaste	22,900	32%	7%
Ordsall and Langworthy	22,100	87%	17%
Total	231,800		100%

The staffing arrangements reflect the priority groups as a proxy for estimating the level of need. There are coaches in each neighbourhood who have various locations within the community, and this means the service is relatively easily accessible (see annex 2 for venue locations). At the same time, coaches have been located to reflect need (e.g. two coaches in areas that have 16%+ of the share of the target).

Summary of key design features

To summarise, the preceding discussion, the BWS service model that resulted from the development work in the initial phase was designed to include:

Key design features

- Dispersed delivery to maximise community linkages and engagement, within a common core service framework and centralised management functions to ensure consistency and opportunities for working as a team;
- Geographical focus which seeks to prioritise the individuals and communities who can benefit most from the service;
- Formal relationships between partners based on sub-contracting and performance management;
- A coaching process which is person-centred, linking to the persons' starting points and other key determinants, and which draws on tools and techniques that have been shown to get results, particularly motivational interviewing;
- A recruitment process which takes account of the skills and values of staff in relation to working rather than formal qualifications with people and a comprehensive competency development framework;
- A structured approach to volunteering so that people who have used the service and want to get involved have the opportunity to support others.

THE MODEL IN PRACTICE

Some of the assumptions and key features identified in the original model are reviewed based on the experience of working with the participants.

The model underpinning the vision for the service was based on a number of assumptions linking to a theory of change approach described above. The available evidence is brought in here to assess how far these have played out in practice.

Referrals

Initial assumptions: The three routes into the service were considered to be referral from a pathway service (i.e. partner organisation), third party referral and self-referral. The main emphasis was on referral from a pathway service, i.e. via a Being Well partner organisation and the potential for close engagement of appropriate participants who could benefit from the service was seen as a key potential advantage of the partnership approach.

Evidence: Referrals come from a wide range of sources (for example, 84 referral organisations were recorded in Q4). The largest share has been self-referrals. Referral data shows that 17% were self-referrals and 81% were referred by another service (2% not stated). Organisations referring most people were Worsley Job Centre (16%), Salford Drug and Alcohol Service (7%) and Social Adventures referral pathway (6%)[14].

The service has promoted itself through a launch, roadshows and media, and has worked alongside local agencies and organisations to identify people who can benefit from the support of the coaches. Broadly around nine out of ten (87%) of those who gave a source heard about the service from other agencies (of which 26% were GPs). BWS media (posters, website, leaflets etc.) informed approximately 7% and 'word of mouth' accounted for the remainder. Future plans include more direct engagement with the community.

There were 933 total referrals in the year (table 2). Referrals have lagged behind the target numbers.

Table 2: Referrals and participants by type of referrals

Referral type/agency	No. of referrals	% of referrals	No. of participants	% of participants	% take-up
Self-referral	153	15%	104	18%	68%
GP/Health	236	24%	118	20%	50%
Drug/Alcohol service	147	15%	74	13%	50%
Employment service	134	13%	87	15%	65%
Mental health services	67	7%	51	9%	76%
Other service	82	8%	62	11%	76%
Other	174	18%	81	14%	47%
All	993	100%	577	100%	58%

[14] Including Six Degrees and GP surgeries

The high numbers of referrals from other agencies is testimony to the relationship building work which the coaches have been undertaking locally. The networks that have been built up have been important for referrals but also to connect BWS participants to activities and like-minded people, with the aim of helping them maintain their achievements. Relationship building is a long process and the initial development and strong emphasis on getting the branding and promotion right, coupled with very pro-active work by the coaches with local organisations was important to establishing the service locally. Issues emerged early on around confusion over the remit of the service, with different partners presenting the service in different ways, meaning there wasn't consistency in communication the vision of the service. Issues about how the service fits with existing provision meant there was a sense of competition for clients rather than the desired service compatibility. A key learning point has been the need to ensure the vision is clearly understood and emphasis on continued engagement with other organisations.

On average just under six out of ten people referred went on to access the service (table 2 above) The number of people who go on to take up the service varies: those referred by mental health services and other services have the highest proportionate take-up whilst GP/health agencies have the lowest uptake rate (accounting for 24% of referrals but only 20% of participants), with drug and alcohol services (15% of referrals and 13% of participants). Self-referrals result in a relatively high proportion of take-up although further analysis has shown that the referrals generated from general publicity and roadshows at the start of the service were less likely to generate actual participants (mainly due to high numbers who did not respond to further contact). There is some suggestion that having more assertive practices in place to identify people who might benefit – as taken by some GP Practices who pro-actively identified potential clients – whilst important in generating referrals does not necessarily translate proportionately into participants (due to the number of referrals that haven't been assessed through being unsuitable for the service, turning down the service, or not responding to contact). In order to reduce the number of people that are not assessed after referral the service is working more closely with services, such as MDAS and GP practices to share information about client contact and progress. Also, coaches have started to work within some referral organisations to provide better information on the service and conduct initial screening on a drop-in basis to help ensure the referrals are appropriate and help improve successful follow-up of referrals.

Identifying multiple needs

Initial assumptions: Eligibility criteria were defined as multiple health behaviours (at least two). It was considered that there is a gap in the evidence about which groups have multiple risk factors, the service will learn a lot about how risks map together through analysis of clients and case studies. Central to the model was a person-centred approach to working with people in a non-judgemental way and to focus on their life circumstances and the factors underlying behaviour and to help them set goals which relate to the individuals' priorities.

Evidence: The participants' data suggests that the service is engaging groups who have multiple health behaviours although it has sometimes proved difficult to get the information to assess this objectively. Table 3 attempts to identify where baseline data shows a particular issue to be addressed. The extent of missing/unusable participant level health information is fairly significant as shown in Table 3. The largest groups identify issues with low mood, being over-weight and lack of exercise, followed by smoking, and then drinking.

Table 3: Assessed participants with various health behaviours

	Of those with data	Of all	% missing or unusable
Smoker	73%	44%	39%
Unhealthy drinking (Audit-C score of 5+)	86%	35%	6%
Lack of exercise (never exercise or only light exercise)	89%	45%	6%
BMI Over 25	93%	38%	43%
Low mood[15]	95%	81%	14%

Figure 1 shows the prevalence of multiple health behaviours, based on a sample of 219 participants on which data for all five types of behaviours was available[16]. The largest group (two-fifths) had three behaviours and nearly a third had four behaviours. The most common combination of health behaviours, shown in Figure 2, were : lack of exercise and unhealthy drinking and smoking and low mood (20%); unhealthy BMI and lack of exercise and low mood (20%); lack of exercise and smoking and low mood (14%); unhealthy BMI and smoking and low mood (8%).

Figure 1: Multiple health behaviours

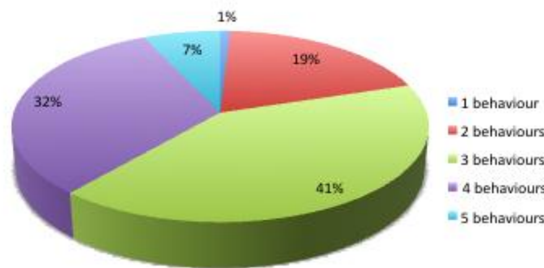
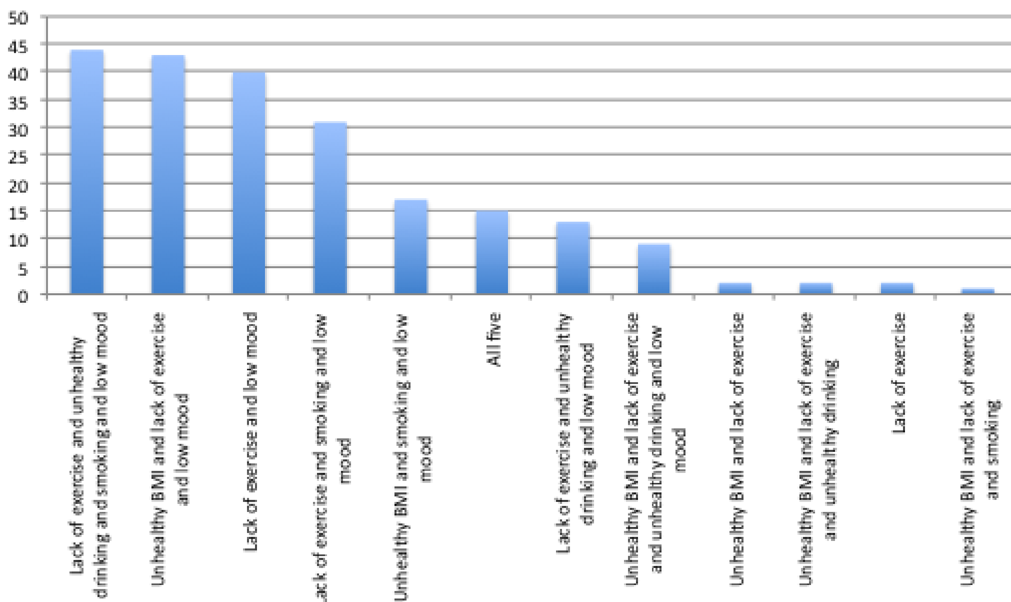


