Personalised Care Additional Roles
10th November 2021
12pm- 12.45pm

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Aims of Today's Webinar

For PCN colleagues to gain an understanding of each role's remit in primary care and hear from the local support offer for the additional roles

For colleagues to understand different ways the roles can work together to deliver high-quality, personalised care, using real-life examples of the roles working together in primary care

To provide an opportunity to offer suggestions for future sessions and share good practice examples

Page 1- What help and support would you like to understand/ embed the roles?

Page 2- Topic suggestions for future lunch and learn sessions

Page 3-Examples of success with the three roles

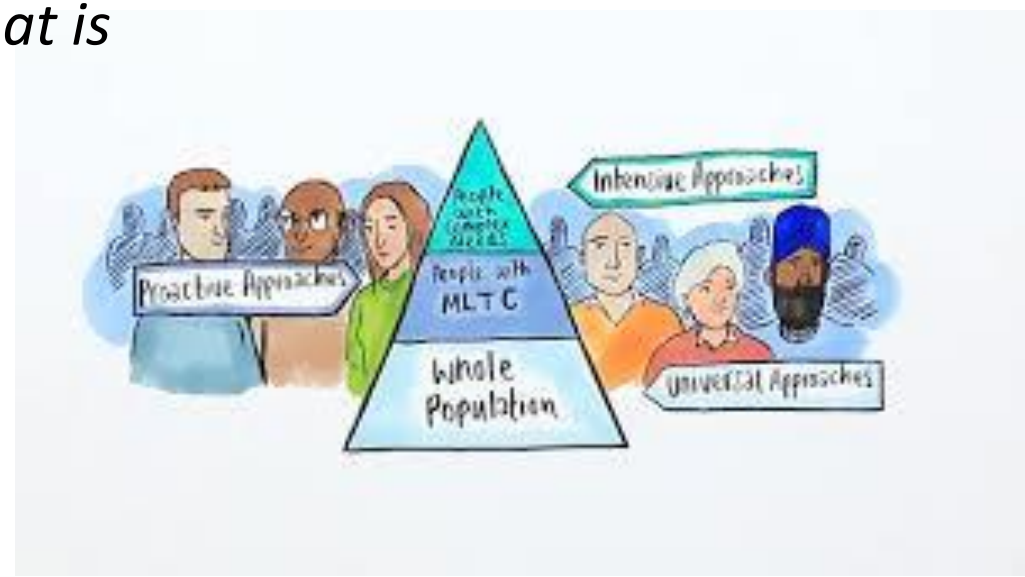
Page 4- Anything else?

