Personalised Care Roles in Newham

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Newham Public Health

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*With special thanks to all members of the action groups for their invaluable contributions to the project.

Contents

EXECUTIVE SUMMARY

Personalised care roles provide support for people's non-clinical needs and enable a preventative health and care approach. A range of personalised care roles have been established in Newham over the last 10 years, with a sharp increase in roles since 2019 in line with the NHS policy directive of personalised care. In 2022, a six-month project was completed to better understand these roles in Newham, as well as the experience of them for residents, the workforce themselves, and the wider health and care sector.

The project focused on six roles:

- Social Prescribers
- Care Coordinators
- Health and Wellbeing Coaches;
- Care Navigators;
- Community Connectors; And
- Community Neighbourhood Link Workers.

These roles are shared across the local authority, primary care, the voluntary sector and the East London Foundation Trust (ELFT), with different funding sources (such as NHS Additional Roles Reimbursement Scheme funding directly to Primary Care Networks, Council funding, and local NHS funding).

The purpose of the project was two-fold: (1) Better understand the personalised care offer in Newham, and (2) identify areas where improvements could be made. The scope focused on three aspects of the offer: (a) Mapping/Clarification of the landscape of all personalised care-type functions across the borough, (b) map and clarify pathways, and (c) how do we provide residents with the same quality experience at all points of access?

Led by the London Borough of Newham's Public Health team, a shared and multi-faceted approach was undertaken. A borough-wide steering group was created which included the managers of these roles and other system stakeholders e.g. voluntary, community and faith sector (VCFS) representation. In order to deliver the project, the work was split into five action groups:

- Quantitative data,
- Qualitative data,
- Mapping &pathways,
- Skills & training, and
- Models & evidence.

Each action group had representation from a range of stakeholders across the system including residents, the VCFS and people in the roles the project was reviewing. Each action group developed their own plan to deliver the objectives of the group set out in the project plan.

The action groups spent the first few months collecting the data necessary for them to review and then develop some recommendations. This included: surveys, focus groups and interviews for qualitative data collection; data sharing of quantitative data from system partners who are responsible for each role; collecting job descriptions and details of the training; meeting with people in each of the six roles to explore the resident pathways to and from them; and collating a range of evidence.

The data collection process faced multiple challenges including a lack of participation from some stakeholders in the qualitative data collection, a lack of quantitative data available, the time it took to access some of the desired information, and a lack of consistency or detail in some data and information.

Findings

The findings in the project are wide ranging, and informed a series of recommendations. The key findings from each action group are:

- **Quantitative Data:** The quality and consistency of data is variable and often lacks specificity, which limits its evaluative value. In addition, there appears to be a mismatch between the presenting complaint and the referrals made, which seems to suggest a lack of the necessary services to meet certain needs (e.g. housing). The action group were unable to access data for the Community Connectors, or data that was specific to Care Coordinators and Health & Wellbeing Coaches.

- **Qualitative Data:** Residents reported both a need and desire for positive experiences with Health & Wellbeing Support Roles however, they don't feel they often receive holistic care in their experiences with healthcare. Across all the audiences engaged with there was a lack of awareness and understanding of the roles, including between the different roles acting as navigators/social prescribers.

- **Skills & Training:** Training that is provided to the roles varies. Despite there being some similar core training need for these roles there is little standardisation. The action group weren't able to confirm the attendance or completion across the various training offers. It was noted that the staff in these roles struggle to find the time to attend training, especially if it is not mandatory. The skills and responsibilities of the roles have significant topic knowledge overlap. All reported a consistently high demand for resident support around form filling. Details and support to provide this is lacking despite the number of roles currently in place. However, while there is a lot of similarity, the group acknowledged the specialisms of each role as well.

- **Mapping & Pathways:** The mapping and pathways group have collated information about how the roles are funded and distributed across the borough as well as the length of support available and the pathways to each role. Due to the data available it wasn't possible to map each individual member of the workforce in order to understand if residents have equitable access to the roles. However, the action group was able to capture an overall picture of the roles to provide clarity on the offer and how residents can access it, alongside identifying barriers to access and opportunities for improvement.

- **Models & Evidence:** The action group reviewed 52 documents and found that the majority of evidence is related to social prescribing, and overall positive in the impact the roles can have. However, the evidence available is weak and skewed by the COVID pandemic.

While a lot of information was available and captured, it should be caveated that some data was missing and the numbers of people who engaged with the qualitative data action group activity was low and not fully representative of all stakeholders (i.e. we were unable to engage any GPs in our interviews or focus groups).

Recommendations

After collecting the data and information required, the groups assessed what they had found in order to develop a set of recommendations and some lessons learnt. These recommendations can be grouped into the following categories summarised below: Communications, Training and Development; Systems and Processes; and Data.

Overall, our data collection analysis clearly supports the need for a workforce that supports residents with the non-clinical, social determinants of their health. The top three reasons for referral to social prescribers were related to housing, general well-being and finance. In addition, residents were clear that they would both like and benefit from a holistic approach to their care, as these roles work to do.

- **Communications** – During the review of the information and the conversations had during the project, it was clear that there is a lack of clarity, and in some cases confusion, about the personalised care roles. This was the case for residents and the wider workforce, as well as between the roles. The need to improve awareness and understanding of the roles was repeated across different audiences and action groups.

- **Training and Development** – The skills and training review showed that there is significant overlap in the responsibilities of the roles. However, it was also noted that the specialised knowledge the roles have is something that should not be lost in any new approaches. In addition, there are still gaps in the support residents would benefit which are not covered by any of the roles (e.g. form filling).

- **Systems and Processes** – The complexity of the landscape seemed to suggest that there were opportunities to streamline processes and simplify how residents and workforce engage with the roles. For example, the different referral pathways can often result in inappropriate referrals, while the use of different record keeping systems means roles are unable to see what support residents have received from other professionals. The need for a consistent directory of service and better methods to bring roles together were suggested as ways to ensure residents had a more equitable and improved experience.

- **Data** – The quantitative data collection process highlighted the system-related challenges identified elsewhere, as the different roles use different record keeping systems. Furthermore, the data collected is inconsistent and not easy to access. In some cases, for example on the North East London social prescribing dashboard, it is unable to distinguish between the different roles making referrals or capturing data via EMIS. While these challenges don't specifically affect the day-to-day operations of the personalised care roles, it did identify some opportunities for improvement which would allow the system to better understand and respond to the needs of residents.

Conclusion

The personalised care roles bring a lot of benefit to residents, and alleviate pressures on the health care system. However, the complexity of the landscape can make it difficult to both understand and navigate for all stakeholders. Nevertheless, there are opportunities to improve the offer for everyone involved both in the short and long-term. With the new Integrated Care System approach, it seems like a good opportunity to review the offer and work together to improve the experience and hopefully the health and wellbeing of Newham residents in the long-term.

All the action groups noted that more work would likely be required to build a fully comprehensive understanding of the landscape such as observations of the roles, engaging with GPs, more

understanding of the variation within the same roles, and access to additional data. Therefore, while most recommendations are likely to be taken forward by the most appropriate stakeholder(s), it may be beneficial to extend the project for phase two to complete some remaining work such as continuing to improve data available, and observations of roles to improve understanding of ways of working.

BACKGROUND

It is known that social prescribing and personalised care are models which can empower, support and reduce the health burden for many people. For example, before the pandemic it was estimated that only 15-45% of contributors to people's health were health/clinical issues, with the majority of people's health being affected by their social and environmental health[1,2]. In more deprived areas, such as Newham, the impact of social and environmental factors on people's health increases. During the pandemic the demand for non-clinical support increased significantly[3], and is expected to continue increasing with the emerging cost of living crisis[4], as well as highlighting the connection between social issues and health status / outcomes.

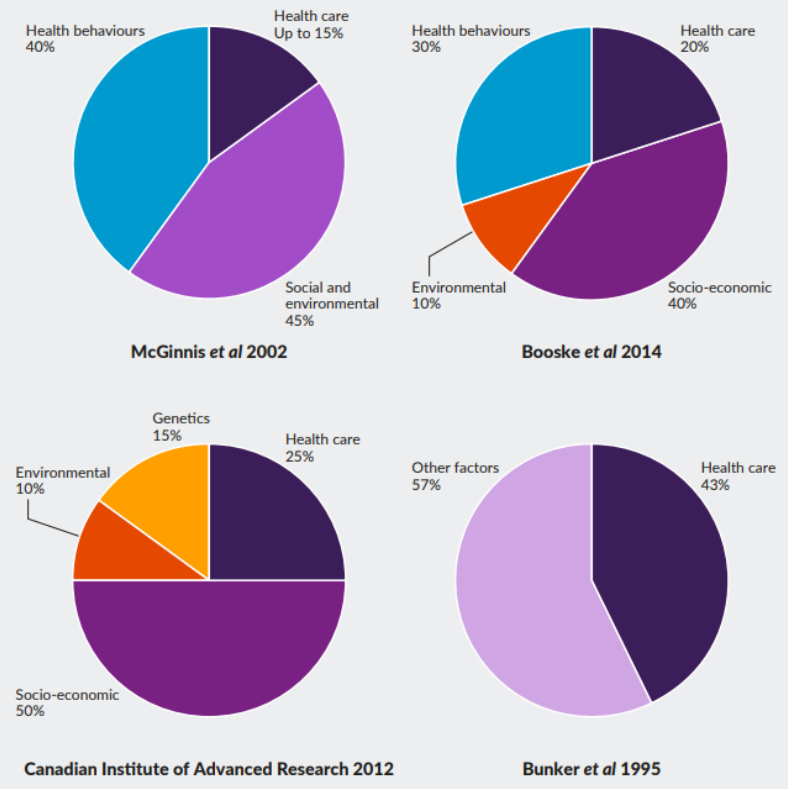

Figure 1: The relative contribution of major determinants to our health.
A Vision for Population Health: Towards a Healthier Future, The King's Fund, 2018.
Sources: Canadian Institute of Advanced Research (2012); Booske et al (2020; McGinnis et al (2022); Bunker et al (1995)

Across Newham, the UK and the world, there are various models for how to provide support to people around the social determinants of their health[5], and empower them to improve their health and wellbeing based on their interests and goals. In Newham, the landscape has developed

[1] Buck D, Baylis A, Dougall D & Robertson R. A Vision for Population Health: Towards a Healthier Future. The King's Fund; 2018. (https://www.kingsfund.org.uk/sites/default/files/2018-11/A%20vision%20for%20population%20health%20online%20version.pdf)
[2] Husk K, Elston J, Gradinger F, Callaghan L & Asthana S. Social prescribing: where is the evidence? The British Journal of General Practice; 2019. 69(678), 6–7. https://doi.org/10.3399/bjgp19X700325
[3] Westlake D, Elston J, Gude A, Gradinger F, Husk K & Asthana S. (2022). Impact of COVID-19 on Social Prescribing Across an Integrated Care System: A Researcher in Residence Study. Health & Social Care in the Community; 2022. 00, 1-9. https://doi.org/10.1111/hsc.13802
[4] Jani A. The Role of Social Prescribing in Relieving Suffering. Social Prescribing Network; 2022. https://www.socialprescribingnetwork.com/blog/the-role-of-social-prescribing-in-relieving-suffering
[5] Polley MJ, Fleming J, Anfilogoff T & Carpenter A. Making Sense of Social Prescribing. University of Westminster; 2017. https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network

somewhat organically, without a clear strategic direction or alignment due to the various funding sources, different priorities and external drivers. The result of this is both a complicated landscape and a lack of join up between different parts of the offer.