Figure 2: How health behaviours mapped together (sample)



15 Defined as those setting goals to improve mood.

16 Low mood defined as working on how I feel.

Readiness to change

Initial assumptions: The service should assess individuals' readiness to change as a factor in the assessment, with a view to making judgements about the suitability of the person for the service (as is common in English health promotion). Readiness to change was assessed using a ladder of contemplation measure (adapted from smoking version)[17]. The specification focused on people with motivation to change.

Evidence: Only a minority (30%) said they were starting to think about or already making changes when they began their participation with the Being Well service. Those who were already thinking of changes or changing tended to score more highly in terms of the well-being measure (table 4). The average wellbeing scores varied by type of goal (lowest for those working on smoking, highest for those working on drinking). However the average score disguises quite a lot of variance in the individual scores. Also, there is a gap in the approach as it has been implemented in that the service does not allow differentiation between readiness to change different health behaviours (i.e. the extent to which a person may be ready for change in relation to one health behaviour but not another).

Table 4: Readiness to change and well-being scoring

	Participants		Average WEWBS score
	No.	%	
Not thinking about making changes (0-1)	4	1%	12.0
I think I need to consider making changes (2-4)	79	20%	16.5
I think I should but I'm still not ready to make changes (5-7)	194	49%	18.5
I'm starting to think about making changes (8-9)	84	21%	21.3
I'm already making changes (10)	36	9%	20.0
Total	397	100%	

Feedback from the coaches and the participant case studies have shown how some people are aiming to make specific changes across different health behaviours. Coaches report that in the main most participants are quite open about their lifestyle and experiences, and in identifying the issues they actively want to work on. Comments from coaches included:

> ***"…most are coming for a reason and want to move forward"***
>
> ***"…the conversation allows them to bring up the things they should be doing which are most important to them"***
>
> ***"..many come because they are ready to make and sustain change long term"*** [18]

A key area of learning for the service is how people who categorise themselves as 'not ready/stilling thinking about change' go on to make changes. The MI approach might be helpful here since it is designed to work with ambivalence, through eliciting motivation and building on change talk. At least on the early evidence those who score more highly in terms of readiness to change are more likely than those with a

[17] http://web.fu-berlin.de/gesund/gesu_engl/conner9.htm

[18] Being Well Salford (2013), Rapid Review of Training

lower readiness score to identify self-declared improvements in the health behaviours in their most recent progress. However this data is somewhat problematic as it includes people at all stages of participation in the scheme.

Table 5: Readiness to change and self-declared changes in most recent progress review

	Readiness under '5'	Readiness '6+'
Self-declared improvement in drinking	18%	40%
Self-declared improvement in weight	13%	30%
Self-declared improvement in smoking	14%	20%
Self-declared improvement in activity	37%	61%

Goal setting

Initial assumptions: Participants would establish clear overall goals related to changes in health behaviours. They would engage in a process of action planning containing small stepwise goals to work on between sessions which would contribute progress to their overall goal, and would be individually driven. A key skill required of coaches is working with participants in a way that ensures they remain goal focused and identifies a realistic action plan for each individual.

Evidence: Even where an individual has unhelpful health behaviours this does not necessarily feed through into the identification of health behaviour change goals. Some 12% of the cohort had not identified any issue to work on. Coaches commented:

> ***"…some people are notably evasive and avoid the real issues, even though they can be quite talkative about non-relevant things"***
>
> ***"…quite a few have been told before what they should do, by doctors etc., but they don't really know what they want to happen"***

The pattern in terms of the categories of main goals set by participants is shown in Table 6: goals around 'how I feel' are most common, followed by activity goals, weight goals and then smoking and finally alcohol. There are differences between women and men. Women are proportionally more likely than men to identify weight goals. Proportionally more men have set smoking and alcohol goals.

Table 6: Behaviour change goals (assessed participants)

	Female	Male	All
Losing Weight	64%	44%	55%
Physical Activity	70%	68%	69%
Alcohol	16%	37%	26%
Smoking	23%	36%	29%
How I Feel	81%	80%	81%

Most people want to work on improving the way they feel, and there is a clear connection here with the service targeted people who are experiencing low mood, although qualitative research with coaches suggests that people who want to improve the way they feel encompass a broad range:

> ***"…feeling like they're stuck in a rut and they want to break out of it"***
> ***"They are depressed or feeling very anxious and struggling to cope"***
> ***"…needing support and looking at what kind of things they can do following a diagnosis of mental health issues"***

The link between how people feel and their health behaviours is a key aspect of the BWS approach. The qualitative case studies very much support the view that mood and health behaviours are heavily inter-linked. More could perhaps be done around articulating this aspect externally to potential referrers.

The review of goal achievement clearly shows that the role of the coaches is crucial for a number of reasons:

- To work with participants to set goals over time where the person is finding it hard to commit to behaviour change. MI is useful here because it is designed to work with ambivalence;
- To make the connection between the individually led participant-centred goals and the objectives of the service;
- To set 'SMART' goals which enable participants to progress and build self-efficacy skills;
- To enable make sure the goal setting and review process is useful for measuring progress to health behaviour change and case management so that participants can be assessed as to their progress in the service and health behaviour outcomes.

In some cases the goals people set may not reflect the persons' problem health behaviours, because the person is working on these with another service outside the remit of participation with BWS. Almost a third (31%) of those with data to assess drinking said they never drink (Audit-C score '0"), and this statistic reflects the number of people coming through alcohol services who are currently abstaining as part of a recovery programme. 89% of those with 0 Audit-C score had identified goals relating to low mood. Only 13% had set goals in relation to BWS to tackling drinking. 72% set weight goals, 86% set physical activity goals and 37% set smoking goals.

Health understanding / awareness

Initial assumptions: The screening and biopsychosocial assessment in session 1 was seen as the first step in raising awareness and increased understanding of the risk factors and benefits of change.

Findings: Information collected from participants during the self-assessment phase suggests that a relatively large majority – two thirds – consider that their health is at risk from the lifestyle/behaviours, although only a third rated this health impact as most high (Figure 3). No particular differences were observed between different groups by sex or age. Based on responses to a series of questions about access to information and support, most participants appear to feel that they are relatively well informed about the issues and what changes may be needed in their lives to improve their health and well-being (61% strongly agreed or agreed to this). Around one in eight (79%) said they know when my lifestyle creates health problems for me, and 73% said they know what changes they need to make to be healthier.

