PERSONALISED CARE FOR LONDON

PCN advisor session: Spotlight on Health and Wellbeing Coaches

@SP_LDN

hlp.socialprescribing@nhs.net

Healthy London Partnership

Join at slido.com #HWBC

NHS England

PCN Advisors

Purpose of the role:

- Supporting PCNS to successfully embed the three, personalised care roles (Social Prescribing Link Workers, Health & Wellbeing Coaches and Care Coordinators) to effectively tackle health inequalities and support primary care
- Build a network of those that employ or are working to embed the three personalised care roles in their work, facilitating a community of practice across London

Dr Hina Shahid

Hina is a Portfolio GP in North West London and has a background in Public Health. She has worked in the VCSE sector for 15 years in community engagement, outreach and health inclusion, and health systems strengthening in the UK and internationally. She is an undergraduate tutor, GP Appraiser and also works in social research and health policy and has supported SPLWs in thinking through culturally appropriate practice

Lianna Martin

With over 20 years experience in the VCSE and social enterprise sector, developing projects and partnership work, and previously at the Bromley by Bow Centre, Lianna is also a Regional Learning Coordinator for Social Prescribing and a Programme Manager at HLP in the Health Inequalities, Personalised Care team. Her time is dedicated to pan London initiatives supporting the development of social prescribing, enabling it to thrive

Objectives for the session

- ✓ Provide clarity on what the Health and Wellbeing coach role is and how it is different to a social prescribing link worker and care coordinator - what is their superpower
- ✓ Share best practice examples of how health and wellbeing coaches are delivering tailored support for patients and tackling health inequalities
- ✓ Demonstrate how they are working with social prescribers and care coordinators
- ✓ Share how best to support and manage health and wellbeing coaches
- ✓ Sign post to resources for best practice in inducting and setting the direction and managing health and wellbeing coaches

It is an informal session – talk to each other & share resources in the chat

REC

The presentations will be recorded & circulated with slides

Join at slido.com
HWBC
To ask the speakers questions

Plan for today...

Time	ITEM
12:30	Introduction to the session, HWBC context
12:40	About the HWBC role Who is a good client– Caroline Haines
12:55	The value of the HWBC role to the PCN and evaluating it – Mohan Sekeram
1:05	How best to support a HWBC – Caroline Haines
1:10	Strategic ICS wide work – Gita Malhotra - NEL
1:20	Case studies of HWBC around London - Caroline Haines
1:35	Open Q&A
2:00	Close

It is an informal session – talk to each other & share resources in the chat

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What do the roles do

Care Coordinators

Work along side clinicians and the MDT, acting as a point of contact connecting patients, their clinicians and other teams involved in their care.

Take time with patient, using personalised care support planning over sessions to identify patient needs and offer to coordinate various aspects of their care.

Act as a bridge between primary care and the community.

Manage their own caseload of patients offering:

- **Continuity of care** – a point of contact alongside busy clinicians with a chance for follow-ups
- **Allyship & advocacy** - conversations to support understanding health conditions and prepare for their appointments, ensuring needs are attended to
- **Signposting** to other personalised care or team members as required e.g. SPLW.

Mostly support those with long term conditions, vulnerable patients or those with complex needs.
Can work with clinicians in certain defined areas: e.g. learning disabilities, cancer care, nursing home residents, or they may have a mixed case load.

Health & Wellbeing Coaches

Work with patients to help them take **proactive steps** to improve the way they manage their **physical and mental health conditions**:

- **Goal setting** - Guide and support people with LTCs to set self-identified health and wellbeing goals
- **Behaviour change** - Use specialist coaching and behaviour change techniques, usually over a number of sessions
- **Help patients to develop their knowledge, skills and confidence** in managing their own health to improve their quality of life

Tend to support with physical and mental health conditions, and with one or more LTCs such as type 2 diabetes, COPD, or those at risk of developing a LTC.

Social Prescribing Link Workers

Address wider issues (social determinants of health) that impact people's health & wellbeing.