In late 2021, the Director of Adults & Health requested a project to better understand the landscape of personalised care support available for Newham residents in order to identify opportunities to improve the offer and experience of the offer. As Well Newham is the public health programme that works to support all residents in the borough around the social determinants of their health, it was decided the project would sit within the Well Newham programme.

After spending some time clarifying the scope, the project began in early 2022 and was called the 'Personalised Care Research Project'. The aim of the project was to gather and interpret information to provide a better picture of the current landscape in Newham, rather than produce a gold standard research project.

When the project was designed, there were six different roles in the borough that provided a personalised care offer to adult residents as their primary purpose. Although it is recognised that there are many more people in the borough who provide similar support, particularly in the voluntary sector, for this project it was decided to focus on these six roles to ensure it was manageable within the timeline. Therefore, it was decided to use the terminology 'personalised care' with regards to the project to more accurately include all six roles. The roles included in the project are:

1. Community Neighbourhood Link Workers
2. Social Prescribers
3. Care Navigators
4. Care Coordinators
5. Health & Wellbeing Coaches
6. Community Connectors

Since the project began, Family Navigators have been introduced in the borough to support families who are new to the borough. In addition, there is work around Family Hub development taking place and there are many roles within Children's and Young People services which offer similar support to those under 18 and their families. This project focused on roles that primary supported adults as that was the focus of the request.

Purpose

The purpose of the project was described as two-fold:

1) Better understand the personalised care offer in Newham including:
    a. Residents' experience of personalised care roles
    b. The experience of the personalised care workforce
    c. The experience of wider health and social care workforce

2) Identify areas where improvements could be made related to:
    a. Consistent and positive resident experience
    b. Workforce roles, training, support and management
    c. Wider workforce relationship with personalised care workforce
    d. Connections with borough-wide strategies and plans

While we were unsure what information would be available or accessible, the purpose of the scope was broken down into three sections:

1) Map/Clarify landscape of all personalised care-type functions across the borough
    a. Understanding differences and overlapping responsibilities in roles
    b. Gap analysis of roles
    c. How they work together – Is this well understood across the system?

        i. Multidisciplinary team meetings and how they work
        ii. Referrals
    d. Neighbourhood level working

2) Map / Clarify pathways
    a. Input points
    b. Output points
    c. Outcome areas
    d. Is a single pathway process possible / feasible?
    e. Links to social care pathway(s)
    f. Links to NHS pathways

3) How do we provide residents with the same quality experience at all points of access?
    a. Standardised offer / function?
        i. Standardised contact process (Making Every Contact Count / Strength based training / values)
        ii. Contact duration and intensity model (fixed / variable)
    b. Standardised job description / training?
    c. Standardised management grading and progression structure?
    d. Quality assurance and evaluation process

While it was recognised that the deliverables of the project may vary depending on what was possible based on the information available, the key deliverables of the project were originally specified to be:

1) Role maps and comparisons
2) System and pathway map
3) Contact skills audit
4) Contact model summary
5) Recommendations including systems and possibly a theory of change process

While the project was initiated by the local authority, the stakeholders are key to this project as the personalised care offer sits across multiple parts of the system (local authority, primary care, community health, voluntary sector). Resident experience of and feedback on the personalised care offer was also highly important for this project.

It appears to be the first time a project of this type and scope has been conducted in the personalised care / social prescribing space in the UK, especially since the introduction of NHS roles (e.g. Care Coordinators and Health & Wellbeing Coaches). Hopefully, the outcomes of this project will both help review our approach locally but also provide an example to others of an approach which may be beneficial to review their personalised care / social prescribing offer.

METHOD & APPROACH

The project reported to both the Council's Adults & Health transformation programme as well as the borough-wide Newham Executive (now named the Newham Health & Care Partnership) in order to ensure it was aligned with the multiple system partners which this project touches.

A steering group of senior leaders from across the system and managers of the six roles came together to agree the parameters of the project and understand the mutual benefits of the project. They agreed that they and their team(s) would participate and cooperate to facilitate the project with the understanding that the project would produce recommendations for them to agree, rather than set out an action plan without their input.

The project action plan had three parts to be delivered by December 2022:

1) Research – collecting data
2) Consolidate – reviewing and combining data
3) Output – recommendations and next steps

In order to deliver on the plan, the project was divided across five action groups; qualitative data, quantitative data, skills & training, mapping & pathways, and models & evidence. Action groups met every three weeks from May 2022 until September/October 2022.

Within each action group we endeavoured to get representation from the local authority, the integrated care system, primary care, secondary care, personalised care roles, the voluntary sector and residents. While it wasn't possible to fill all these roles, all action groups had representation from most stakeholder groups. The Council's co-production team were closely involved in the project and assisted with resident recruitment and support throughout.

Each action group co-designed their approach to fulfilling the objectives set out in the project plan and took shared responsibility for completing the necessary tasks. For some members of the action groups this type of work was quite new to them, and some found their capacity to participate varied throughout the project with a few people having to step down due to their availability. In addition, some action groups required significant cooperation from those outside the project team/s, which affected their ability to collect all the information they wanted to review. Each action group completed their tasks to the best of their ability; however, most of the action groups have said more could be done to make the outputs of the project more comprehensive.

Below is a summary of the approach each action group took. The final output from each action group is a set of recommendations for improvements and further research/work required, as well as some of the lessons learnt during the process.

Quantitative Data

The original objectives of the quantitative data action group were:

1) To identify the data that is currently being collected, how it is being collected, and how consistently it is collected
2) To identify what gaps exist in the data, and how processes could be improved
3) To review and analyse the data to identify trends showing areas of success and areas for improvement

The action group also decided to add a fourth objective to the list above to describe the personalised care workforce through the data available if possible.

Note: The quantitative data action group is one of two action groups that did not have resident representation.

While the key task was clear - to identify, request, access and review data available for the roles of interest, there were some challenges because we were unsure of what data would be available, and the data is held by different organisations and on different systems. Due to the challenges of data sharing and in some cases understanding who was able to provide permission to share the data, it took the group a significant amount of time to identify the data available and access it, limiting their ability to look at the data in as much detail in the timeframes available.

The group requested anonymised, case level data for the last 24 months if available. In order to evaluate the data consistently across the different roles the group decided to develop a set of questions to apply to each set of data, in addition to reviewing overall trends. The questions the group developed can be categorised into 3 themes: data availability/accessibility, data quality, and data responsibility.

Data Availability/Accessibility	Data Quality	Data Responsibility
What data is available?	What formats are the data in?	Which personalised care roles are providing the data?
What data is missing?	Is ethnicity recorded and if so, what level and style? (e.g. detail of ethnicity)	Does the data collected by the different roles differ? If so, how?
How much data do we have? Is it enough to show a trend?	Are there any issues around the data that are seen frequently?	
Could we have more data? (i.e. are all the staff providing data)	What is the confidence in the data e.g. to tell a story or to support evaluation?	
Where does the data sit? Is it easy to share with other parts of the system?	What is the confidence in the data e.g. to tell a story or to support evaluation?	
What data exists that we can't access / link?		

The group saw value in reviewing additional, more detailed data fields such as the group wanted to review were:

1) Number of referrals
2) Who referrals were made from?
3) Why referrals were made?
4) What action was taken / onward referrals were made?
5) What is the outcome of the referral?

The group were able to meet their three original objectives, however were unable to produce an accurate description of the workforce from the data. This was because some data didn't identify who entered it.

Qualitative Data

The objectives of the group were:

1) To understand people's understanding of the personalised care roles including what they offer, how to access/refer to them, and experiences and the perceptions of the roles.
2) To understand the experiences of those in personalised care roles including how they work with the wider system and residents.

The group agreed with the objectives, and decided to gather data via a survey, 1:1 interviews, observations, case reviews and focus groups. They split the audiences for all data collection methods into three audiences: residents (and carers); personalised care workforce; and the wider health and care workforce (including council staff). It was decided to hire an external contractor to conduct the interviews, focus groups and observations. Unfortunately, due to a lack of availability, we were unable to complete the observations and case reviews as planned during the timeline of the project.

The survey was the first phase of data collection with questions developed by a sub-group, and then approved by the wider action group. In developing the questions for the survey, it was clear that the term 'personalised care' had different definitions and meanings for different people. Therefore, the group decided to use the term 'health and wellbeing support roles' in the data collection processes to avoid excluding people who didn't see 'personalised care' as relevant to them or were unclear what it referred to. The six roles the project is interested in (Social Prescribing Link Worker, Health and Wellbeing Coach, Health and Social Care Navigators, Community Connectors, Community Neighbourhood Link Workers, Care Coordinators) were included and referred to specifically in the survey as well as being listed on the council's website.

The primary method of completing the survey was via the Council's Newham Co-Create online platform. In order to enable as many people as possible to complete the survey, the survey included a phone number and QR code to access translated, audio, braille or large print versions. There were ways to respond to the survey offline – either by downloading a printable copy from the Council website, or by accessing a printed copy at one of the Council's libraries. The library teams were able available to help people complete the surveys either online or using the printed copies. The printed copies of the survey could be returned by post, email, Whatsapp, or by returning them to the library.

The survey, as well as opportunities to take part in the interviews and focus groups, were shared via multiple channels ranging from the Council's resident newsletter to voluntary sector groups and personalised care roles. The action group worked closely with co-production to raise awareness of the opportunities to engage with a wide range of possible participants across the different audiences.

