COMMUNITY ALTERNATIVES TO A&E

Working with Clinical Coaches in the Royal Borough of Kensington & Chelsea (RBKC)

AT A GLANCE

The Approach

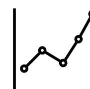
- **Project aim:** High Intensity User (HIU) patients were included to mirror a similar piece of work (*Community Approaches to A&E)* in North Westminster in conjunction with Community Champions, aiming to **reduce patient risk of hospitalisations** in the **RBKC**.
- **Cohort:** Adult patients over 18 years with long term conditions (LTCs), frailty & miscellaneous other conditions who would benefit from coaching, and HIU in primary care (who have had five or more GP attendances in the recent three months & two or more LTCs).
- **Personalised Care Team:** Clinical Coaches based outside of PCNs and working collaboratively with PCN staff & GP practices.
- **Referral:** HN identifies patients from queries with GP practices and invites those suitable. HN also encourages direct referrals from any GP staff.
- **Who:** NWL ICS in collaboration with resident & community groups in Royal Borough of Kensington & Chelsea (RBKC).

FUNDING

- Winter access funding: £130k for rising risk and HIU patients.

THE CHALLENGE

- A clear correlation was seen between sudden high use of secondary care services and a **rising use of primary care services** in the preceding months.



- The team were unable to recruit Health & Wellbeing Coaches due to Omicron. Instead **Health Navigator (HN)**, a partner organisation delivering health coaching, were commissioned to provide Clinical Coaches.

THE ACTION PLAN

- HN were commissioned to provide **four clinical coaches for one year** (trained nurses providing support to empower & enhance self care for patients, thereby reducing risk of hospitalisations).
- It was a remote service via telephone, video call, WhatsApp.
- A **therapeutic relationship** with patients developed over three months.
- In Clinical Supervision Meetings for PCNs, HN introduced the service, explained the process and explored how to work together & share information.
- Evaluating the service through tracking patient progress and sharing thematic outcomes in discharge summaries.

IMPACT

- HN demonstrated a **41% reduction in clinical contacts** by patients receiving the service.
- This activity decrease **persisted 6 months** after conclusion of the service.

BARRIERS

- Effective **communication and engagement** with multiple key stakeholders involved or those who needed to be aware of the pilot. Capacity & competing priorities were blockers.
- **Lack of local capacity** to promote the service led to less awareness of the benefits and impact.
- Demonstrating the **distinct roles of clinical coaches** from traditional Health & Wellbeing Coaches.

MORE INFORMATION

Health Navigator: Empowered Patients, Sustainable Healthcare

LEAD: Colin Paget, Head of Delivery and Implementation, Health Navigator.