Take time with patient, using personalised care support planning, motivational interviewing & health coaching approaches, **over several sessions to identify what matters to the person and connect them with:**

- practical, social and emotional support within their community
- activities that promote wellbeing e.g. arts, sports, natural environment.

Act as a bridge between primary care and the community - Identify and nurture community assets by working with partners such as VCSE, LA and NHS.

Tend to support people experiencing loneliness, complex social needs, mental health needs or multiple LTCs.

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Healthy London Partnership

Regional Mentor for HWBC

Health and Wellbeing Coach – Regional Mentor: Caroline Haines

Purpose of the role:

- Create a network of HWBCs & provide support
- Scale up the HWBC service and create consistency
- Supporting conversations with PCNs interested in implementing HWB coaching

Who is in post:

Caroline qualified as Health Coach in March 2020 with the Health Coach Institute and has been a Health & Wellbeing Coach in East Merton PCN since Jan 2021. Prior to this she worked in banking & finance but always with a keen interest in nutrition, fitness and holistic care.

Sign up to receive support:

If you are a HWBC or have HWBCs in your network, please ask them to complete this form

Who is a good client?

- If someone wants to improve their health using behaviour change but they feel stuck or they feel like they have some obstacles in their way, then they are a great candidate for coaching.

- Typical coachees:
  - Diabetes / other long term conditions
  - Mental health
  - Obesity

A good client needs to be ready to put in some effort to change

- Motivation – those with higher levels of motivation to change are better clients. The coach can help them to increase their motivation by helping them to find their intrinsic motivation.

Health and wellbeing coaches
East Merton primary care network

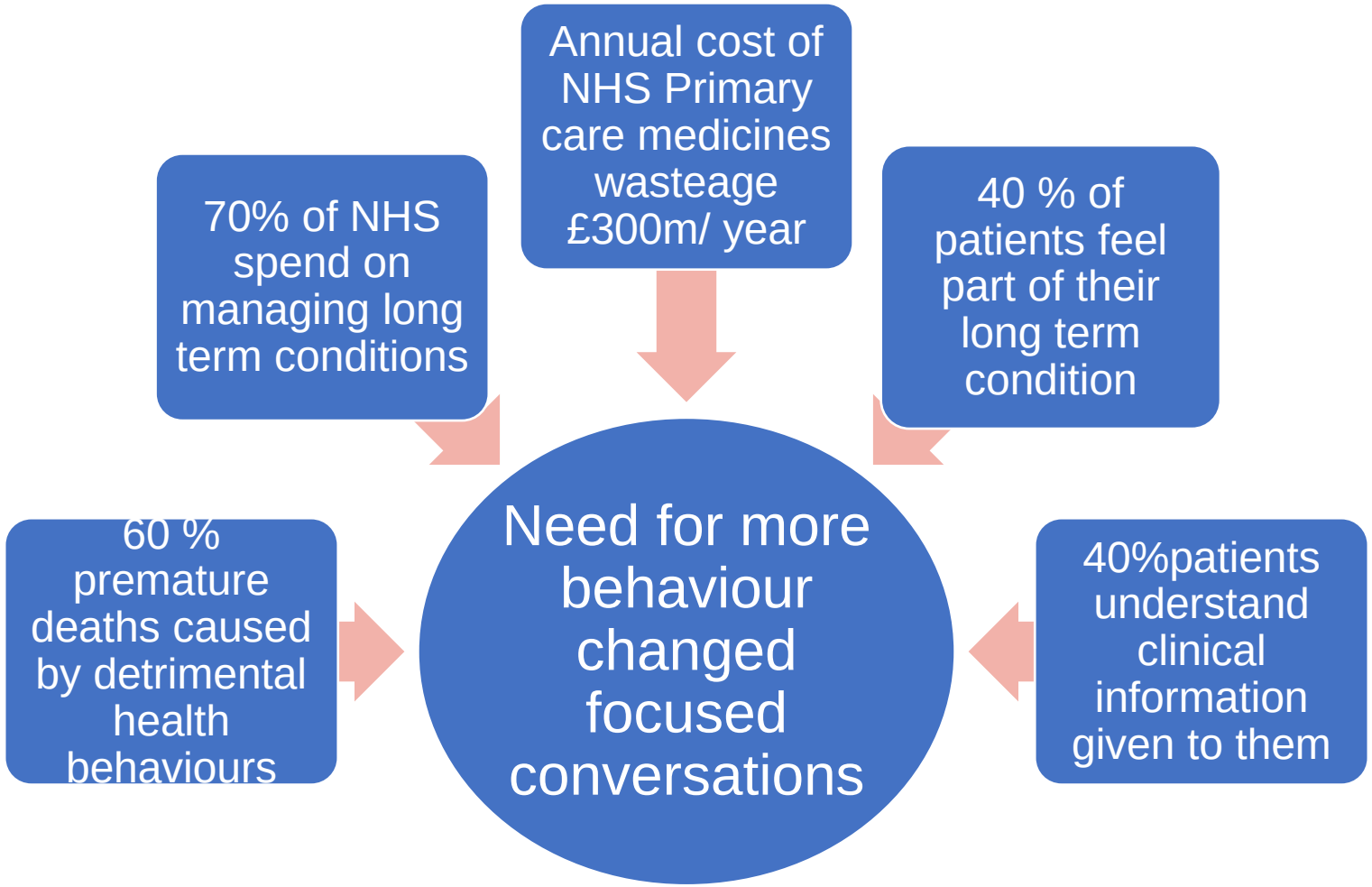
Mohan Sekeram (Clinical lead Personalised care SWL)