All surveys were completed anonymously, although we did ask for people to identify the audience sub-group they fell into and some demographic information. Interviews and focus groups were arranged directly with the external contractor to ensure people could feel comfortable coming forward and being honest. Interviews were conducted individually and according to the preference of the person participating e.g. in-person, phone and online, and at different times of day. The focus groups were split according to audience and took place online at varying times to best suit each audience group. An in-person focus group was arranged for residents, however due to all participants no longer being able to attend this was cancelled at the last minute. Where we were unable to reach particular groups through other channels, the external contractor attended some existing meetings to reach these groups e.g. Learning Disability & Autism Residents Group, Personalised Care Forum. Unfortunately, despite several attempts we were unable to reach some key respondents (e.g. General Practitioners) which would provide a lot of beneficial input if we could gather their insights in the future.

Skills & Training

The objectives of the group were:

1) To understand and audit the training currently offered to personalised care roles and the training required
2) To understand and audit the skills required of personalised care roles (e.g. within job descriptions and based on experience) and the skills the workforce bring to the role (e.g. languages and local knowledge)

The action group wanted to be able to get some data about attendance at training and reasons for not attending however we were unable to access this data, in part because of the challenge of training for these roles being provided by system-wide (e.g. pan-London or national) providers which are in addition to the induction and compulsory training provided within Newham.

In addition, the group was aware that the roles of interest to this project are often asked to complete surveys and other feedback processes around similar topics so conducting a skills audit would be difficult, while also possibly duplicating work done by the North East London Personalised Care team and others. In order to avoid adding burden to the roles, the group agreed to complete a desktop audit exercise instead.

While it was difficult to get data, the group was able to access example job descriptions with relative ease, and most of the training information. However, the variation in how some people with the same title enact their role was difficult to capture within the documentation. Comments on the variation in the roles was captured through some of the action group discussions as well as other action groups.

In light of the above, the group decided to focus on two key aspects: (1) reviewing the roles through job descriptions, responsibilities and skills needed for each role, and (2) reviewing the training provided to each role including what is compulsory or optional, who provides the training, and how often the training takes place or is refreshed. In order to do this the group developed some questions to review each aspect (in addition to comparing and contrasting the documents), as below.

Job Descriptions	Training
What are the duties and responsibilities listed?	What is required training?
How work is administered?	What is optional training?
What skills are required?	Who provides the training?
How do they wrap around a person as a team?	How frequent is the training? When is it refreshed?
Any special demands / requests?	What supervision / management is provided?
What qualifications are required?	Any other support available?
What supervision / management is provided?	Is training certified or accredited?
Do they require local knowledge?	Is training transferrable? Are the skills developed transferrable?
	Does it provide career development opportunities or support aspirations?

Furthermore, the group thought it would be helpful to consider the following about skills, knowledge and experience in addition to the job description and training specific questions, if it was possible:

1) What do people bring to the role that is helpful but not part of the job description?

2) Is there reference to particular behaviours or attitudes?
3) Is there reference or a requirement for lived experience?
4) Is it clear how career development opportunities and aspirations will be supported?

Once all the documentation was collated, the group reviewed the documentation independently using the above questions and then shared their reflections and findings.

Mapping & Pathways

The objectives of the group were:

1) To map the position of personalised care roles in the system
2) To map the pathways to, from and between the personalised care roles
3) To identify opportunities to simplify / streamline pathways or where (clear) pathways are missing
4) To map the personalised care roles and their responsibilities to identify where there is overlap or gaps in provision

The action group decided to approach the objectives, of which they were all in agreement, to understand what the 'ideal' or expected pathway is for each role, and to then review each pathway to understand how it works in reality.

Once the 'ideal pathway' was provided by a representative of each role, the action group invited a representative from each role to take part in a pathway deep dive. Conducted online, during a deep dive, the representative would walk through the pathway from their perspective including how they collect data, contact residents and make onward referrals. Once the walk through was complete, the action group asked the representative questions to better understand the process and how residents may experience it.

After the deep dive sessions were completed for each role, the action group met for an in-person workshop to review the pathways alongside each other. The workshop focused on identifying remaining questions or gaps in information, best practice, opportunities/suggestions for improvement, connection points, and apparent gaps in the pathway.

Finally, the group mapped how the roles fit into the system overall understanding a range of useful factors including who employs and funds them, where they're based, and what systems they use for data collection.

Models & Evidence

The objectives of the group were:

1) To gather and evaluate models of social prescribing and personalised care roles from elsewhere considering how they could be applied in Newham or the lessons that could be learnt
2) To gather relevant evidence about the benefits of the roles and models that apply to them

Note: The models & evidence action group is one of two action groups that did not have resident representation.

The action group were in agreement with the objectives and discussed the importance of focussing on the lessons learnt and benefits from the different models that may be found in the course of the research. Therefore, they decided to focus on four different categories of information:

1) The current/existing Newham / NEL model
2) Examples outside Newham / NEL

3) Research on personalised care
4) Benefits of personalised care / different models

The members of the action group shared and collected articles, reports, training guides and other useful materials which were collated according to the above categories. Group members did their own research as well as reaching out to their networks and key organisations, including library services, to ensure as much relevant evidence and documentation was collected as possible. Once the group felt they had identified all possible relevant resources, the collection of documents were split between the group to be reviewed.

The review was conducted using the following twelve questions to evaluate the documents assigned to each group member.

1) What seems to work well for beneficiaries / residents/
2) What seems to work well for staff?
3) What doesn't work well for beneficiaries / residents / staff?
4) How is the system impacted?
5) Is there evidence of the impact that is being claimed?
6) What are the financial implications or costs incurred?
7) What are the lessons learnt?
8) What do we like about it? (e.g. way of working, principles)
9) What could be applied in Newham and why?
10) Where might the system affect the implementation of this approach?
11) Is there a key take away / lesson from this approach?
12) Any other comments?

While the group did their best to ensure all possible relevant evidence and models were included in this process, it is inevitable that some materials were missed. In addition, some relevant reports were published just before this project was concluded. In these cases, the reports were shared with the group for information and the opportunity to add their thoughts on the report if helpful.

FINDINGS

The findings from each action group have been summarised below. All the action groups found their findings addressed more than one of their original objectives. Additional details on their findings are available in the supplementary documents or on request.

Quantitative Data Action Group

The findings for the data action group have been grouped according to the data source.

Data from Social Prescribers, Care Coordinators and Health & Wellbeing Coaches

The quantitative data action group gained the most comprehensive picture of social prescribing through the social prescribing dashboard. The social prescribing dashboard uses data associated to social prescribing referral codes (SNOMED) from the primary care system (EMIS) where it is extracted into the Discovery data warehouse and presented in the Social Prescribing dashboard. The group were unable to access data specifically from Care Coordinators or Health and Wellbeing Coaches. However, it is possible that some of this data is captured in the social prescribing dashboard as it uses SNOMED codes which these roles also use. Extracts of some of the data available are below.

In April 2022, to improve the consistency of data collected, a standardised data template was introduced for Social Prescribing Link Workers to complete. The group deemed that data collected since the introduction of the template was of higher quality and complete enough to show useful trends and some outcomes. It is also worth noting that there is a NEL social prescribing evaluation group, that local authorities feed into, which seeks to drive increased use of the template in order to improve the quality and the use of data.

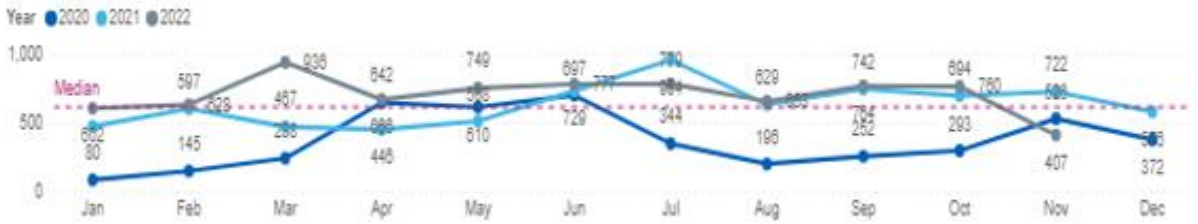

Figure 2 Social Prescribing Dashboard - Unique Patients Referred by Month

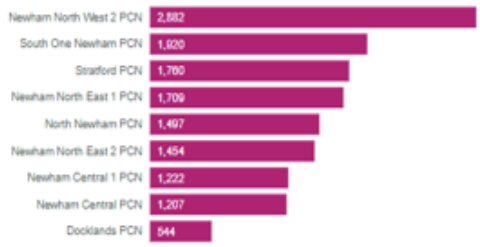

Figure 3 Social Prescribing Dashboard - Unique Patients Referred by PCN

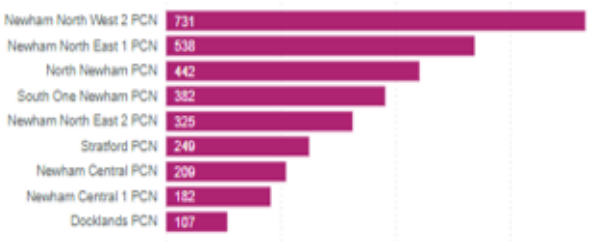

Figure 4 Social Prescribing Dashboard - unique Patients Referred Per 10 000 by PCN

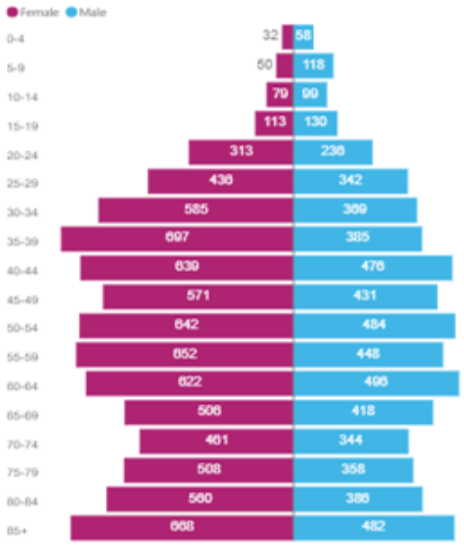

Figure 5 Social Prescribing Dashboard - Unique Patients Referred by Age Band and Gender

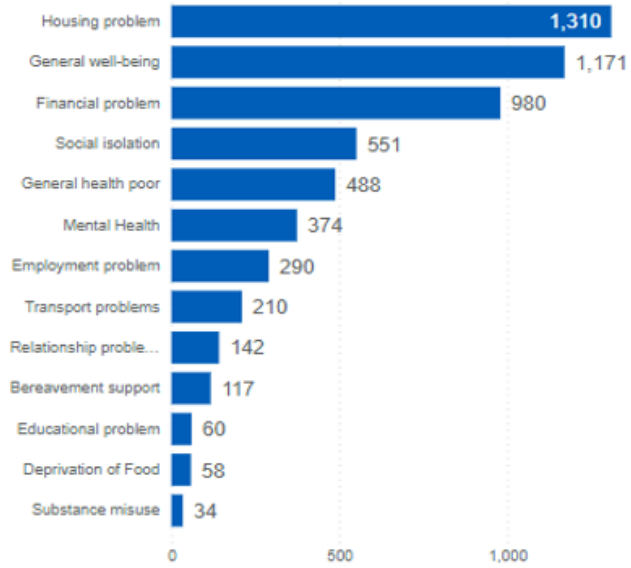

Figure 6 Social Prescribing Dashboard - Reason Referral (where recorded)

Despite a high number of useful data sets, summarised in the table below, the action group identified gaps in the data from the social prescribing dashboard that would help show additional successes and areas for improvement.