Outline for the session

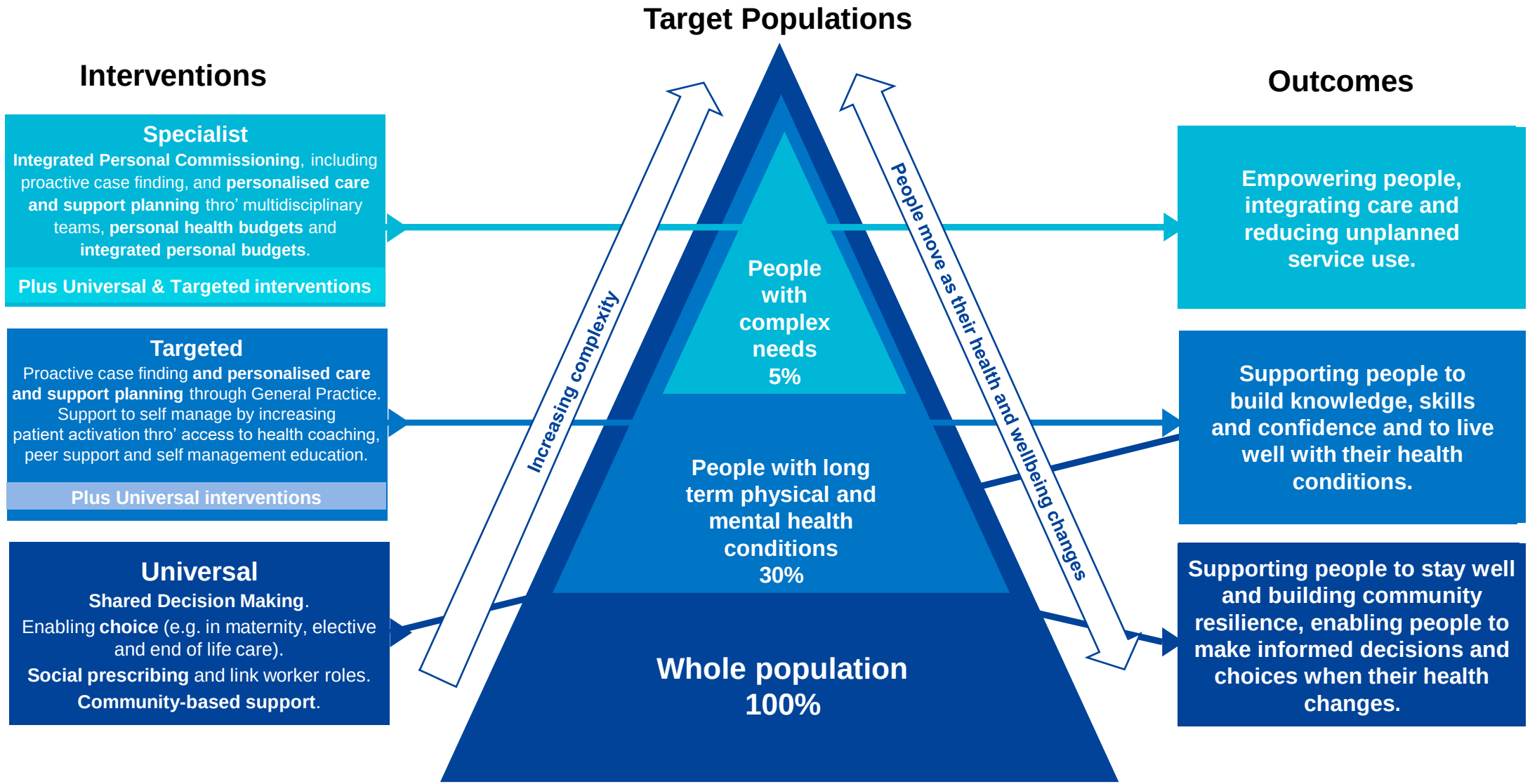
- Context of personalised care
- The three roles- what they are and what do they do
- How do they work together
- Regional support offer

*Personalised care means people have **choice** and **control** over the way their care is planned and delivered. It is based on '**what matters' to them** and their **individual strengths and needs**. Personalised care is fundamental to the changes the NHS is seeking to make over the coming years – to deliver better health and wellbeing for individuals; better quality and experience of care that is integrated and tailored around them; and more sustainable NHS services.*

https://www.england.nhs.uk/personalisedcare



Comprehensive Model for Personalised Care



Personalised Care Roles Overview

The Network Contract DES Specification 2020/21 provides reimbursement for three personalised care roles based in PCNs: SPLWs, HWBCs and CCs

The introduction of HWBCs and CCs from 01 April 2020 is in addition to the existing SPLW role which has been in place since July 2019.

Working together these three roles reduce and support the workload of GPs and other staff by supporting people to take more control of their health and wellbeing and addressing wider determinants of health such as poor housing, debt, stress and loneliness and to offer targeted support for people with more complex needs within the health system.

From within their Additional Roles Reimbursement sum, a PCN may determine which of the additional roles that can be engaged or employed, taking into account their overall workforce considerations and needs. The PCN DES states that PCNs must have a social prescribing service. Whether provided by a VCSE organisation or directly employed.

Care Coordinator

Provide them a faster and better-quality service with continuity

Single support plan which identifies all their needs. Ensure they only have to tell their story once.