At the same time, there is a disconnect between what participants say in terms of having the knowledge and understanding of health behaviour information, and how this is translated into practice in people's lives. On the one hand, coaches report

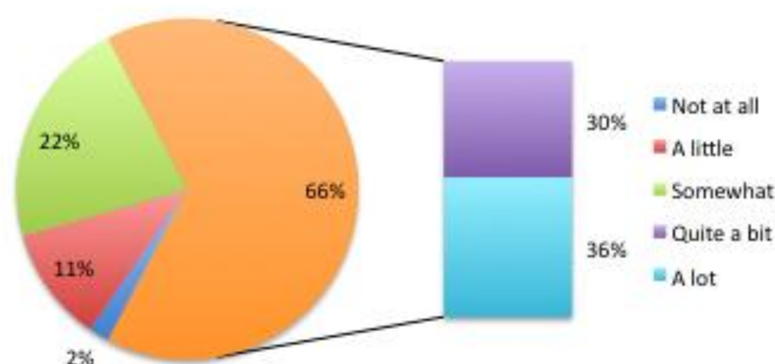
some people appear to have mistaken health beliefs (even though the person themselves may rate their understanding as high). On the other hand, even where participants are fairly well-informed, translating this understanding into practice is a different matter. Only under half (47%) said they were confident about managing their own behaviour. Coaches report that many participants are discouraged from making positive changes due other issues (and not so much by having negative health beliefs). The link between mood and health behaviours comes out as a key issue. Comments from qualitative research with tem members include:

> ***"Some people have been put off by failure to follow-through on making positive changes in the past and think they can't do it";***
>
> ***"…the participants say they know what they should be doing… but say it's hard to fit in their lives, or they're influenced by mood which knocks them off course, emotional eating for example"***[19]

The importance of this finding to the theory of managed behaviour change on which the BWS service model is based is that information provision and awareness raising was seen as the first step. In practice participants feel they have information already (even though coaches report mistaken health beliefs and problems translating into action). The role health information and understanding plays appears to depend on a number of factors:

- The skill of the coaches in being able to integrate health information provision as part of an MI process;
- The confidence that the coach has in delivering the key health messages;
- The extent to which collecting and researching health information is led by the coach or used as a focus for the participants' activities and skill-development.

Figure 3: To what extent do you think your current lifestyle/behaviour is putting your health at risk? (assessed participants)



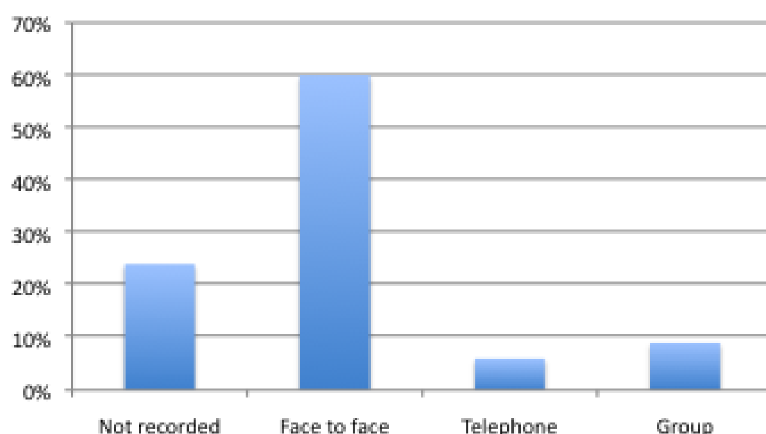
Pattern of provision

Initial assumptions: The team of coaches work with people on a one-to-one, telephone and group basis in order to offer a range of alternative ways of participating to suit everyone, and to maximise the delivery capacity.

[19] Being Well Salford (2013), Rapid Review of Training

Evidence: Face to face contact represents by far the most common way of working with participants, as shown in Figure 4). The ‘not recorded’ group represent face to face contacts recorded prior to groups starting. Group work has faced certain challenges, particularly in terms of recruiting people and attendance, although there has been an improvement over time in the number of group contacts (accounting for 17% of client contacts in Q4)[20]. At this stage it is not possible to draw any conclusions about the profile and outcomes of participants taking part in different types of provision.

Figure 4: Appointments completed in 2013-14 by type



Evaluation of the group work identified the main problem as being to do with lack of interest/take-up. BWS is trialling different approaches to group work in the next period of the project.

Delivering behaviour change goals

Initial assumptions: Sessions 2 onwards were conceived as brief interventions using MI, action planning and goal setting, and drawing on online and web support/tools where appropriate with a view to building increased knowledge, motivation and firm commitment to behaviour change. Individual action and group activities/peer provision were both seen as being part of what should be delivered in this phase.

Evidence: Information on the number of sessions to set plans and measure shows that three quarters had more than one goal setting/review session, of which the largest group (31%) had had 2-3 sessions[21]. Around a fifth (17%) had 4-5 sessions and a further 20% had 6*10 sessions. 7% had had over ten sessions, of which 3% had over 16 sessions (this is current participants whose participation is ongoing rather than leavers)[22].

Analysis of time in the service of all participants in March 2014, and the average number of sessions recorded for participants of different duration with the service (table 7), suggests that on average most people have 1-2 contacts a month.

[20] 197 group attendances out of a total for the year out 322 were in Q4 (62%). 53 participants took part overall.

[21] Based on sample of 404 participants in marchMarch 2014.

[22] Note this data is based on the dates of data entry for the person. It may under-represented the number of sessions in a small number of cases of data was entered on the same date.

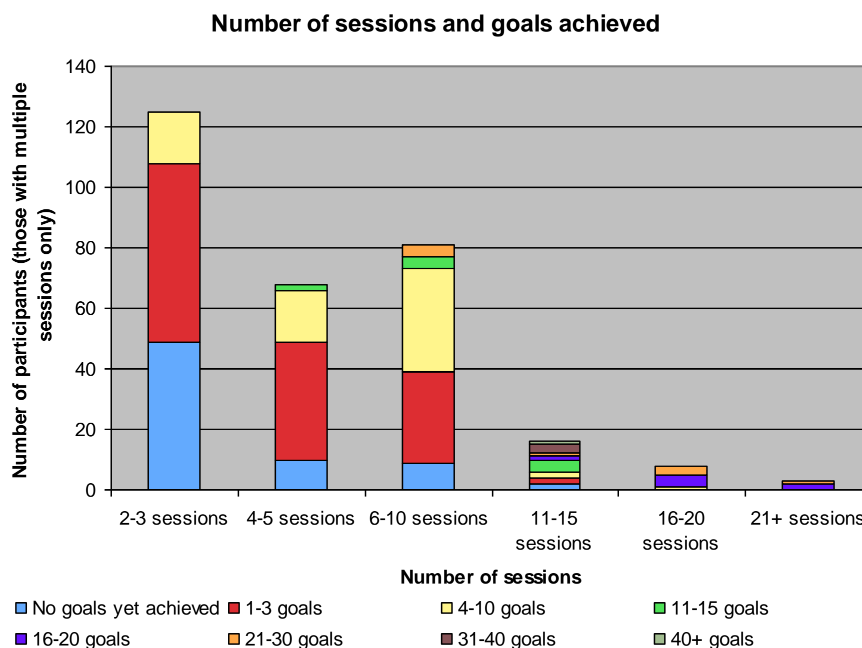
Table 7: Participants by time with the service[23]

	No. of participants	% of participants	Average no of sessions (including assessment)	Average no of goals achieved	% who achieved 3+ goals	% who achieved 6+ goals
Assessment only	138	25%	1			
Less than 1 month	110	20%	2			
at least 1 but less than 3	112	20%	4			
at least 3 but less than 6	103	19%	6	3		
at least 6 but less than 9	56	10%	9	6		
at least 9 but less than 12	29	5%	14	15		
All	548	100%	4			

Figure 5 shows the number of specific goals that were achieved by participants in terms of the small steps set between the sessions. Only a minority of these participants for which data is available (12%) said they had not achieved any goals by the time they had taken part in more than 4 sessions. Two-fifths achieved 1-3 goals after they took part in 4+ sessions, and almost half (48%) achieved four or more goals after this point. Note these refer to the steps which participants agree at the sessions in order to make progress to their overall objectives (i.e. the steps to the overall goal and not their ultimate target goal).

[23] Based on calculating the difference between data entry date for latest coaching session and the corresponding date for when the person's initial assessment was undertaken.

Figure 5



Further work is needed to analyse the types of goals and their usefulness to tracking progress towards health behaviour change. Moreover, an initial analysis of the goals recorded for participants suggest that there are differences in how goals or the vision of a participant are formulated. While smaller goals or steps are SMART, the vision often isn't. The service will be focusing on making the vision SMARTer but will also aim to learn more about what is important for participants when setting vision and taking the steps towards sustained change .

Behaviour changes

Initial assumptions: Sessions 6-8 were thought to be around the time when behaviour change would start to be seen. These sessions were thought to be about revisiting goals/reflection, exploring additional support, and using tools including online and web support.