Social Prescribing dashboard data available	Social Prescribing dashboard data missing
Age of patient	Patient waiting times
Gender of patient	Community/voluntary capacity
Ethnicity of patient - 5 major ethnicity groups and 16+ ethnicity sub-groups	Outcome by service type
Service user postcode	Filtering the data by multiple demographics
Reason for referral outcomes/destination	Activity by social prescriber
Outcome/destination of referrals	Data showing on whether social prescribing results in people presenting less frequently to primary and secondary care
Referrals from GP practices	There is only one option for reason for referral, useful to have more than one referral option
Referrals from PCNs	

Analysis of the reason for referral and outcome/destination data reveals housing is the most common reason for referral to a Social Prescriber. However, as the graph below shows, patient's onward referral and support was not housing focused, in fact most often being diet education. In light of this, the group suggested developing a process to directly link patients to council services when housing is the main reason for referral.

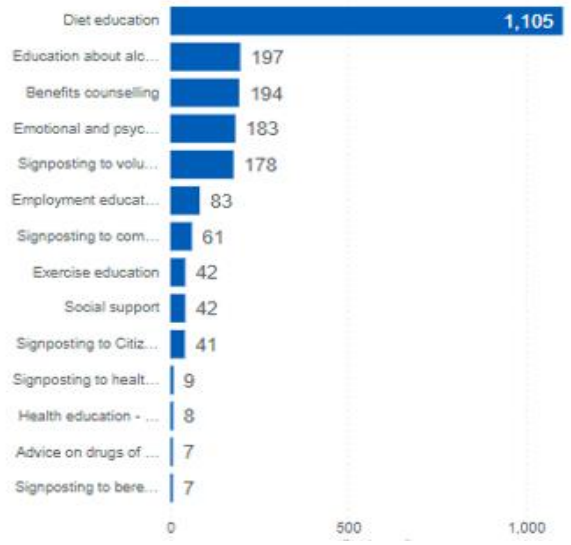

Figure 7 Social Prescribing Dashboard - Unique Patients by Support Offered

It is likely that Care Coordinator and Health and Wellbeing Coach activity data is also captured on the social prescribing dashboard, as it cannot give a breakdown of which role recorded the information. Ideally this would be added to the dashboard, and discussions with these roles about their data capture tools and processes will help identify the best way to enable this. No standalone data for these roles was identified.

Data from Care Navigators

Data from Care Navigators was requested from their employer the East London Foundation Trust (ELFT). The data received (for 2021 and 2022 financial years) was deemed to have good levels of completeness and sufficient to show trends and outcomes. However, some confidence in the data was lost due to the number of open text fields which can lead to inconsistent inputs.

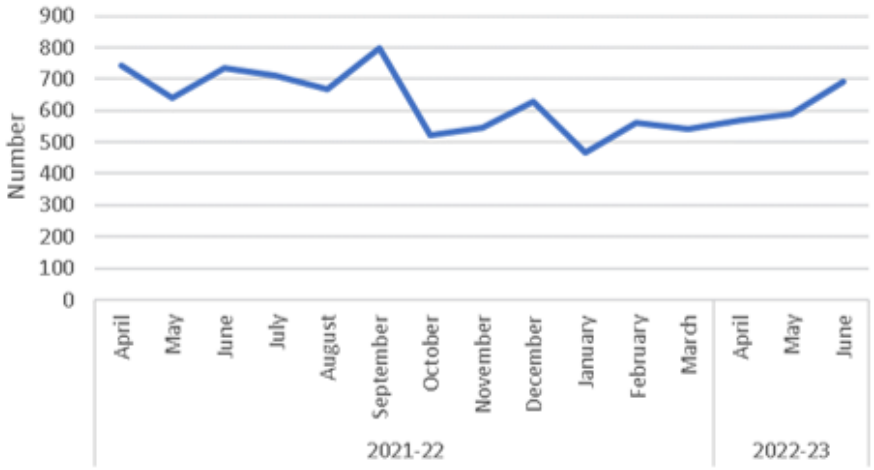

Figure 8 Care Navigator Data - Referrals by Financial Year

Further analysis of the care navigator data shows that most referrals to the role are received from community health services and general medical practices. However, there are some limitations in the referral data as referral reason is often recorded as 'not known' making analysis and comparison difficult.

Source of Referral	2021-22	%
Community Health Service/ (same or other Health Care Provider)	3764	49.8%
General Medical Practitioner Practice	3087	40.8%
Self referral	414	5.5%
Acute Hospital Inpatient/Outpatient Department	166	2.2%
Source of referral not known	43	0.6%
Local Authority/Social Services	25	0.3%
Care Home	18	0.2%
Hospice	14	0.2%
Carer/Relative	9	0.1%
Ambulance Service	8	0.1%
Independent Sector	7	0.1%
Dental Practice	2	0.03%
Emergency Care Department (including Minor Injuries Units, Walk In Centres and Urgent Treatment Centres)	2	0.03%
Grand Total	**7559**	**100%**

Figure 9 Care Navigator Data - Source of Referrals 2021-22

Reason for Referral	2021-22	%
Reason for referral not known	3640	48%
Complex Social Factors (as defined by NICE guidance)	913	12%
Rehabilitation	905	12%
Problems with Activities of Daily Living	551	7%
Equipment Provision	439	6%
Family Support	416	6%
Mobility Problems	284	4%
Haematology/Phlebotomy	119	2%
Structural/Functional Impairment	50	1%
Falls Risk	41	1%
Other	201	3%
Grand Total	**7559**	100%

Figure 10 Care Navigator Data - Reason for Referral 2021-2022

In addition, there are also gaps in the onward referral data. The table below, showing outcome of contact, is the only onward data available – there is no Care Navigator data available on where the patient was referred to or the support offered.

Outcome of Contact	2021-22
Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT	7141
APPOINTMENT cancelled or postponed by the Health Care Provider	372
APPOINTMENT cancelled by, or on behalf of, the PATIENT	43
Did not attend - no advance warning given	3
PATIENT arrived late and could not be seen	
Grand Total	**7559**

Figure 11 Care Navigator Data - Appointment Outcome, 2021-22

The table below summarises Care Navigator data available and missing.

Care Navigator data available	Care Navigator data missing
Reason for referral	There is no outcome data with regard to where the person was referred to, only details about their appointment
Ethnicity of patient - 5 major groups and the 16+ ethnicity sub groups	Specific age (only year of birth captured
Patient's year of birth	Specific postcode data. Partial postcode is available (eg E15), this level would not be useful for mapping, for example, as it covers too large an area. LSOA would be more helpful
Gender of the patient	
GP practice code and name	
Consultation medium (phone/face to face etc.)	
Source of referral	
High level postcode data	

Data from Community Neighbourhood Link Workers

Community Neighbourhood Link Worker data is presented on a Power BI dashboard. The quantitative data action group has access to the dashboard and complete access to all the raw data collected using Azeus. The data is shown in months and years, and sufficient to show trends.

The graph below shows overall referrals since January 2020. Data is also available to look at trends for reason of referral, source of referral, and who is being referred (age, gender, ethnicity).

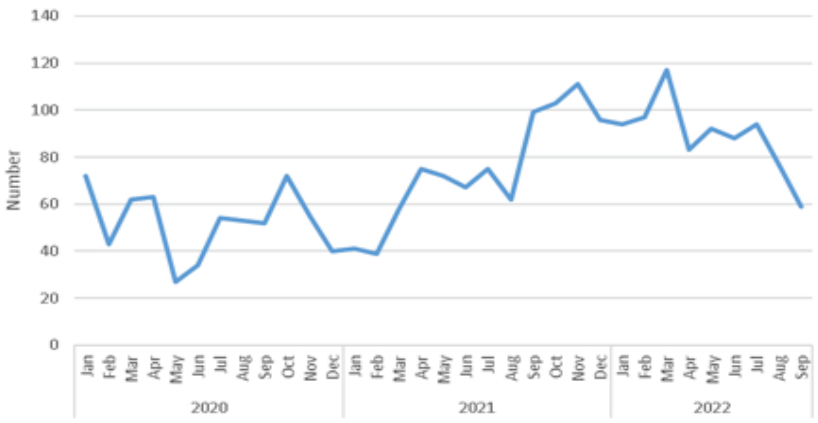

Figure 12 Community Neighbourhood Link Worker Referrals 2021, 2021, and 2022

Referred by	2020-2022
ASC: Access	881
Health: Other	264
ASC: Mental Health	131
ASC: North East Newham	115
ASC: Supporting Care	102
Community Neighbourhoods	100
ASC: Review	99
Self	90
ASC: Community Neighbourhood Link Worker	56
ASC: Transition	56
ASC: North West Newham	49
ASC: South & East Newham	47
ASC: Enablement and Intervention	43
ASC: Hospital Assessment and Discharge	42
ASC: Learning Disabilities	42
ASC: Integrated Discharge Hub	35
Health: Care Navigator	31
Community Mental Health Team	21
ASC: Carer's Team	20
ASC: West Newham	18
Health: GP	16
ASC: Enabled Living	12
Blank	79
Total	2349

Figure 13 Community Neighbourhood Link Worker Referral Source 2020-22

Referred for	2020	2021	2022
Community Activities Awareness	173	196	130
Community Activities AwarenessForm Filling	25	32	42
Community Activities AwarenessSocial Isolation/Loneliness	190	403	270
Community Activities AwarenessSocial Isolation/LonelinessForm Filling	53	49	108
Form Filling	51	88	174
Social Isolation/Loneliness	113	114	65
Social Isolation/LonelinessForm Filling	22	15	34
Blank		1	1
Grand Total	**627**	**898**	**824**

Figure 14 Reason for Referral to Community Neighbourhood Link Worker 2020, 2021, and 2022

Community Neighbourhood Link Worker data available	Community Neighbourhood Link Worker data missing
Ward level geography data	Reason for referral
Long term health conditions of the patient	Limited outcome data - no pre and post outcome for the patient
Source of referral	
Date of referral	
Age of patient	
Gender of patient	
Ethnicity of patient - 5 major groups and the 16+ ethnicity sub groups	
Where patient was referred on to	

However, similarly to Care Navigator Data, the Community Neighbourhood Link Worker referral data has limitations. Over half of 'type of contact' and 'intervention services provided' data has been recorded 'blank'.