Support a patient through their care journey

Help people to prepare for or follow-up from clinical conversations they have with primary care professionals

Health and Wellbeing Coach

Highly skilled in coaching, and behavioural change.

Support people to develop their knowledge, skills and confidence to become active participants in looking after their own health.

Support people to reflect on and change their health-related behaviours
Help people reach their self-identified health and wellbeing goals

Social Prescriber

Address the wider determinants of physical and mental health such as poor housing, debt, stress and loneliness.

Work collaboratively with a variety of local partners and connect people to Local community groups and agencies for practical and emotional support.

Activities that promote health and wellbeing (such as the arts, sports, or natural environment

Social Prescribing Link Workers

- **Address the wider issues** that affect people's health & wellbeing
- **Take a person-centred approach**, **to identify what matters to the person**
- **Connect people to:**

✓ practical, social and emotional support within their community; and

✓ activities that promote wellbeing e.g. arts, sports, natural environment; and

✓ positive people, positive places and positive things

- **Identify and nurture community assets** by working with partners such as VCSE, local authorities and health
- **Tend to work with** people experiencing loneliness, complex social needs, mental health needs or multiple LTCs

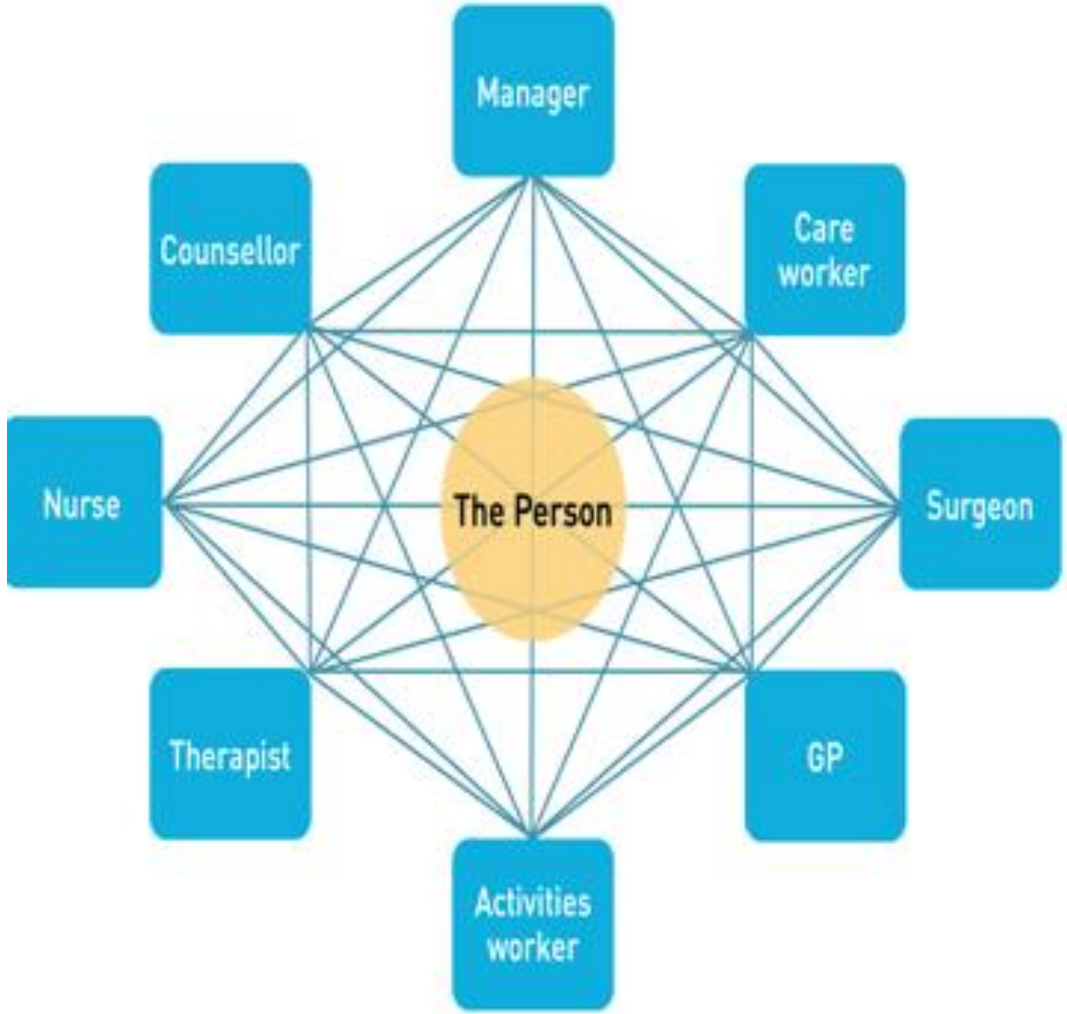
Spotlight on health coaching video

https://youtu.be/oY-pe3yMdeM

Overview of the Health & Wellbeing Coach role

- Support people to take pro-active steps to improve the way they manage their own physical and mental health conditions, based on what matters to them as individuals.
- Support people to increase their own knowledge, skills and confidence to improve their health outcomes and quality of life.
- Offer a person several sessions to help them identify their needs by providing a platform to have a conversation about those needs and any goals or aspirations they have to take control and move forward.
- Bring a range of skills that include, good communication skills, behavior change and motivation techniques, knowledge and access to other interventions such as peer support, self management and education.
- Foster a non-judgmental approach, empathic in their understanding of the reality of living with a long-term health condition. They work to empower a person to identify existing issues and encourage a proactive and positive approach to their health both now and in the future.