Evidence: By March 2014, 304 people had commented on progress to their main goal (others did not specify or it was too early to say because they had only one session). Of those that gave a response, the largest group (45%) said they had made a start, over a fifth (22%) had made good progress (Table 9). Only a very small minority (2%) had achieved their goal[24]. Importantly due to the relatively few numbers reaching the end of participation with BWS it is hard to draw any conclusions about how effective the service is at helping people to achieve their goals. As expected the proportion saying they have made progress to goals increases with the number of sessions (Figure 6).

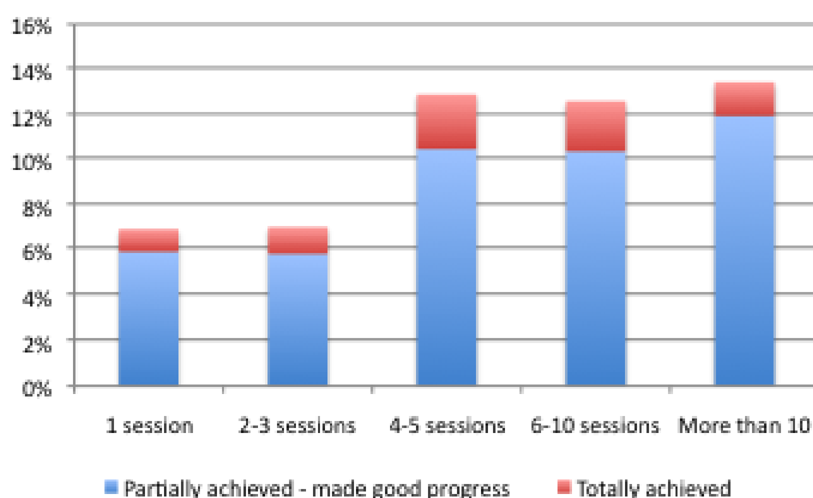
Table 9: Which of these describes how much progress you have made in achieving your main goal (based on response in most recent session)?

[24] Note this is based on the response given at their most recent session (some people achieved a main goal but stayed in the service and they may not have achieved their revised goals at the time of the latest session, so the figures here might slightly under-represent all who had already achieved a main goal).

	No.	%
Have made a start	138	45%
Partially achieved - made good progress	66	22%
Totally achieved	6	2%
Same as before	83	27%
Worse than before	7	2%
Not sure	4	1%

Progress is relatively slow in terms of fully achieving health behaviour goals and after 6 sessions 3% said they had fully achieved their main goal, although a further fifth (22%) said they had made good progress towards it.

Figure 6: Achievement of main goal



A Key issue for BWS is the relationship between the achievement of goals and changes in health behaviours.

Moving on

Initial assumptions: Planned exit from the service was considered to be at the point when the participant had achieved the health behaviour change goals they had identified for themselves and were in a position of confidence to maintain. This could be up to 12 months but in practice would be decided by the participant and coach together.

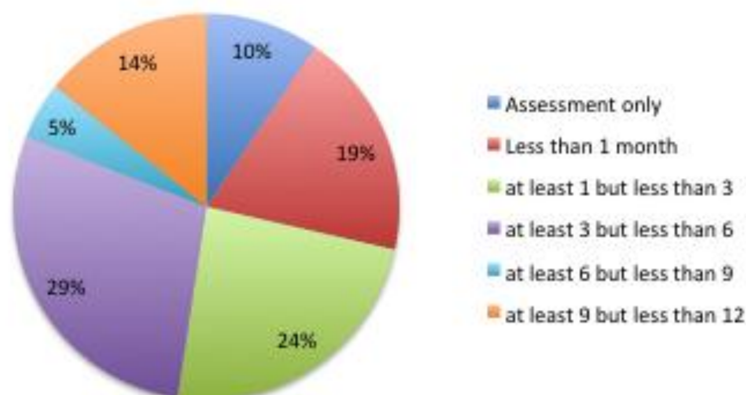
Evidence: There have been relatively few planned exits from the service – 26 leavers so far - representing only 5% of all participants (3% of closures[25]). When this figure is considered together with the data in Table 7 which shows that 15% have been with the service over 6 months[26] it seems that issues relate to the lack of progress of health behaviour change goals achieved and the fact that some people dis-engage after a few sessions. Of the leavers who could be matched to participation data, well over a quarter were with the service for less than 1 month (based on calculating the difference between data entry date for latest coaching session and the corresponding date for when the person's initial assessment was undertaken). The largest group attended for 3-6 months (Figure 7). This is perhaps broadly in line with what was expected. One of the difficulties of unplanned exits is

[25] 30% of closed cases were unsuitable and 73% could not be contacted post referral.

[26] Based on calculating the difference between data entry date for latest coaching session and the corresponding date for when the person's initial assessment was undertaken.

the collection of progress data, as the participant doesn't complete an exit form. To ensure we have progress data for all participants we are ensuring data is collected by coaches at each session and will follow up with unplanned leavers to ask about the experience they had in the service.

Figure 7: Leavers time in service



Outcomes

Initial assumptions: It was expected that the data at 3 months would show changes in attitudes, feelings and confidence. By 6 months participants were expected to develop new skills, increased confidence to change, and have created new relationships to support positive changes. By 9 months participants were expected to have increased their self-efficacy, made positive behaviour change and have coping strategies to sustain change. Review at 12 months was expected to show significant health improvements, and at this point there would be the offer of support for self-management, referral (level 0.1) step-down and sign-posting to other services.

Evidence: The approach taken to assessing outcomes was to compare health behaviours of participants on exit against the baseline and at 12 months. The relatively small number of leavers makes assessment of outcomes somewhat problematic at this stage (see some further information in next section below). As a general point the analysis and case studies highlights differences in participants who might be considered as 'rapid progression' and people that take longer to progress. In one example of a rapid progression is provided in case 1, this person made rapid progress to her goals in four months. However case 2 was facing various other issues which meant that goals changed over time. The positive role the service played here was to maintain (and achieve) this person's long term goals on exercise, despite the challenges faced.

Looking at responses to questions about participants perceptions of how their health behaviours have changed gives some suggestion that some people make improvements relatively quickly, especially in relation to self-assessed improvements in mood and activity levels. Proportionally more people who had been with the service over a longer period said their weight and activity levels had improved. For some health behaviours the impact of the service appears to diminish over time, perhaps reflecting the very complex needs of the target groups who stay with the service for a long time. The proportion who self-assessed their drinking and

smoking as improved compared to the start of the service was lower for cohorts who had been with the service for longer. However, these figures should be treated with caution however because it is self-assessment rather than an objective measure, and due to the difficulty in grouping cohorts in this way given most people are still participating in the service, and the small sample sizes for groups who have been with the service over a longer period.

Case 1: Rapid progression

Participant characteristics	Female aged 55
Route into the service	Referred from Hulton District Health Centre. Rated 3 out of 10 in terms of readiness to change on entry to the service.
Overall goal	Stop smoking, manage weight, mood & activity
Outcome – self-assessed	Health behaviour goal achieved (smoking) and made good progress towards improved mood.
Outcome – health behaviours	Had quit smoking (from 15 cigarettes a day). 6lbs weight loss.
Other outcomes	Joined weight watchers. On exit participant identified herself as having lots of support at the moment and finding it easier to manage when not alone. Reported "I feel so confident and I feel like shouting from the rooftops". Self-efficacy score increased from 17 to 30. Well-being score increased from 18 to 26.
Participation profile	4 face to face sessions (including assessment) between June-September 2013.
Overview of goals setting and progress	Specific goals set at first planning sessions were to use a smoking cessation inhalator and undertake research into healthy eating (researching recipes and official guidance not 'fad diets'). By the second session this person had made good progress and set goals to maintain the positive changes.

Case 2: Longer progression

Participant characteristics	Male aged 66 years
Route into the service	Self-referral to BWS following a Roadshow Rated 6 out of 10 in terms of readiness to change on entry to the service.
Overall goal	Goals around losing Weight, increasing fitness/Physical Activity
Participation profile	21 face to face and telephone sessions (including assessment) between May 2013 and February 2014. During this time this person was diagnosed with a serious condition and underwent an operation.
Outcome – self-assessed	Achieved weight and activity goals. Physical activity level, mood and weight self-assessed as much better than before.
Outcome – health behaviours	Exercise increased from 2-3 times a week to 7 days a week, including 5 days moderate physical activity of at least 30 mins
Overview of goals setting and	The goals were adapted over time due to the

progress	changing circumstances of the individual, and new goals identified to fit – e.g. around finding out and undertaking bed-based exercises, and building in physical activity as part of a recovery programme.