Data from Community Connectors

As of November 13th 2022, there has been no access to community connector data. When the group requested data, the group was told that community connectors have been asked to consistently record information on Rio in a way that data can be collected and extracted. The group are trying to access any available data for the previous 12 months.

In the process of completing their tasks, the action group noted that the data required varies depending on the decisions being made. For example, this project was trying to understand the roles but not evaluate their effectiveness or efficiency. If a review of their effectiveness or efficiency was required, different and additional data would be required, which may not be available at present. If this is something that would be beneficial in the future, it may be helpful to consider what data would be necessary and ensure it starts to be collected as soon as possible.

If an evaluation of the effectiveness and efficiency of the roles was to be conducted, as a start, the quantitative data action group agreed it would be useful to capture and analyse data on:

- Pre and post referral outcome of the resident for all the roles (e.g. wellbeing score changes)
- Whether people present less frequently at secondary and primary care because of personalised care support
- Whether support offered matched reason for referral

During a focused data sub-group workshop, when analysing data accessible for each role, the group noted that if we wanted to understand patients' need for personalised care better, it would be useful if the reason for referral data was adjusted. Currently, data that is accessible for the roles only shows one reason for referral to the personalised care role. However, it would be useful if more than one referral reason was recorded to capture if the resident has multiple needs. This will also give more details on how the roles support the wider health system by taking different types of referrals.

Anecdotally it has been reported that in some cases the support provided by Community Connectors has improved resident confidence in accessing services and therefore their frequency in service use increased.

Qualitative Data Action Group

The findings of the qualitative data action group have been categorised into the two elements; a commissioned report, and surveys.

Commissioned Report

The commissioned research report, based on interviews with residents and those in personalised care roles, produced some valuable insights on people's understanding of the personalised care roles and how those in personalised care roles work in the wider system. The qualitative research consisted of twenty-three 1:1 interviews, three focus group discussions, and attendance at two existing stakeholder meetings.

Key points from the report include:

- Newham residents deeply need and desire the type of engagement the Health and Wellbeing Support roles promise to provide. However, there is low awareness of the roles and it can be difficult for both residents and providers to navigate, which may limit their potential impact.
- Residents felt that they often experience non-personalised care, which can have a significantly negative effect on their health and wellbeing
- Due to sustained experiences of trauma and mistrust, a significant number of the residents in this study had crafted roles as advocates for themselves, their loved ones, and other people in their communities.
- The Health and Wellbeing Support roles sit in an interesting space between and across boundaries in the NHS, local authority, and VCS. This creates tension in balancing the needs of the individual versus the system, the ideals of unconditional care vs self-reliance, and the act of signposting versus servicing.
- From the interviews, residents seem unclear whether Health and Wellbeing Support are a universal service, or a special resource for a limited population.
- Resident's lack of awareness of the roles implies that the need for Health and Wellbeing support and the task of communication and awareness around this type of support is continuous and ever evolving. In particular, residents need very clear description of the support they can receive from health and wellbeing support roles, at multiple touchpoints, in the context of their daily lives and access of other services.

The full report can be found in the supplementary documents.

Surveys

To help summarise and highlight key results from the surveys, the responses have been categorised into key themes; awareness, barriers to services, service experience, impact, and referrals (as appropriate). Caution needs to be taken making generalising statements based on a small sample, but the responses indicate that there is low awareness of the roles, however people really value the service elements offered once referred, and most perceive being referred to the roles as having a positive health and wellbeing impact.

Resident Survey

Awareness

5 of the 15 respondents agree or strongly agree with the statement "Before I was referred to health and wellbeing support, I knew about these roles and the support they offer". However, 9 said they disagree or strongly disagree. Of those, 8 were of Black or Asian ethnicity, supporting evidence that raising awareness among people from an ethnic minority group is an area in need of development.[6]

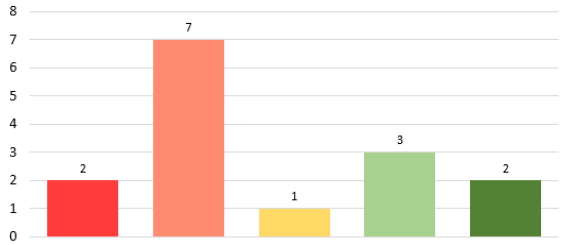

Figure 14 Resident Survey: Before I was referred to health and wellbeing support, I knew about these roles and the support they offered

[6] 'What does the evidence tell us about accessibility of social prescribing schemes in England to people from black and ethnic minority backgrounds?' Evidence-summary-BME-accessibility.pdf (socialprescribingacademy.org.uk)

Barriers to service

When asked about the barriers that stopped them or made it hard for them to access the services, people not being able to find a phone number or other contact details was the most popular response. This shows the link to awareness and communication of the personalised care roles, as it suggests residents do not have the information needed to receive support. It may also highlight some of the gatekeeping currently in place for these roles such as those that only accept referrals from medical professionals.

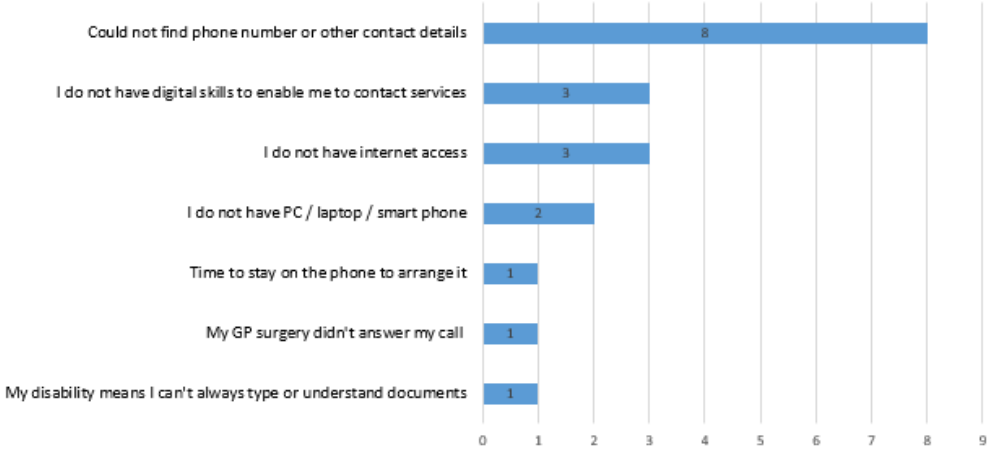

Figure 15 Resident Survey: Do you feel that there were barriers that stopped or made it hard for you to access the service?

Service Experience

The responses to the survey indicate that residents value the personalised care service elements of follow up conversations and being connected to activities and sport in the community. However, fewer people found having someone to accompany them to a chosen activity as helpful.

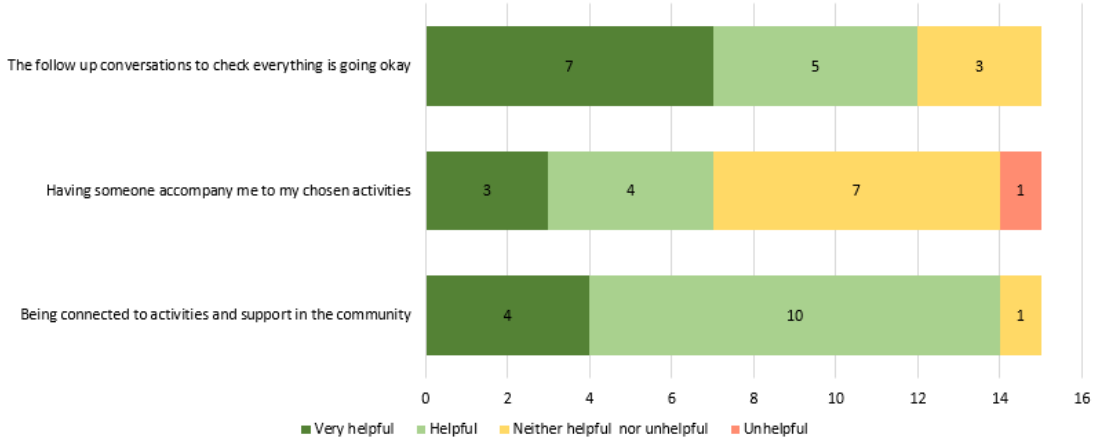

Figure 16 Resident Survey: what elements of the service did you find the most helpful?

Impact

The resident responses show that the impact of these roles is mostly positive. None of the respondents provided negative responses to the questions about impact. These responses reflect the evidence and assumptions about the benefits of these roles.[7]

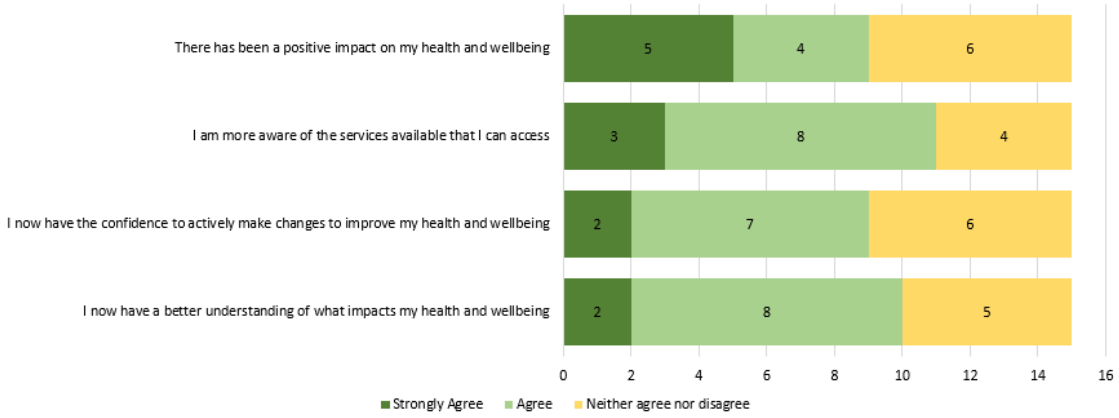

Figure 17 Residents Survey: As a result of the support you have received from health and wellbeing services, how strongly do you agree or disagree with the statements

> *"The worker I had was awesome. My case has been complicated and my needs had multiple layers but she took time with me, she was empathetic and professional while being honest and open. She truly put me at the centre of the support and exchange. She has been a true example of support that works. I have 12 disabilities and 1 learning difficulty but she navigated it well."*

The feedback received, such in the quote above, reflects the benefits these roles offer and how the way they work (e.g. having more time with residents) enable these positive outcomes. Despite the challenges experienced regarding awareness and access, the overall take away from residents was that the roles provided a positive benefit.