Why health and wellbeing coaches ?

Embed into PCN

Evaluation

Why health and wellbeing coaches ?



Embed into primary care network

- Pre plan
  - Awareness to network / practice (new environment)
  - Link with other roles (Social prescribers / care coordinators)
- In post
  - Induction (kick off meeting)
  - Attend clinical meetings / Socials / feedback..
- BAU
  - Update on feedback / appropriate cases / follow up
  - Webinar to rest of the network -
  - Supervision (practice / network/ peer / clinical)

Referral / evaluation

- Management of long term condition – **Obesity**/ **diabetes**/ CVD
  - Hba1c
  - Bmi
  - Cholesterol
  - Bp

- Gp appointments
- Adherence to medication
- Better control of their long term condition

Evaluation (small numbers thus far)

- Quantitative
  - Wellbeing scores (PAM to ONS 4)
  - Weight reduction of 5 % (n=15)

- Qualitative

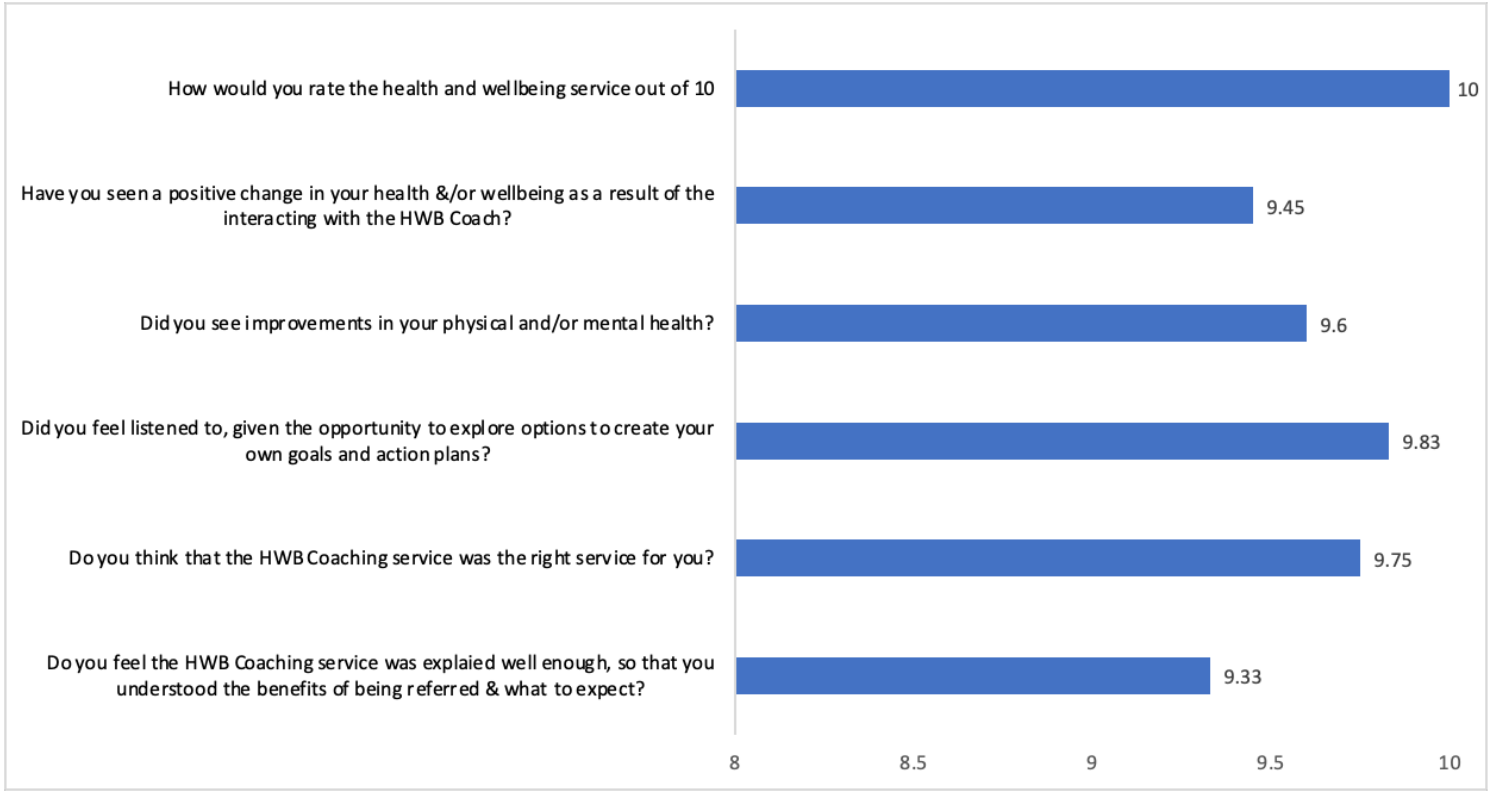
"When I look back, I've lost 3 stones. If it weren't for her I wouldn't have got this far."

"Currently my health and wellbeing is better and in future maybe open to more sessions. And regarding my GP, I'm seeing them less, and my headaches are depleting."

"It was difficult but with the help of regular counselling sessions with my coach I have developed a

positive outlook towards life. And it helped me being stable to an extent"

Satisfaction of the service (n = 15)



Link in with other roles

- Social prescriber - up skill of local service
- Care coordination - identifying patients who could benefit
- Video group consultations of above roles
- Health and wellbeing in workplace - yoga/ walks ….
- Link with community assets - Obesity

Challenges	How best to support the role
Lack of ongoing professional development	• All HWBCs need their 4 day accredited HWBC training • Continuing professional development via additional training relevant to HWBCing • Support training during work time
Lack of supervision	• Clinical supervision • Coaching supervision from a qualified coaching supervisor
No consistent ICS level peer support	• Encourage HWBCs to utilise all the peer support that is on offer

Challenges	How best to support the role
Varied understanding from practise staff	• Invite them to team / staff / MDT meetings • Help the HWBCs to promote the service
Bad referrals / lack of referrals	• Create easy referral pathways • Ensure that all referrers understand what a HWBC is and who they can help • Check that they are referring
Feelings of isolation	• Ensure they are part of the team even if they work remotely

How best to support HWBCs

Training:

- At the very minimum all HWBCs need their 4 day accredited HWBC training
- Continuing professional development via additional training relevant to HWBCing
  - Make sure they are allowed to do training during work time

Clinical supervision

Coaching supervision

Invite them to team / staff / MDT meetings

Ensure they are part of the team even if they work remotely

Create easy referral pathways and ensure that all referrers understand what a HWBC is and who they can help and check that they are referring