Summary of model in practice

Key features

People have been referred from a wide range of services, and many have contacted the service directly. The rates of subsequent take-up vary and there may be a trade-off between assertive promotion and rates of take-up.

The service works with people with multiple issues rather than a single one, and the data suggests that those involved have high rates of unhealthy behaviours, however, most people focus on the thing that is most important to them. A key skill of coaches is to help people to become goal focused, and to link individual goals to behaviour change. Coaches can spend more time with people helping them to understand and deal with the root causes of the behaviours they want to address.

Although the service has targeted people who are ready to change, in practice participants have been at different stages in terms of their readiness to change. Using MI the service has been able to work with ambivalence, although more needs to be done to link participant goals to health behaviour change.

Many people already know what they should be doing and understand the health messages (although coaches also describe mistaken beliefs). Coaching activities focus on translating health information into reality, including connecting people up to the activities and opportunities that will help and filling gaps.

The vast majority of the provision has been through 1:1 work and it is not possible to assess the effectiveness of different ways of working at this stage.

As might be expected the number of goals achieved increases by length in service. More needs to be done to link goal achievement to behaviour change outcomes.

There have been relatively few planned exits from the service, and this is an issue for case management. Analysing the outcomes achieved by participants is rather problematic and more data is needed (through having more leavers). Qualitative evidence suggests that the service is working with people with varying levels of needs and this is reflected in the timescales involved for behaviour change.

DELIVERING THE SERVICE

The review of take-up and flow through presented here shows that the numbers involved has been below the target, although when you look at the targeting and who benefited it does appear that the service is doing well against the priorities for the service. The evidence on how the service is doing against the targets and key performance indicators established for the service suggests that there have been improvements over time but that further progress is needed, especially in generating the volume of participation originally anticipated, and also in relation to how the service works effectively with participants to achieve good take-up and flow-through, and health behaviour change outcomes.

Work flow

The number of new participants completing assessments with the service was only 43% of the planned target by the end of the year (table 10). A key issue was relatively slow progress in generating referrals to the service (approximately 250 people were referred on average a quarter in year 1). From Q3 onwards there was an increased focus on working with the partners to develop and implement and action plan to focus on recruitment, flow-through of participants and data collection improvements. The data on participants suggests that this approach has provided a very useful focus for effective delivery. The number of referrals in Q4 following the implementation of the action plan was up by 100 % compared to the previous quarter.

The number of new clients assessed in Q4 following the action planning process was up by 38 % in Q4 compared to the previous quarter. A further issue was the number of participants who ‘did not attend’ (DNA) or who could not be contacted following referral. Around six out of ten (58%) of referred clients had progressed to assessment by the end of the first year. The rate of DNA (did not attend) for appointments was also high in the services, with an average of 27% of appointments made not attended by participants. While this is reflective of the environment that we work in, we are aiming to understand DNAs more and will be setting targets to reduce them

Table 10: Referrals and assessments in year 1, against target assessments

	Referrals	Assessments	Target new clients (assessed)	% of target
Q1	189	76	150	52%
Q2	225	139	263	56%
Q3	193	152	375	47%
Q4	386	210	563	37%
Total	993	577	1351	43%

Delivery to scale

A key issue for the partnership was how to deliver the model to scale with a view to meeting the ambitious targets for the service. The model was worked out on the basis of being able to generate target capacity, of 750 new clients per quarter, 250 new clients per coach p/a, once the service was at full capacity with fully trained and competent coaches. Planning was based on a series of assumptions about the proportion of direct participant contact time for each coach, the time required to deliver different types of the provision on average per participant (assessments, 121

coaching, telephone and group work), average contacts per participant (by type), and the division of labour between coaches and volunteers/apprentices. To deliver to the number of target new clients within the human resource available was estimated to require 60% of time in 1:2:1s (60 minute sessions with coaches) and 40% of time in groups, back up for existing participants by brief/phone sessions (30 minutes) as well as 121s and to include work with coaches and volunteers and apprentices. In practice the vast majority of participants have received a 121 provision. 6% of participants were recorded as having telephone contact and 9% were group participants. It Is estimated that most (95%) of coach delivery time was spent in 1:1 meetings (including assessments) (table 11). It is hard to draw conclusions at this stage, although the data on through-put and how the service operated in practice does highlight a potential issue for management in terms of balancing a concern to maximise the delivery capacity and number of new participants, with service values which stress individually-tailored ongoing support over a relatively long time.

Taking data from the last quarter when the service was fully resourced indicates that there were 1197 participant contacts with an estimated delivery time of 1143 hours.

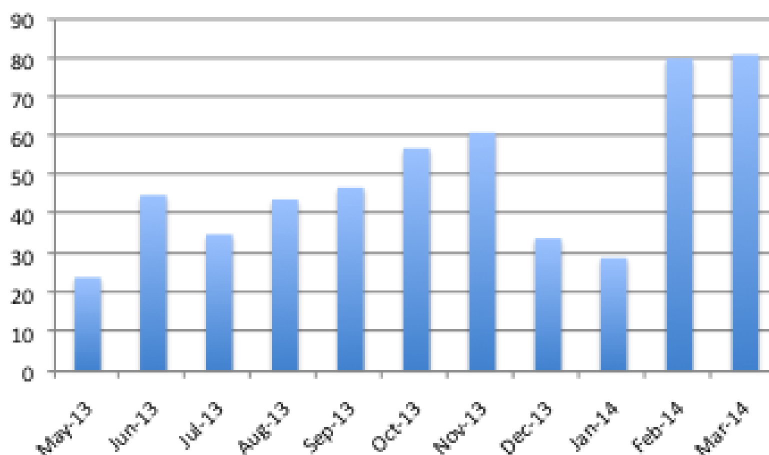
Table 11: Appointment type Q4 2013-14 (Jan-Mar)

	Number of participant contacts	Time estimate (delivery hours)	%
Assessments	210	315	28%
1:1 meetings	762	762	67%
Groups	211	52	5%
Final meeting	14	14	1%
Total	1197	1143	100%

The average number of appointments per month for the quarter was 135, although there are differences by month: some 45% of the quarters appoints came in March and only 25% in January, reflecting seasonal variation in the provision.

The pattern of referrals and assessments by month suggest a seasonal effect on workload, and planning for seasonal variation is something which the service is going to be factoring into the service delivery model (Figure 8). The upward trend in the number of referrals assessments per month was interrupted in July and December-January due to such factors as seasonal holidays. The services is working to understating any other influences that may effect referrals at this time and ensuring that assessments in the services can still be completed with a reduction in coaches at certain periods in the year.

Figure 8: Assessments by month



Who benefited?

Over half (57%) of all participants (and 63% of those with a valid ranked Salford postcode) were from areas in Salford classified as within the 20% worst deprived nationally on the Index of Derivation 2010[27]. Men were proportionally more likely than women to be from the most deprived areas.

Participants were measured in relation to levels of well-being as indicated by the Warwick-Edinburgh Mental Wells Being Scale short form (SWEMWBS)[28]. Almost three-quarters (72%) were rated ‘low’ on this well-being measure. The Mean value was 19.2 (with standard deviation = 5.6). There is a cluster at the top end of the ‘low’ banding.

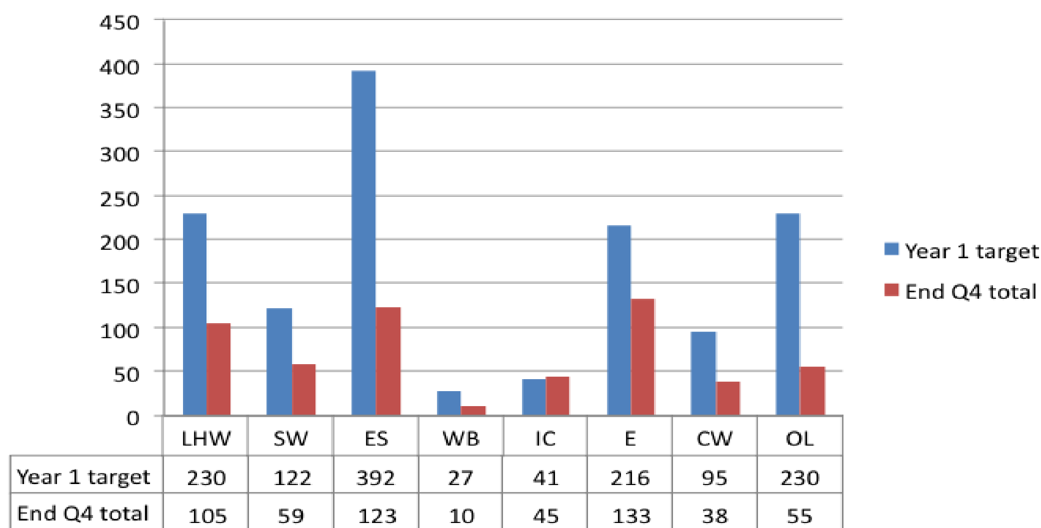
Those working on smoking objectives recorded the lowest average well-being score (although statistical tests would need to be performed to assess whether there are any statistically significant differences between the groups).