Council Staff, Health and Social Care Staff, and VCF Survey

A total of 18 people completed the survey - 4 Council Staff, 10 Health and Social Care Staff, and 4 Voluntary Community and Faith Sector Staff. The full results of all the survey questions broken down per role is included in the supplementary documents.

Awareness

General awareness of the six personalised care roles in Newham was quite low. When asked if they are aware of each of the roles, respondents were most aware of social prescribers, then Community

[7] Chatterjee H, Camic P, Lockyer B, & Thomson L. J. M. (2018) 'Non-clinical community interventions: a systematised review of social prescribing schemes, Arts & Health', 10:2, 97-123, DOI: 10.1080/17533015.2017.1334002. And Kellezi B, Wakefield JRH, Stevenson C. (2019). 'The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision'. BMJ Open;9:e033137. doi: 10.1136/bmjopen-2019-033137

Neighbourhood Link Workers. Over 50% answering either 'neither agree nor disagree' or a negative response to the other four roles. The graph below compares the role the most people were aware of, social prescribers, with one of the roles with the least awareness, care navigators.

Furthermore, most respondents felt they do not fully understand what the health and wellbeing roles do to support residents.

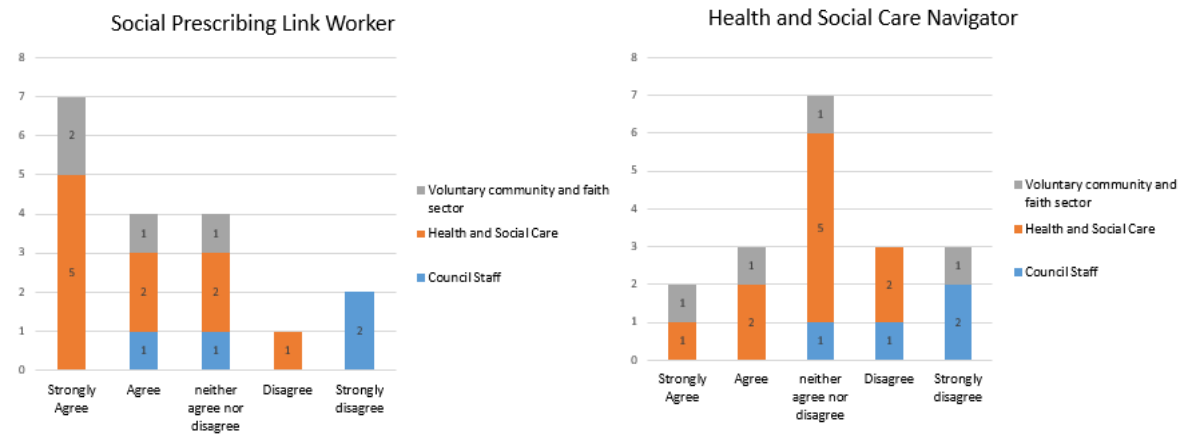

Figure 18 Council Staff, Health and Social Care Staff, and VCF Survey: I am aware of the health and wellbeing support roles in Newham

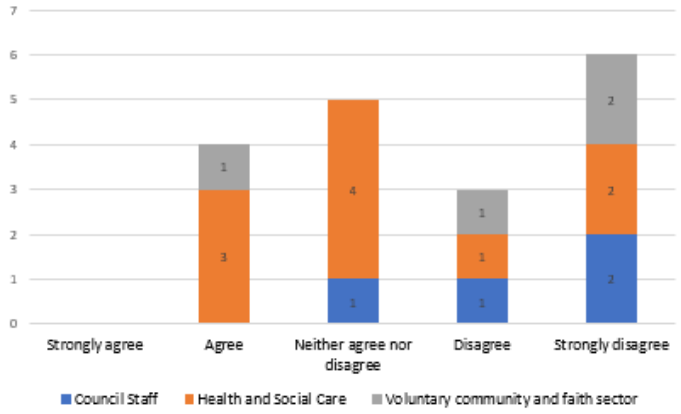

Figure 19 Council Staff, Health and Social Care Staff, and VCF Survey: I understand what the health and wellbeing support roles do to support residents

Experience

Some of the questions were designed to understand council staff, health and social care staff, and VCF sector experiences of personalised care roles. The responses below suggest that improvements could be made to improve the access and navigation processes of personalised care roles. Information about the experience of referring to these roles can be found in the sub-analysis about referrals.

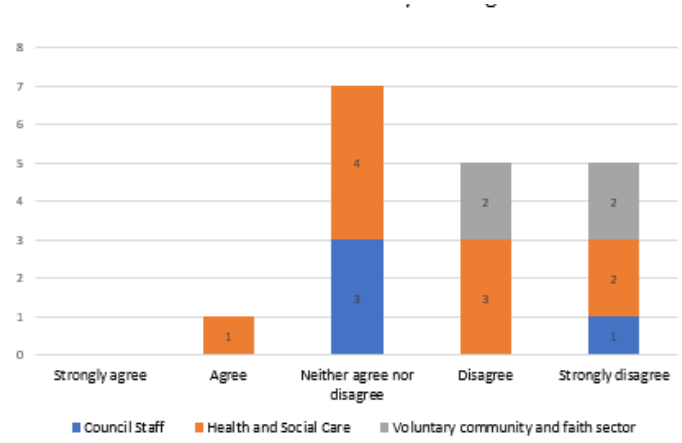

Figure 20 Council Staff, Health and Social Care Staff, and VCF Survey: The health and wellbeing support roles and processes for accessing them are clear and easy to navigate

Impact

The survey also wanted to understand if council staff, health and social care staff, and VCF sector staff perceived personalised care roles to have a positive impact on resident health and wellbeing. While some people agreed with this statement, most were neutral in their response. This may be in part due to the fact that only some of the respondents had made referrals to the roles, see referrals sub-analysis for more detail.

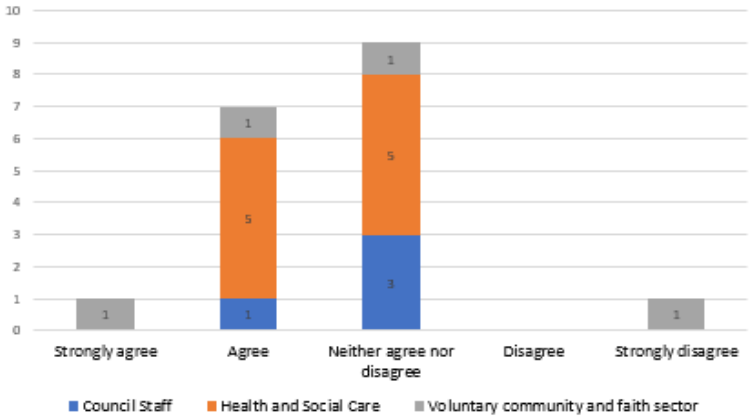

Figure 21 Council Staff, Health and Social Care Staff, and VCF Survey: The support from the health and wellbeing roles and the services that my patients were connected to have a positive impact on their health and wellbeing

Referrals

The action group also wanted to collect how people refer into the personalised care roles, if they receive referrals from them, and their related experiences. Most of the respondents stated that they do not refer into the roles, for example all 18 stated that they have never referred to Care Navigators. However, of the six personalised care roles, Community Neighbourhood Link Workers and Social Prescribers were referred to most frequently. However, as shown in the graphs below, the number of referrals were still low in this group of respondents.

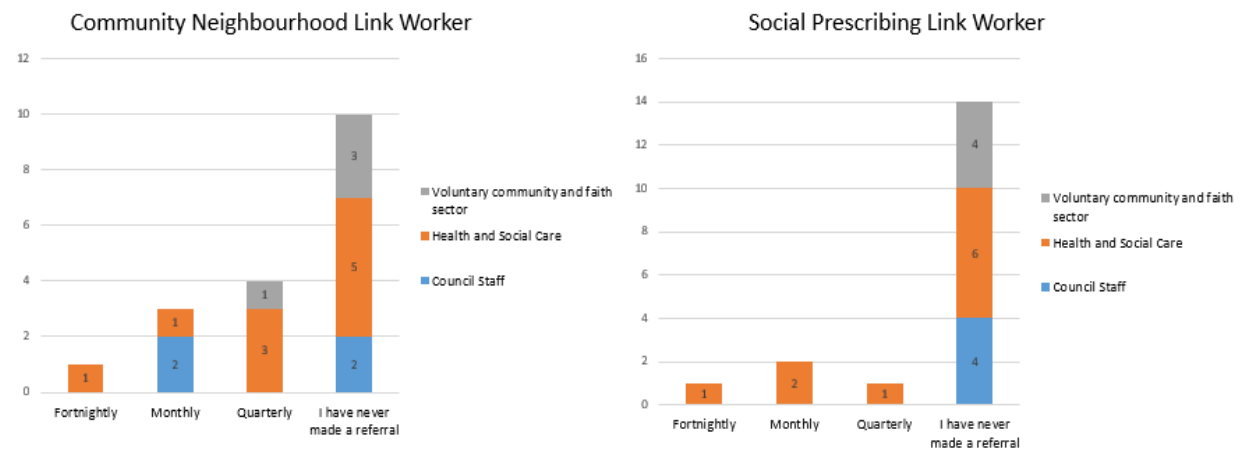

Figure 22 Figure 22 Council Staff, Health and Social Care Staff, and VCF Survey: How often do you refer a person to a health and wellbeing support role?

In addition, the responses indicate that while some respondents know how to refer to Social Prescribers and Community Neighbourhood Link Workers more than the other personalised care roles, the general understanding of how to refer is still low. The tables below compare how respondents answered to knowing how to refer a resident, when needed, to Social Prescribers and Care Navigators.