- Target patient population- anyone requiring support with behaviour change to improve their health. Typical examples, LTC, Type 2 diabetes, hypertensive, High BMI etc..

Spotlight on care coordination video



https://youtu.be/l-2-UJTAPNI

Overview of the Care Coordinator role

- **Proactively identify and work with people**, including the frail/elderly and those with long term conditions, to provide coordination and navigation of care and support across health and care services.
- Work closely with GPs and practice teams to manage a caseload of patients, acting as a central point of contact to ensure appropriate support is made available to them and their carers: **supporting them to understand and manage their condition** and ensuring their changing needs are addressed.
- **Bring together all the information about a person's identified care** and support needs and exploring options to meet these within a single **Personalised care and support plan**, based on what matters to the person. review patients' needs and **help them access the services and support they require** to understand and manage their own health and wellbeing, referring to social prescribing link workers, health and wellbeing coaches, and other professionals where appropriate.
- Provide time, capacity and expertise to **support people in preparing for or following-up clinical conversations they have** with primary care professionals to enable them to be actively involved in managing their care and supported to make choices that are right for them. Your aim is to help people improve their quality of life.
- This role is intended to become an **integral part of the PCN's multidisciplinary team**, working alongside social prescribing link workers and health and wellbeing coaches to provide an all-encompassing approach to Personalised care and promoting and embedding the Personalised care approach across the PCN.

Referral
Via a single point of access

WHAT MATTERS TO ME

PERSONALISED CARE

Social prescribing link worker

- Mental health needs
- Lonely and isolated
- Long term conditions
- Complex social needs

Link to

- voluntary sector
- community
- other statutory organisations
- wellbeing activities

Health and wellbeing coach

- Low motivation
- One or more long term conditions
- Physical & mental health needs
- Low confidence

Link to

- confidence
- knowledge
- skills
- self-management

Care coordinator

- Need information
- Uncoordinated care planning
- Frail/ Elderly
- Multiple appointments