Encourage them to utilise all the peer support that is on offer

North East London Personalised Care Programme

Health & Wellbeing Coaches

Strategic system wide work

Gita Malhotra

Personalisation / Social Prescribing Strategic Workforce Development Lead

March 2022

gita.malhotra@nhs.net

North East London context

- 7 boroughs
- Population of 2 million
- 47 PCNs
- 272 general practices

23 Health & Wellbeing Coaches in NEL.

Value and worth of the role is not in question

A system wide approach to HWBCs

North East London Health & Care Partnership

- Commitment to strong **role remit, recognition and identity** across ICS
- **Phase 1 discovery work** in autumn 2021 highlighting variation in:

- training, support & supervision
- understanding the role and its potential
- sense of belonging in PCNs: ranging from part of a team to real isolation

- **Engagement,** consultative approach and relationship building to develop strong rationale for action and next steps
- Established **ICS collaborative partnership** with Hackney based voluntary sector organisation Shoreditch Trust

Where are we now?

- A **NEL HWBC Network** established in 2021 – for coaches to be recognised, valued, to mitigate isolation, a network of advice and support
- Mapped **baseline training and supervision position** for all HWBCs
- Developed relationship with **PCI approved provider** for HWBCs
- NEL NHS Futures workspace for NEL coaches being trialed
- By year end 2021-22 **all HWBCs** will have
  - Completed 4-day PCI training programme
  - Started 1-year monthly skills development programme
  - Embarked on 6 months of 1-1 supervision with accredited coach supervisor
- NEL ICS and Shoreditch Trust joint commissioned of Kings College London to do an **evaluation of health coaching** in North East London - underway

What Are We Doing Next

- Still thinking! Pause and review. Ask HWBCs what next for 2022-23
- Review the HWBC Network – frequency, focus and approach
- Use evaluation findings to support next phase
- HWBCs awareness of other components of the model – PHBs, SDM…
- NEL Training Hub delivery arm linked to intel and evidence from us in personalised care
- Developing model for engaging primary care and PCNs and further integration of personalised care roles –
- Surface examples and models of integrated working between PCN linked roles what are the conditions for success?

From the frontline

"Its the best form of preventation;we can make a huge difference to the lives of our patients and reduce the load on Doctors and NHS in general.

It's the way forward for personalised and quality care and a v fulfilling job. I would recommend it to all those who like to coach/counsel and are happy to work with people in their community" (Coach 1)

"Patients feel heard for the first time and understood, then they are motivated…they understand that they set goals for themselves, which I support…you can see [the] results quite dramatically. Sometimes its small steps, then its like a snowball" (Coach 2)

Thank You

North East London Health and Care Partnership is our integrated care system, which brings together NHS organisations, local authorities, community organisations and local people to ensure our residents can live healthier, happier lives.

www.northeastlondonhcp.nhs.uk | Follow us on Twitter @nelhcp

North East London Health and Care Partnership Citizen's Panel

Join our Citizen's Panel and help us shape health services in north east London.
Help create services that work for you and others in your area and get your voice heard.
enquiries@northeastlondonhcp.nhs.uk

Examples of the types of HWBC work being done across London

All

Set up the service. Including:

- Defining the referral pathways
- Developing patient resources
- Educating the practice / PCN about the role and how a HWBC can help
- Learning how to operate across many surgeries which can be challenging as different surgeries work in different ways
- Usual patient cohorts are:
  - Obesity
  - Diabetes
  - Mental Health / Stress

Examples of the types of HWBC work being done across London

North West London

Babylon, GP @ Hand:

- They have got a well tested self referral route for patients. Patients are proactively targeted with a text inviting them to self refer for HWBCing.
- So far the following cohorts have been tested:
  - SAD
  - Obesity
  - Diabetes
- Next they plan to test texting people around their birthday as birthdays can be a reflective time when people are more motivated to make a change
- GPs can also refer in the usual way

In other parts of NWL:

- A HWBC is working closely with the SPLW and the referral route is through the SPLW which is working well for them
- In Hammersmith & Fulham the HWBCs are helping with diabetes VGCs