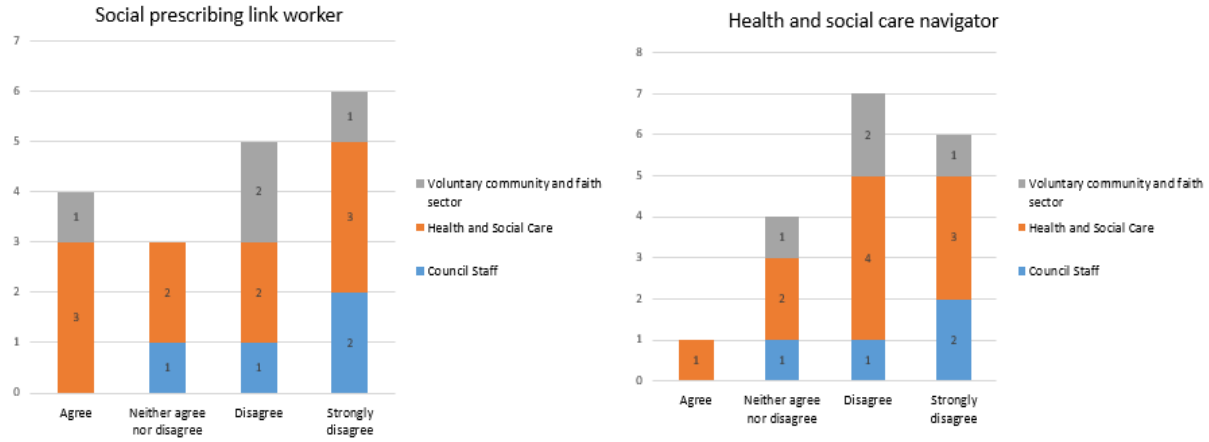

Figure 23 Council Staff, Health and Social Care Staff, and VCF Survey: I know how to make a referral when I need to refer a resident to the health and wellbeing support roles

Furthermore, most respondents feel they do not have access to all the right information to enable them to refer a resident to any of the personalised care roles in Newham. For all of the roles, most of the responses to the question 'I have access to all the right information to enable me to refer a resident' were 'neither agree nor disagree', 'disagree' or 'strongly disagree'. The graphs below compare Community Neighbourhood Link Workers, the role respondents felt they had the most information to enable a resident referral, with Health and Wellbeing Coaches, the role respondents felt there was the least information available about referral. Despite being the role with the highest number of positive responses, 10 respondents did not have the right information to refer to Community Neighbourhood Link Workers.

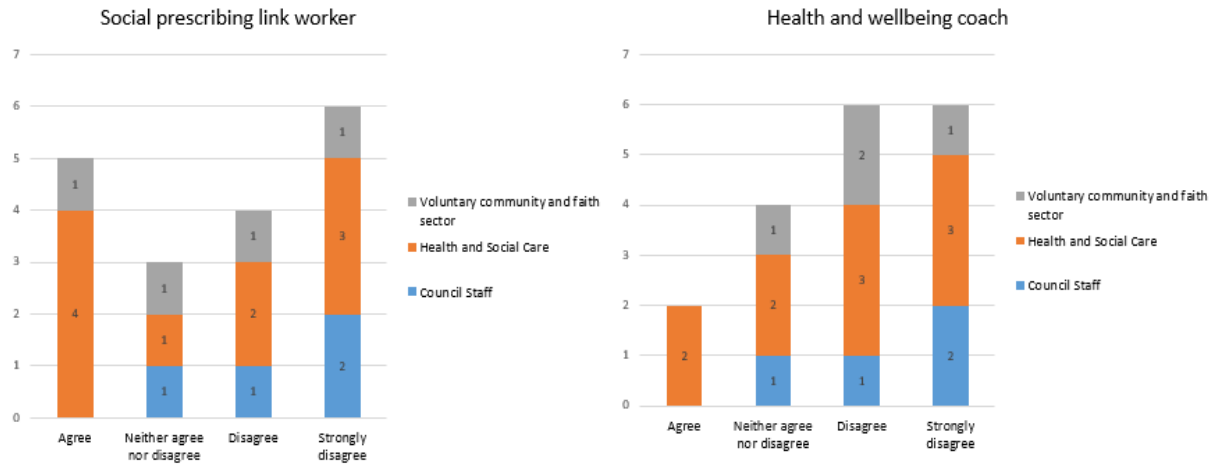

Figure 24 Council Staff, Health and Social Care Staff, and VCF Survey: I have access to all the right information to enable me to refer a resident

There were a series of questions in the survey created to collect if council staff, health and social care staff, and VCF sector staff receive referrals from the personalised care roles. Under 50% of respondents recorded that they receive referrals from Social Prescribers, Health and Wellbeing Coaches, Care Navigators, Community Connectors, and Care Coordinators. 11 of the 18 responded that they receive referrals from Community Neighbourhood Link Workers.

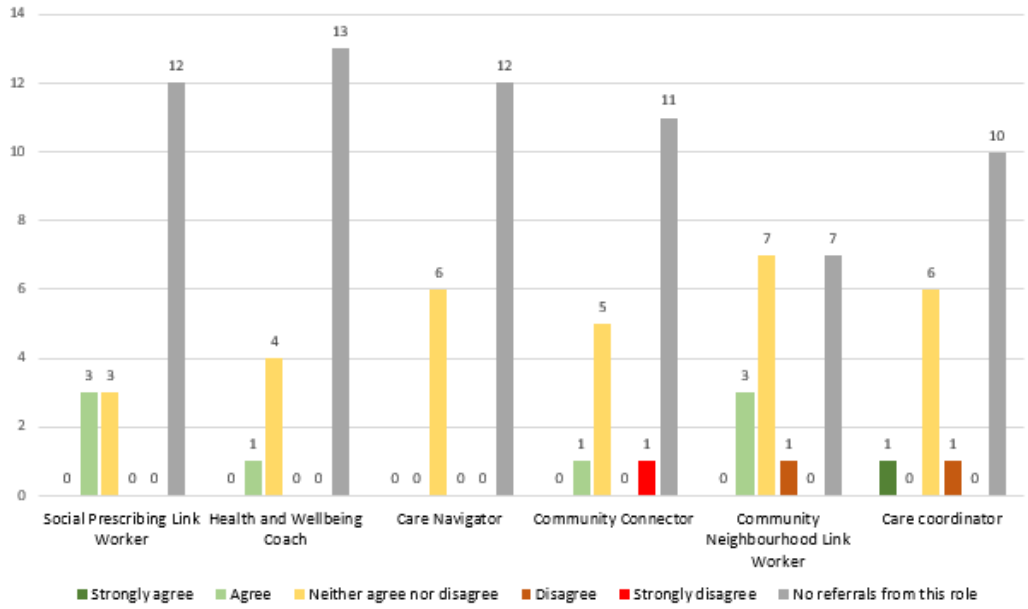

Figure 25 Council Staff, Health and Social Care Staff, and VCF Survey: Referrals are sent to me by the health and wellbeing roles in good time to enable me to support residents

For those that do receive referrals, most respondents answered 'neither agree nor disagree' for questions focused on the referral experience and information provided.

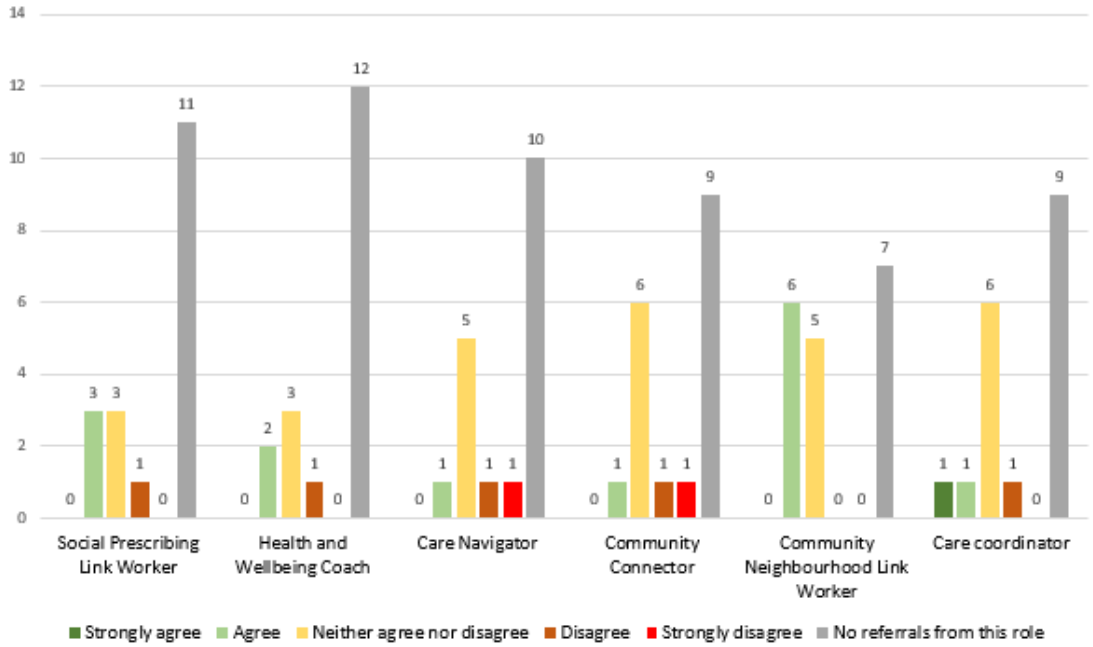

Figure 26 Council Staff, Health and Social Care Staff, and VCF Survey: I am provided with the right information by the health and wellbeing roles to understand resident's needs so I can plan consultation

Personalised Care Workforce Survey

The third and final survey looked to understand the experiences of those in personalised care roles and how they work with the wider health system and residents. 15 people responded. Of these the breakdown of roles was: five Social Prescribing Link Workers; four Community Connectors; two Health and Social Care Navigators; one Health and Wellbeing Coach; one Community Neighbourhood Link Worker; one Care Coordinator; and one don't know/other.

Awareness

A high proportion of the respondents were aware of the other personalised care roles in Newham and stated they understand the differences between the roles. However, as the graph below highlights, understanding of the aims and purposes of the roles and what they offer varies.

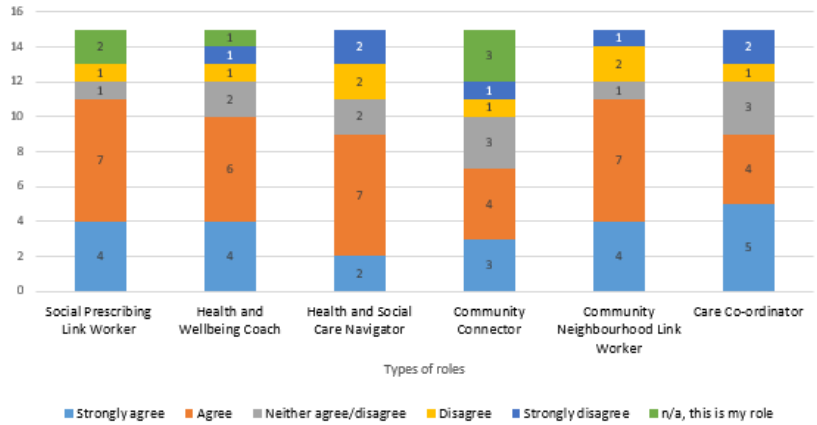

Figure 27 Personalised Care Workforce Survey: I understand the aims and purposes of the health and wellbeing support roles and what they offer

Experience

The action group devised a question to capture how people working in personalised care understand their roles and responsibilities engaging with, and supporting, residents to improve their wellbeing. Respondents were presented with six statements about how they operate, and as the table below highlights, most strongly agree and agree with the statements.