Link to

- community services
- secondary care
- mental health teams

https://drive.google.com/file/d/1mi6gbYNNQj93N6S-FxrEKK5-A6fFwwFk/view?usp

Unique contribution of each role

Social Prescribing Link Workers	Health & Wellbeing Coaches	Care Coordinators
Address wider issues that affect people's health & wellbeing. **Use personalised care and support planning and health coaching approaches**, usually over several sessions to **identify what matters to the person** and **connect them** with; • practical, social and emotional support within their community and • activities that promote wellbeing e.g. arts, sports, natural environment. **Identify and nurture community assets** by working with partners such as VCSE, local authorities and health. **Tend to work with** people experiencing loneliness, complex social needs, mental health needs or multiple LTCs.	**Proactive identification and caseload management** of people with LTCs. **Guide and support people with LTCs** to reach self-identified health and wellbeing goals. **Use specialist coaching and behaviour change techniques**, usually over a number of sessions. **Tend to work with people** with physical and mental health conditions, and with one or more LTCs such as type 2 diabetes, COPD, or at risk of developing a LTC.	**Proactively identify patients** who need support to: • prepare for follow-up clinical conversations with primary care professionals • be actively involved in managing their care and to make choices that are right for them • develop personalised care & support plans • understand and manage their condition, ensuring changing needs are addressed. **Provide coordination and access** to other appropriate services and support. **Tend to work with** people with multiple appointments, frail/elderly and people with LTCs.

How PCNs support these roles

- Induction, training, line management, peer support and ongoing *professional* supervision.
- Promoting multidisciplinary and cross-agency working.
- GP IT Systems and smart cards so staff can access patient notes and record referrals.
- Equipment to work remotely (laptop, phone, VPN token).
- Individual NHSMail accounts, to enable secure sharing and transfer of data in line with GDPR requirements.
- Rooms and venues available for meetings in the same way that these are available to other PCN staff for consultations.

Regional Learning Coordinator Role

Facilitating monthly peer support sessions and workshops for Social Prescribing Link Workers (SPLWs) across the region (for those directly employed by PCNs as well as by the CVS)

Organising and delivering regional learning events for SPLWs, as well as disseminating key information such as SPLW training opportunities/programmes and materials that support them in their role

Working with NHS England personalised care regional teams and social prescribing associates to support systems to embed social prescribing within a wider personalised care approach

Working closely with Health and Wellbeing Coach and Care Coordinator Regional Mentors to embed integrated working between the three roles. Sharing local good practice regionally and nationally

HWBC Mentor Role

Providing one to one mentor support to HWBCs in the Midlands. Facilitating HWBCs to come together for peer support and learning, with the aim of these networks become self – sustaining and lead by HWBC Champions.

Encourage use of the Supported Self management platform Promote NHS England and NHS Improvement's supported self-management resources for HWBC.

Ensure that knowledge, confidence and expertise to implement HWBC is shared with peer organisations to enable them to implement the roles effectively and at scale. Share and promote best practice models.

Enable the delivery of Personalised care to more people in their local areas by working closely with NHS England and NHS Improvement regional colleagues to support the implementation and scaling up of HWBC roles within primary care.

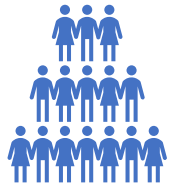
Care Coordinator Mentor

- Currently the post is vacant for the midlands.
- Interim offer from the national mentor Deborah O’nyons
- Monthly peer support sessions (Midlands)
- Monthly share and learn webinar sessions (National)
- Encouraging support to access the futures platform and appropriate resources related to recruitment and support
- deborah.onyons@nhs.net

PCN Advisor Role

Support the ongoing development and delivery of social prescribing and supported self-management.

Provide targeted support to PCNs with the implementation of the three personalised care roles.



Support the scaling up of numbers of the roles ensuring that PCNs are set up to support and develop people in these roles and to integrate them within PCN and practice teams.

Take forward social prescribing within the wider context of whole system working, community development and volunteering.

In practice…

- Facilitating monthly regional PCN support workshop/webinars including PCNs, focusing on workforce development, retention, training and development needs and supervision.

- Work with PCNs to support the workforce development of SPLWs, HWBCs and CCs, helping to embed the wider personalised care model in local systems.

- Working collaboratively with the social prescribing RLC, care coordinator and health and wellbeing coach mentors to address issues raised by SPLWs, HWbCs or CCs, ensuring people in these roles are directed to appropriate support and advice.