Examples of the types of HWBC work being done across London

North Central London

Barnet:

- A group coaching model is working really well (alongside 1-2-1 coaching). So far they have had the following groups:
  - Diabetes. The group clinic was a team effort including a GP and a chef
  - Menopause clinic planned for next week, including a GP but many practice staff involved in recruiting patients and planning the session

Examples of the types of HWBC work being done across London

South West London

Sutton:

- In Sutton PCNs they have a team of 5 HWBCs which creates a very supportive environment and allows them to share ideas and challenges. Although they are not physically in the same location they have a call once a week

Merton:

- Long COVID group clinics (virtual & in person)
- Across the PCNs in Merton there are 6 HWBCs. They recently collaborated to create & deliver an event on workforce wellbeing to support all Primary Care staff in Merton
- Focus on mental health coaching in SW Merton using CBC based models

Battersea:

- Enable (in conjunction with SW London training hub) are running peer support sessions once a month for coaches in SW London

Resources

Health and Wellbeing Coaches Future NHS space: resources for understanding the role, embedding and recruiting

Events

Health and Wellbeing national NHSE conference: Wed 30th March. Sign up here.

Resources for those managing and embedding the roles

Implementation guide for health coaching (including about training, commissioning a service)

Officially endorsed health coaching courses and providers

Recruitment pack

Practice leaflets

To share with your HWBCs

Sign up to the London HWBC mailing list and peer supports

Welcome pack

Webpage for new HWBCs

E-learning programmes

Further reading and research on the impact of health coaching

The PCN advisor offer (1)

Our offer of support:

Pan London, the PCN Advisors aim to:

- Develop a network of people across the capital to connect to build sustainable models of good practice - you are all the pioneers in this forward thinking and evolving field after all!
- Collate, make sense of and share case studies and resources useful to this work
- Complement local efforts to support the embedding of the three roles

This will be delivered through the following:

- **A monthly, pan London 'Connect and Share' session** for those that employ and/or are looking to embed the three personalised care roles in their PCN: **themed and open sessions** with presentations of good practice case studies across London plus time for Q&A and discussion.
  - **Thu 18th November 12.30pm:** Embedding the three personalised care roles. RECORDING HERE
  - **Thu 13th Jan 2022, 12.30pm:** Open session (workshop) exploring different ways personalised care roles can support primary care and communities at this time: Slides here.
  - **Feb 2022:** Spotlight on Care Coordinators and how best to use them (Wed 16th Feb 3pm); Recording here.
  - **Mar 2022:** Spotlight on Health and Wellbeing Coaches and how best to use them (Thur 24th March 12:30pm)
  - **Apr 2022:** PCN advisor connect & share: Population health & the PC ARRS roles: 20th April: 12:30-2pm: SIGN UP HERE.

The PCN advisor offer (2)

- **1-1 support** – every Wednesday there will be 30 minute slots available to….
  - Ask questions, explore challenges, think through strategies to use the personalised care roles, get advice on resources or peers to connect with.

  Book in via the following link: https://calendly.com/pcn-advisors-london/30min.

  Available to present at meetings: The PCN advisors can come and speak at PCN or CCG meetings with CDs, PCN or ARRS managers on topics such as embedding the personalised care roles, social prescribing, how the roles can tackle health inequalities. Email us: hlp.socialprescribing@nhs.net

- **WhatsApp group** for those that employ and/or are looking to embed the three personalised care roles in their work to connect with each other informally. We have set this up and trial and see if it is useful. We're open to suggestions on alternatives but for now you can join the group. Use this **THIS LINK** to add your details and access the group.