To an extent the take-up by neighbourhood appears to reflect local factors. Eccles accounted for the largest share of participants (26%), followed by East Salford and Little Hulton (20% respectively). Females are in the majority in most areas (except Little Hulton and Swinton), and the share of females is higher in some areas such as East Salford. Irlam and Cadishead has the largest share of participants in the oldest age band. East Salford and Ordsall and Langworthy have proportionally younger participants under 36 years. All neighbourhoods were below the target numbers except Irlam and Cadishead (Figure 13).

[27] Deprivation rank is a statistical exercise carried out by the Department of Communities & Local Government approximately every 3 years. The 2010 rankings, published in March 2011, are mainly based on 2008 data.

[28] See http://www.healthscotland.com/documents/5238.aspx

Figure 13: Assessments by neighbourhood



	LHW	SW	ES	WB	IC	E	CW	OL
Year 1 target	230	122	392	27	41	216	95	230
End Q4 total	105	59	123	10	45	133	38	55

The assessment of participants has identified the relatively many who are experiencing various negative situations in their lives including job loss and bereavement. Two fifths (40%) in the latest cohort had experienced job loss/redundancy. Almost two-thirds (63%) mentioned bereavement and a third (35%) had experienced divorce/end of a relationship. Relatively many said they were experiencing depression/anxiety (90%) and loneliness/isolation (80%).

The vast majority of participants – nine out of ten - were White. Male participants were proportionally more likely than females to be White (92% of males were White compared to 87% of females). The most prevalent ethnic minority group was Black ethnic origin and ‘other’. Some 3.2% of female participants were Black ethnic origin and 2.1% were from ‘other’ ethnic minority groups. The average age of ethnic minority group participants (including mixed ethnic group) was 39 years, compared to an average age of 47 for White participants.

The client data meets the expected profile in terms of the profile across neighbourhoods, and appears to be appropriately targeted in terms of benefiting people in deprived communities. The participant demographic broadly matches the 2011 censure profile of Salford (90.1% of Salford are White). However some ethnic minority groups are underrepresented, particularly in the Male demographic and this will be an area for increased focus in the next period building on the Equalities Impact Assessment for the service.

Furthermore there have been referrals received about people that do not have English as first language and the service has found it difficult to engage with them due to practicalities of interpretation. Work to engage with the communities not accessing the service will be focus for the second year

Performance indicators (outputs and KPIs)

Table 12 reviews the findings so far against the outputs and KPIs established for the service. The service has taken some time to get up to speed in terms of meeting the service standards identified for delivery and response times. Data for the latest quarter shows the number of referrals contacted within 5 days of referral is below the target, although there had been an improvement over time (up 3% the previous quarter). Although the service has not reached the expected milestone of 90% of referrals triaged within 5 days, the reason has been due to the availability of

participants. The service has attempted to contact 97% of each referral with in 5 days.

The time between referral and contact has been identified as a factor contributing to the relatively large proportion of closed cases who could not be contacted (51% in Q4)[29]. BWS has started to trial different methods of contacting clients in different neighbourhoods to see how improvements can be made in reaching service quality standards.

The statistics on goal achievement are low at this stage in the service, although improve when you take account of people who had partially achieved behaviour change goals.

Table 12: Outputs and KPIs[30]

KPI	Target	Progress
Number of requests/referrals acknowledged and recorded within 5 days	90%	54% of referrals were triaged within 5 days (Q4)
Number of first appointments within 10 days	90%	32% of referrals had an assessment (session 1) within 10 days
Number of action plans co-produced target	Target 100%	78% of assessed clients identified health and well-being goal(s)
Participants report they are satisfied with the service	90%	100% of leavers so far rated their satisfaction with the service as at least 8 out of 10. Some 91% rated satisfaction as at least 9 out of 10 and 43% rated their satisfaction as 10 out of 10.
Number of people who say they are thinking of quitting smoking (Make a firm commitment to smoking related behaviour change)	90%	61% of participants who were smokers set goal(s) around smoking. 23% said they were thinking of quitting.
Clients report increased awareness of opportunities/services	90%	95% of leavers agreed they know where to go for support and advice on my lifestyle if they need it (48% of leavers strongly agreed)
Clients say they are able to navigate and know how to access appropriate support	90%	95% of leavers said they were confident that they would be able to get support and advice if they needed it (35% of leavers strongly agreed)
Clients report increased confidence in self-managing their well-being issues	90%	74% of leavers said they were 'more in control of their life'
Achievement of individual well-being outcomes (the number	80%	52% of leavers said they fully achieved their main behaviour

[29] Three attempts are made to contact people at various times and the service sends them a letter/postcard.
[30] Data on leavers should be treated with caution due to small numbers at this stage.

achieving their specific well-being goal(s) in their individual action plan		change goal.
Clients have adopted at least 3 behaviour change goals by month 6	90%	70% of participants who had been with the service at least 6 months had achieved 6 goals.
Alcohol related: Number of people who reduce alcohol consumption	40% men 50units+ and women 35units+ per week	Information needed on more leavers to be able to calculate this
Weight related: Number achieving 5% weight loss at 6 months	53%	Information needed on more leavers to be able to calculate this
Smoking related: Number of people who attempt to quit at 4 weeks	50%	39% of smokers reported ‘zero’ cigarettes per day after attendance in 1-2 sessions

SERVICE ACHIEVEMENTS SO FAR

Analysis of the health behaviour change and well-being outcomes recorded for participants shows mixed results. A key issue is the small number of leavers so far.

Health behaviour change outcomes

There are only a small number of service leavers to date. In regular reporting it has been necessary to draw on the qualitative information on goals achieved to fill the gap in relation hard outcomes. Comparison between the health behaviour information recorded in their latest session and a baseline score could be made for a subset of participants (the precise number varying according to the specific health behaviour measure). Latest figures on outcomes show the following (although it needs to be noted that most of these people are still participating and have not reached the end of their time with the service):

- Over half (52%) addressing drinking recorded a reduction in the amount they drank per week. Almost a quarter (23%) had said they had not drunk at all in the previous week to the most recent session (based on 122 cases with baseline and comparison data for the number of units they drank per week, non-drinkers excluded);
- Almost half of the people for which comparative exercise data was available said they were doing more exercise per week in their most recent session than at their baseline (based on 111 cases for which data was available);
- Over a third addressing weight issues (35%) reduced their weight and of these one in ten made a significant reduction of more than 5% of their starting weight (based on 123 cases for which data was available);
- Of the smokers in the programme, well over a third (37%) quit completely in the week to their most recent session. A further fifth reduced their smoking by 5 or more cigarettes a day (based on 164 cases for which data was available).

Improvement in well being

In terms of measuring changes in well-being, a mean change above two points for large groups (or range two to four points for small groups) can be considered meaningful. The mean value across the group at the start for those for which there is comparative information was 19.0 points, which had risen to 22.7 in the latest round of sessions (up 3.7) which suggests a small significant improvement in well-being in the cohort as a whole for which data is available.

The data also allows analysis in terms of changes made on an individual level basis. A baseline SWEMWBS score and a score from the latest session was provided for some 375 participants. Overall almost two-fifths can be considered to have made significant progress (over a four points increase in their score which is considered to be meaningful and unlikely just to be down to chance). Scores appear to worsen for people who may have participated in a smaller number of sessions (over a fifth recorded worsen scores in their more recent session than in their baseline), although proportionally more people appear to have improved scores after participation in 10 or more sessions. The average number of sessions for the group of people who recorded a change in score of more than 4 points works out at 5.4 sessions (not including initial assessment).