- Work with NHS England and Improvement to write up stories and case studies and develop tools to support delivery of the three personalised care roles.

Discussion

8th December

12th January

9th February

9th March

12pm-1pm

What support is needed to understand / embed the roles?

PCN's really need to understand the scope and range of what a care coordinator can do.

Help with fully understanding the DES and how it affects us and how we work

Personalised Care is for all not just theses three roles. We all have to take a patient centred approach in our care of patients

PCN needs to consider the time and support a care coordinator needs to develop their skills, their links and networks. If they're offered too many admin / reception tasks it distracts from the essence of their

As PCNs we need to deliver PSCP, but we need to have clear coding for clinical systems so we can measure the progress and cases that have been supported.

PCN's to understand what a Care Coordinator role entails

Is any where focusing on patient groups rather than individuals as a means of offering support via care coordinators?

PCNs need to be clear about roles. Not calling someone a care coordinator when they do not have a care coordinator job description. Job titles are inconsistently applied across the ICS

what does a personalised care plan look like? Who is responsible for them? The CC or the GP? These need to be carried out in care homes - can a CC do this or does it need to be clinical?

what size case load would a care co-ordinator be expected to take on? or is it dependant on needs required by specific patients? how long would you keep them on your case load?

If staff are working across a PCN, they need support to work with each practice within their PCN. Staff have moved on because they didn't feel connected across the whole PCN

Estates are a big issue in the city centre practices. Often SPLW have no space to meet patients.

Help understanding the DES - requirements for the care coordinators

PCNs need to understand the benefits of Care Coordinators using the Patient Voice or real life outcomes.

More specific and defined job titles. The job title 'care coordinator' can be too generic

more support in understanding the different roles of a care co-ordinator, especially if care co-ordinator is not clinical and is doing it from an admin perspective

What training is on offer for these roles?

More support/ongoing support for development of individuals in their roles - training and ongoing day to day support especially new roles of CC & HWBC

Support with clinical directors understanding the role of a care coordinator - not just using them to help with work they should already be doing

Important for existing SP link workers, health coaches etc to understand how all these roles complement each other as well.

Is there any additional funding for training for these roles aside from the ARRS reimbursement?

Topic suggestions for future lunch and learns

Different types of care coordinators - do we need separate ones for cancer, admission & discharge, frailty care etc What can they do and examples or job descriptions etc

Training and Professional development each role needs to be supported on

Focus on one role at a time. Care Co-ordinator seems like a large topic to cover along with others in 45 minutes

There is a health coaching qualification for staff in these roles

Focus on one role/topic at a time. Seems quite ambitious to get through all of this in 45 mins

Definitions of different care coordinator roles....i.e frailty, cancer, covid

which training is needed to empower each role with the right skills?

Remember the Personalised Care Institute - who have free training and signposts to other providers of training

A 45 min session is great.

Apprenticeships and how they support these roles

SPLW / HWBC in our area have been invited to attend various sessions with the training hub. They have covered mental health, motivational interviewing, safeguarding etc.

Liaison or working relationships with local neighbourhood teams and how the 3 roles will link with these?

Examples of success with the three roles

South Lincoln Healthcare PCN has a Living Well team made up of these three roles, plus OTs and mental health practitioner etc

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jamboard.google.com/d/1V6zLvaC0am0JiDDSdxNOMDBrsCXZjS562tC7mxOMiK0/viewer?f=3

Apps | Health and Wellbei... | NHSmail Sign In | e-LfH Hub | viewpoint | Amazon.co.uk: Low... | Reading list

PCN Webinar 1

4 / 12

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Share

Set background | Clear frame

Anything else??

How many patient would you expect to be on a care coordinator case load and how long for?

Do you have examples of a personalised care plan - what does it look like - paper, electronic..... How do you agree it has been completed?

care coordinators are utilised on as extra admin support rather than doing their actual job.

A Phone would be great to separate work from ordinary life also. Plus giving the patient and carers direct access to care coordinators and staff

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