We also hope to :

- **Send a monthly email** with updates, resources, answers to common questions being asked, useful events and so on
- **Communicate challenges up to NHSE** and the wider system, developing ideas for projects that might usefully mitigate some of these challenges
- **Co-produced PCN toolkit & FAQ Guide** including useful case studies

Supportive Self-Management: key resources

1.	**Measurement and evaluation within supported self-management** **This guide describes the steps for planning hot to use measurement within supported self-management, based on evidence and good practice.**
2.	Health & Wellbeing Coach Welcome pack - The welcome pack is designed for newly appointed health and wellbeing coaches in primary care networks.
3.	Care Coordinator workers Welcome pack - The welcome pack is designed for newly appointed care coordinators in primary care networks.
4.	Health Coaching guide and technical annex Designed to support the delivery of health coaching. This guide should be used when commission and when deciding what can or should be counted and reported as health coaching in a local area.
5.	Care Coordinator recruitment pack An optional resource to provide support to PCN's in the recruitment or engagement of care coordinators. The resource includes: • Sample job description • Sample person specification • Sample job advert • Sample interview questions
6.	Health & Wellbeing Coach recruitment pack An optional resource to provide support to PCN's in the recruitment or engagement of care coordinators. The resource includes: • Sample job description • Sample person specification • Sample job advert • Sample interview questions
7.	Care Co-ordination practice leaflet - Primary Care practice leaflet to explain the role of Care Coordinators to patients
8.	Health and Wellbeing FAQ's
9.	Care Coordination- Primary Care leaflet - This document provides an in-depth summary of the roles and application of the Care Coordinator within primary care.
10.	Health & Wellbeing Coach Mentor: Caroline Haines, caroline.haines1@nhs.net
11.	Care Coordinator Mentor: Dr Ali Hassas, alihassas@nhs.net
12.	FutureNHS Collaboration Platform - Source of good practice guidance, webinars, updates and more. Something we should be encouraging link workers to join. To join please email: england.supportedselfmangement@nhs.net

Social prescribing and personalised care: key resources

1.	**Summary Guide, which gives a clear picture of what a good social prescribing scheme looks like for everyone - also includes a common outcomes framework to help measure the impact of social prescribing on people, the local system, and the voluntary and community sector.**
2.	Reference Guide for PCNs supports PCNs with information on setting up social prescribing services including support for recruitment, induction and supervision - also outlines quality assurance measures, and how info can be gathered to help develop a consistent evidence base for social prescribing.
3.	Welcome and induction pack for link workers in primary care networks (PCNs).
4.	Handout for practice staff to give to people who are referred to a social prescribing link worker.
5.	Themed fortnightly webinars for link workers
6.	Regional Learning coordinators (London = lianna.martin@nhs.net) provide learning and peer support for link workers (SPLWs) at both a regional and Primary Care Network (PCN) level
7.	Regional Facilitators support local system leaders to bring partners together to create and deliver place-based plans across the ICS/STP footprint which support the development of social prescribing and community-based approaches and to embed link workers in every Primary Care Network.
8.	Regional PCN Advisors - support PCNs to embed the three personalised care roles within primary care: Social Prescribing Link Workers (SPLWs), Health and Wellbeing Coaches (HWbCs) and Care Coordinators (CCs) (London = lianna.mrtin@nhs.net + hina.shahid1@nhs.net)
9.	Accredited online training through Health Education England
10.	Personalised Care Institute - Free courses available through the Personalised Care Institute. Core skills training shared decision making and personalised care and support planning training that is available free online from the PCI would be, on the whole, relevant and of benefit to the personalised care roles.
11.	Social Prescribing Slide deck Generic slide deck for social prescribing presentations
12.	Directed Enhanced Service sets out how commissioners must offer to primary medical services contractors the opportunity to participate in the Network Contract Directed Enhanced Service (DES). It outlines the eligibility requirements and process for primary medical services contractors to participate; and sets out the relevant rights and obligations for PCNs and commissioners.
13.	Network Contract DES – VAT Information This document is an information note from NHS England regarding the Network Contract DES and VAT
14.	IIF Implementation Guidance 2021-22 This document sets out guidance for primary care networks (PCNs) implementing the Investment and Impact Fund, as per the requirements set out in the 2021/22 Network Contract Directed Enhanced Service (DES) Specification.
15.	Key DES-IIF and operating changes 2021-22
16.	FutureNHS Collaboration Platform Source of good practice guidance, webinars, updates and more. Something we should be encouraging link workers to join. To join please email: england.socialprescribing@nhs.net