Building linkages and support structures

At the start of their participation two-thirds (65%) agreed or strongly agreed that they knew where to go for support and advice on their lifestyle if they need it, proportionally fewer agreed they have access to support (53% strongly agreed or agreed to this). The sample is rather small; however, nine out of ten leavers agreed or strongly agreed that they knew where to go for support and advice on their lifestyle if they need. There was an increase in the share of leavers agreeing they have access to support (96% strongly agreed or agreed to this statement).

Is the approach working?

Analysis to judge the success against a number of service aspects are given in Box 1.

There are some fairly positive signs that the service is working for some people. However overall the hard outcomes suggest that the volume of health behaviour changes achieved are taking time to show. Some people take longer than anticipated to achieve their goals. Other groups drop out of the provision early. The fact that there are only a very small group of planned completions on which to assess outcomes from the service makes the analysis of the overall impact somewhat problematic.

Box 1: Summary of achievements

AIM	OUTCOME
Improved health status	
Clients achieving or partially achieving personal health goals, weight, smoking, alcohol, exercise, improved mood	38% of those who had 6+ sessions achieved goals or made good progress towards
People achieve long term behaviour change to improve their health	too early to say
Improved well-being	
Clients showing improvement on well-being scale	42% of people who had taken part in 4+ sessions showed an improvement considered significant (up at least 4 points on SWEMWBS measure)
Reduced health inequality	
% of clients from most deprived IMD areas	63% of those with a valid ranked Salford postcode were from areas in Salford classified as within the 20% worst deprived nationally on the Index of Derivation 2010
Community engagement	
Mapping of and contact with groups	wide range of organisations noted in referrals (83 in Q4)
Participation in events etc.	large number of engagement activities on ongoing basis reported as part of the regular reporting
Increased self-care	
Number of clients showing improvement in self-efficacy scores	25% increased self-efficacy by 4+ points on exit
Persistence of goals	too early to say

Number of participants reporting increased knowledge and techniques to manage behaviour	too early to say
Number of participants joining or forming self-help groups	too early to say
Improved direction of services	
Number of participants directed to other services	need more data to assess
Quality of relationships with other agencies	referrals increasing from key agencies, good working relationships and shift to collaborative approaches (e.g. joint participant review and data sharing with SDAS)
Cost saving	
Cost-benefit analysis	too early to say
Satisfaction with the service	
Participants report being happy and safe within the service	100% of leavers so far rated their satisfaction with the service as at least 8 out of 10
Former participants volunteer to be involved in supporting others	need more data

Annual Review day

On 13th June 2014 Being Well Salford held an annual review with stakeholders, to review the 1st year of the service, celebrate the achievements of the service and gather feedback from stakeholders about what we can do better and how we can work together to improve the health of Salfordians. There were over 50 attendees at the event who contributed by providing feedback on the following 3 areas

- What we should do better
- What can we do collectively to make sure people in Salford get the right service for them (alongside BWS)
- What we can do to ensure we get the right people referred to BWS

An executive summary of this report was presented to the group before each table worked on the discussing the areas and making recommendations, in summary, the key areas of feedback were (details of feedback in full can be found in Annex 5)

- Continue to develop Partnership working, Engagement and Collaboration
- Understand how participants think in terms of behaviour change (and setting goals including self reported measures)
- Improve system flow (speed of contact / assessment and DNA rates)
- Increase user involvement
- Improve evidence base and outcomes
- Develop promotional and marketing plan, improving clarity of service provision.

FINDINGS AND RECOMMENDATIONS

Findings

- The development phase was important in putting in place the structures to maximise the potential of the service to deliver a good result by: getting agreement on an embedding a common service framework; establishing the working relationships between partners; building the competences of staff to a high level; and integrating data collection processes into the model to generate action learning.
- The analysis of participant data and other information suggests a gap between design and delivery, and the progress that still needs to be made to implement the model. This perhaps reflects the challenges inherent in putting theory into practice on this scale, and the need to embed the service first.
- The service has worked hard to make sure the targeting is appropriate, and the neighbourhood model has helped here to focus delivery on areas of need, which complements the partnership model.
- The experience of BWS has shown the importance of good regular communication externally and internally. Identification of local targets has also been essential to underpin action planning and performance management with partner organisations which has helped to increase the flow of potential participants into the service over time.

Recommendations

- The experience of working with participants on goal setting raises a number of issues around what goal setting means/what goals are and the relationship between goal setting activity and behaviour change. It would be useful to do some work and share good practice on what constitutes an effective goal.
- Understanding the end point is important and work is needed on how coaches interpret this, both in handling participant expectations, and effectively managing case endings. More probably needs to be done to link individual goals to the anticipated behaviour change outcomes, and it would be useful to build in reviews of the ‘hard’ data regarding behaviour health outcomes alongside individual level goal achievement.
- A key learning point is the need to have a clear vision, clearly articulated, about what the service can offer and how it adds value. The promotional strategy, communication with other agencies and potential participants, should be continually reviewed for impact
- The work needs to continue on assessing the outcomes for participants as the sample sizes become large enough to make conclusions. There are some significant data gaps in the health behaviour data which can be used to baseline participants and measure progress and over time, and data quality issues, and these should be addressed to ensure the data is as robust as possible. It would be useful to look at how the outcomes on health behaviours compare with topic based services.
- Continue to share the learning from the service on an ongoing basis with partners and other stakeholders, as it is important to reflect the experience of development/implementation and to maximise the ability to learn from the data that was designed into the model, and to maintain the ability to make refinements as part of the ongoing development. The review day provided an opportunity to do this and should be continued in the future

ANNEX 1: INFORMATION SOURCES

Participant data

Tracking data

Case studies

Partners video presentations (People's Voice Media)

Meeting notes and Board papers

Performance review meetings

Team sessions

Qualitative research activities

Group evaluation report

Coaches training rapid review 2013 (qualitative research)

ANNEX 2: VENUES

Salford UCRC (Eccles)

84-86 Liverpool Road, Manchester, M30 0WZ

Eccles Jobcentre (Eccles)

Sentinel House, Monton Road, Eccles, M30 0NA

Eccles Gateway (Eccles)

28 Barton Lane, M30 0TU

Walkden Gateway (Worsley)

2 Smith Street, Worsley, M28 3EZ

Salford Health Matters (Little Hulton)

Haysbrook Avenue, Little Hulton, M28 0AY

DAAT (Little Hulton)

Haysbrook Avenue, M28 0AY

Energise Centre

3 Douglas Green, Charlestown, M6 6ES

Broughton Hub

50 Rigby Street, M7 4BQ

Abbots Lodge

4 Brindle Heath Road

Hamilton Davis Trust

Hamilton Davis House, 117c Liverpool Road, Cadishead, M44 5BG

Fairhills Road

Irlam, Manchester, M44 6BA

Wardley Community Centre (Swinton)

30 Ash Drive, Swinton, M27 9RS

Swinton Library

Chorley Road, M27 4AE

The Angel

1 St Philips Place, Salford, M3 6FA

Pendleton Gateway

1 Broadwalk, Pendleton, Salford, M6 5FX

Langworthy Cornerstone

451 Liverpool Street, Salford, M6 5QQ

Bethany Community Centre

Kenyon Way, Little Hulton, M38 0EN

Garden Needs

Radford Street, Salford, M7 4NT

Manchester Y Club

Liverpool Road, Castlefield, Manchester, M3 4JR

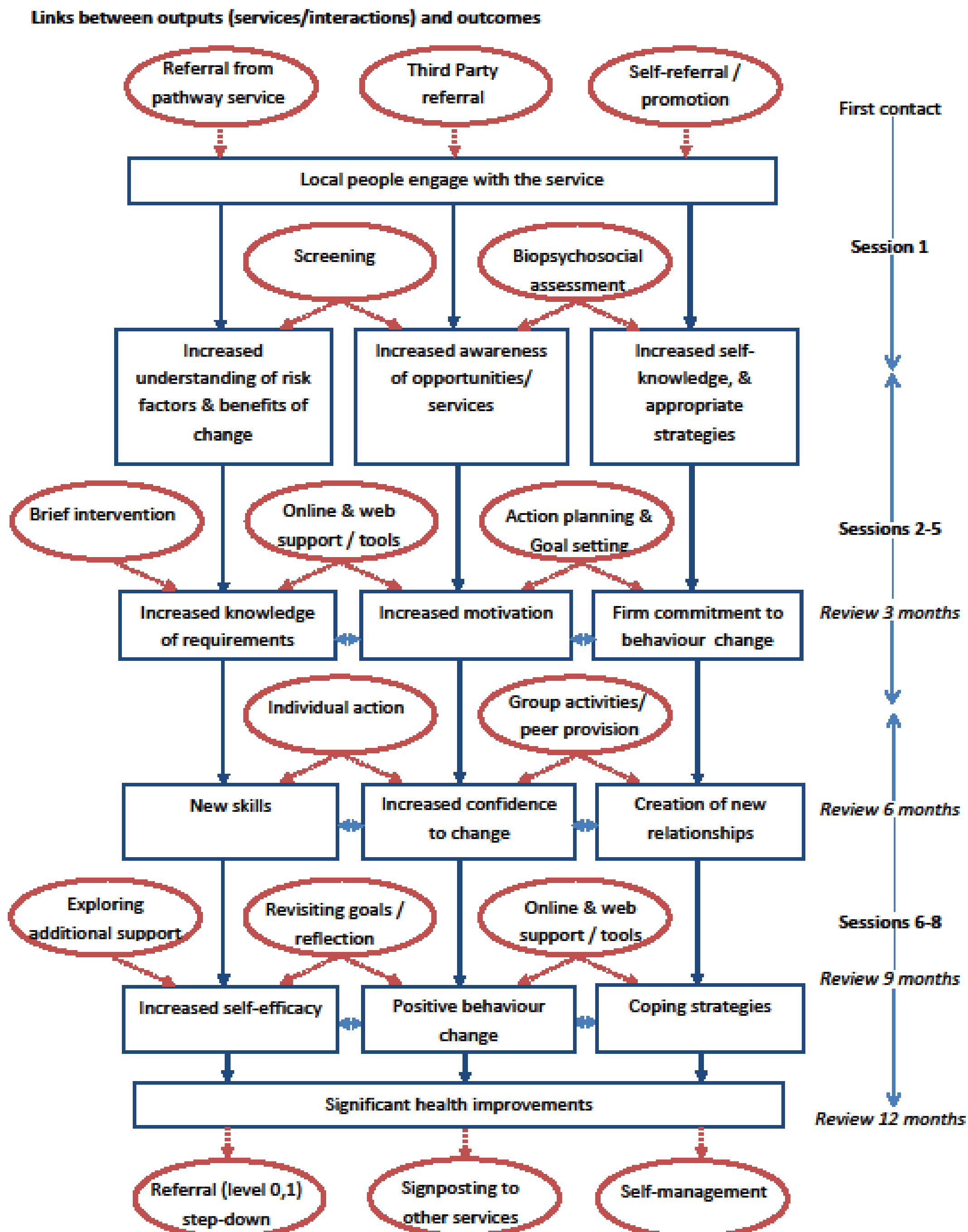
Ordsall Neighbourhood Office

2 Robert Hall Street, Salford, M5 3LT

Salford City Reds Foundations

Salford Stadium, 1 Stadium Way, Eccles, M30 7EY

ANNEX 3: THEORY OF CHANGE



ANNEX 4: WORK STREAMS

Work stream	Purpose
Operational group	To agree the operational model and all associated work to set up and run the service.
Training and education	To determine the scope and content of training and education for the staff including apprentices and volunteers, referrers and service users, and ensure timely delivery. To inform the development of the service model and evaluation
Communication and engagement	To ensure that all stakeholders are effectively and appropriately engaged and involved in the design and continuing development of the service. To produce a marketing plan to support roll-out of service
Measurement and evaluation (Intelligence Group)	To finalise the methodology, framework and responsibilities for measuring the outcomes and impact of the service. Refining understanding of the target population Refining intervention, service system and SROI measures Developing a timetable for reporting and evaluation Informing the development of the client management system Informing the development of staff training

ANNEX 5: ANNUAL REVIEW DAY

What we should do Better

To make sure the service keeps evolving, don't rest on laurels

- Right time to move on
- Consolidate partnerships- Review what works well and what can be improved
- Review barriers to receiving exit forms- Disengagement
- University to look at how they can open up use of their facilities
- Improve speed of contact/assessment for participants, to reduce people falling out of the system
- To better understand how participants think in terms of behaviour change/journey
- Newsletter updates
- User involvement
- Make more of the "people like me" case studies, showing videos elsewhere, live UK channels
- Creative approaches
- Joint working- Referrals
- DNA- outreach call centres, knock on doors
- 30% of referrals choose to change- Mainly GP's
- Do they know enough about the service
- Review process for DNA's- 3 months
- Health buddy-help them to attend appointment such as the buddying system in Blackpool
- Home visits
- Referral meetings with BWS and agency to build out more about debt situation
- How do we set the service to be understood, It can be hard to describe. Who will benefit and how do we cut confusion
- Better links with health trainers and other frontline workers including G.P receptionists
- How well are Being Well Salford working with people with disabilities and can Being Well evidence this?
- Work more collaboratively with other services, how best to maintain relationships
- Link in with other complimentary services
- Be very clear about what the service is- be clear on what all services (health and wellbeing) deliver. Always say the same thing, consistency, collaboration
- Have one description that could describe what is being delivered by BWS and by health improvement team
- 'coach' terminology could make people think about a weight MMT service
    - need to ensure clarity so doesn't sound like just weight or smoking
- Can feel disbanded, services could work better together

What can we do collectively to make sure people in Salford get the right service for them (alongside BWS)

- Partner agencies to meet regular to share information and best practice
- Partners to become better integrated and understand different levels of intervention
- Clarity around wellbeing pathway
- Communication

- Don't let information governance get in the way, become smarter about how we work together
- Ask the participants about the question, they are the experts
- Simplify the choices
- Single point of access for all health services with knowledgeable admin staff
- People don't know about the services that are available
- How can we work together more
  - Provide a focus on the wellbeing system
- Communication between services on clients referred
  - Share with GP
- Recognise the value of asking gate keeper into communities
- People on the ground (creating networks) understanding of what everyone else does
- Team Meetings- Teams are not just about people working for the same organisation
- Its not all about systems and processes-
  - Create systems that nobody knows are there
- BWS and health improvement team meeting with frontline staff to develop key messages, not to drift from messages.
- Ensure we think about peoples needs- signpost's of other services would have a greater impact
- Case load management between agencies
  - Teams/hubs in each area of different services in the eight areas e.g. Little Hulton
- Networking events in each area-
  - Bring people together so they fully understand what each other do-
  - Talk about the people

What we can do to ensure we get the right people referred to BWS

- Self help could increase referrals-include as past of their assessment
  - Appropriate referrals
  - Further discussions
    - Impairing links
    - Partnership
- 3000 home visits from fire services in Salford
  - How they increase
    - Raising awareness of BWS
    - Referrals into the services
      - Increased partnership, future partnership , working in the fire service
- University could look at how they can net students and staff
- Feedback to referrers- easy process
- Continual promotion- Same message each time
  - Innovative
    - Twitter
    - Facebook
- Relevant easy to read case studies for direct engagement with community
- User involvement
- Information sharing about the client

- Need to ID the people and target through engagement and marketing
- Asking people about design of material
    - Does it make sense
    - Text referrals
- People need to understand what the service is so people can make an informed decision re: referrals
- Need to keep reminding-
    - People what the service is
    - Keep reminding people of referral
- Being Well Salford is quite a narrow service
- Single point of entry to services
    - Pass referrals on
    - Client exchange between services
    - Use of short and sharp referral form
    - It is not either/or it is a package of care
        - Not to bounce between services
- Develop relationships to ensure app referrals
- Clarity around what's provided with referrals and how they fit in with other services
- Clarity around criteria, e.g. how overweight/underweight, what is low mood
- Marketing could better reflect self efficacy, putting people in control and be motivating. will test this out
- Targeting GP's
    - Need absolute clarity on marketing material
    - Description of what different services provide BWS, Health Improvement Service and health trainers
- All services to promote each other , cross refer