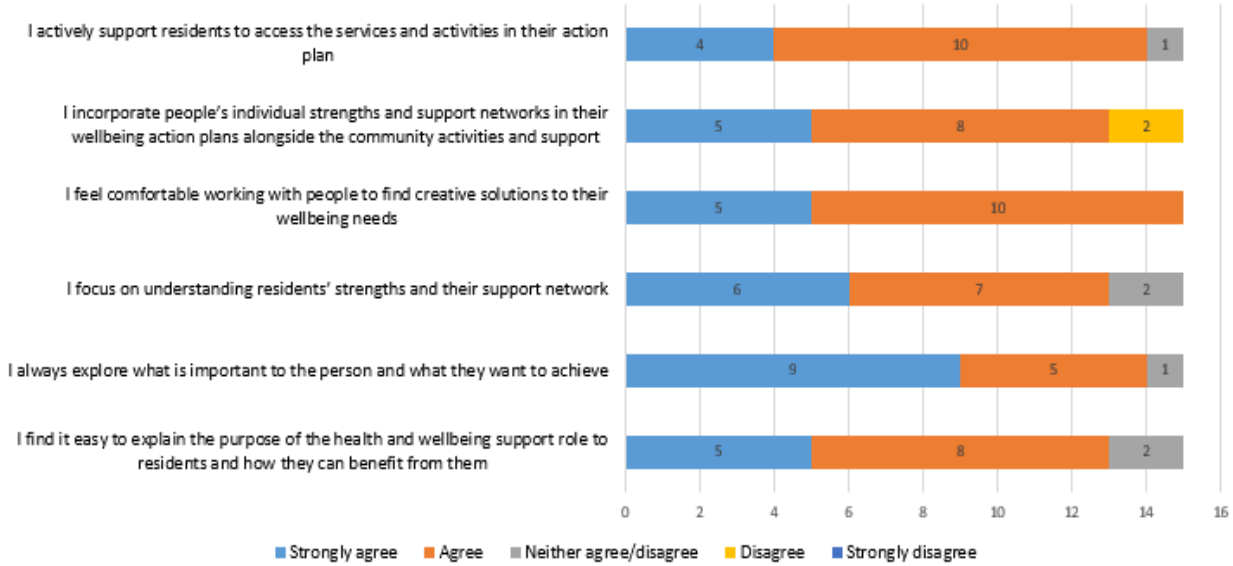

Figure 28 Personalised Care Workforce Survey: How strongly do you agree or disagree with the following statement?

How positively workers in the roles perceive the other personalised care roles varies. However, this may be affected by their awareness of the other roles. The roles respondents perceived less positively were those that respondents had less understanding of overall.

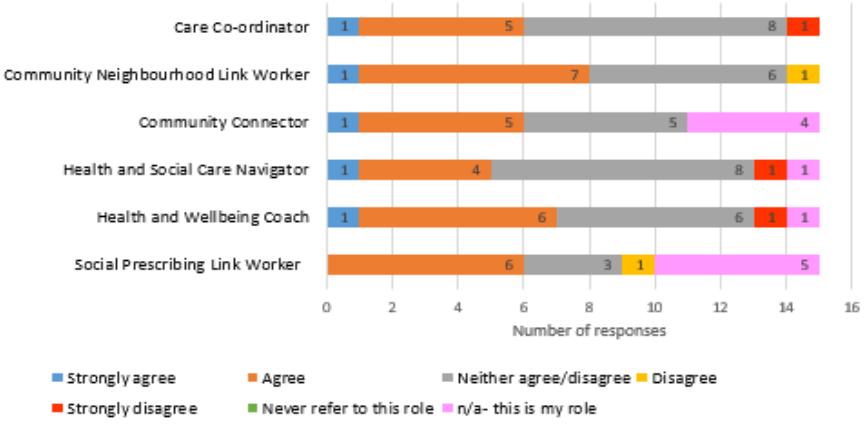

Figure 29 Personalised Care Workforce Survey: I have a positive perception of the service provided by other health and wellbeing support roles

Impact

To help understand how those in personalised care roles judge their impact and outcomes, the survey asked about resident's wellbeing following intervention and if there are re-referrals. The graphs below suggest that the respondents feel their work with residents has an impact on wellbeing but not enough to stop all re-referrals.

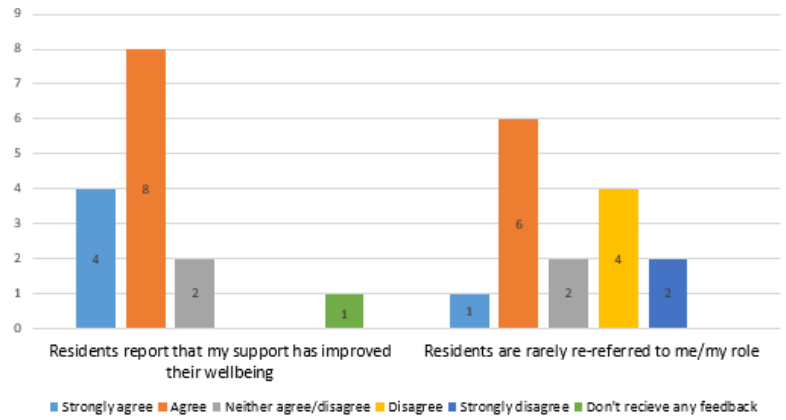

Figure 30 Personalised Care Workforce Survey: How strongly do you agree with the following statements? 1) Residents report that my support has improved their wellbeing 2) Residents are rarely re-referred to me/my role

Referrals

Making onward referrals to other support services is a key function of the personalised care roles. The responses reveal those working in personalised care roles find some services easier to refer residents to than others, with Newham adult social care being the easiest and Newham housing service being hardest. This reflects the quantitative data action group finding that housing is recorded most often as the reason for referral on the social prescribing dashboard. Challenges referring to housing services can affect the ability of these roles to offer the necessary support to residents, and in turn avoid re-referrals.

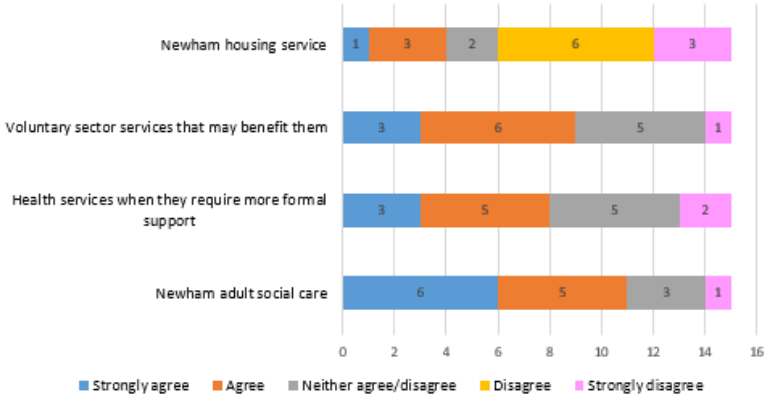

Figure 31 Personalised Care Workforce Survey: I find it easy to refer to the following services when required 1) Newham Housing Service 2) Voluntary sector services that may benefit them 3) health services when they require more formal support 4) Newham ASC

Skills and Training Action Group

Training

Through the Newham Training Hub website, the group were able to access the minimum training standards for Social Prescribers, Health and Wellbeing Coaches, and Care Coordinators. These roles have different required training, with completely different mandatory modules. Social Prescribers are required to complete the most comprehensive training, with twelve modules on a variety of topics with some focused on specific resident demographics and needs. In comparison, the required training for Health and Wellbeing Coaches is less extensive and mostly focused on coaching. The table below summarises the training requirements that we were able to collect by 1st December 2022. Text in italics notes training unique to each of the roles, while an asterisk identifies mandatory training.

Social Prescribers	Health and Wellbeing Coaches	Care Coordinators	Health and Wellbeing Coaches	Health and Social Care Navigators
• *Introduction to SP Role** • *Developing PCSP Plans** • *Developing Partnerships** • *Introducing people to community groups and VCSE organisations** • *Safeguarding vulnerable people** • *Keeping records and measuring impact** • *Supporting people with their mental health through social prescribing** • *Social welfare, legal support and money guidance** • *Social prescribing for children and young people** • *Supervision** • *Social prescribing and the Armed Forces Community** • *Culturally responsive practice**	• *Four-day health coaching training if no previous coaching experience or two-day health coaching training if you have coaching experience outside of the NHS.** • Healthy Weight Training • Personalised Care Core Support Skills • Shared Decision Making	• *Two day coaching or motivational interviewing course or complete a PCI accredited course for Care Coordinators** • Personalised care and support planning* • Shared decision making* • Healthy Weight Training	• *Data Protection** • *Data Quality** • *Equality in the workplace (TRID)** • *Fraud Prevention** • *Freedom of Information** • *Information Security** • *Introduction to Local Government** • *Introduction to Safeguarding Adults for Newham Employees** • *Introduction to Safeguarding Children for Newham Employees**	• *Motivational coaching** • *Communication barriers** • *End of life** • *Psychology** • *Resilience** • *Mental health first aid**

• Healthy Weight Training				

However, the members of the action group shared that it can be difficult for people working in personalised care roles to have time to access training within their workload and expectations. Therefore, as the group were unable to do a full audit of completed training for each of the roles, it is unknown whether all Social Prescribers, Health and Wellbeing Coaches, and Care Coordinators in Newham have done the recommended training.

There is a lot of work happening to ensure the roles have the training they require. Social Prescribing required training standards are nationally set and provided by e-Learning for Health or the Personalised Care Institute. The North East London Personalised Care team have commissioned the required health and wellbeing training and supervision for all Health and Wellbeing Coaches, and ensured Care Coordinators have access to the Personalised Care Institute accredited training. Community Connectors will have a continuing professional development and competency framework in place in 2023. While Community Neighbourhood Link Workers complete training to become qualified Trusted Assessors, as well as receiving training from a number of teams in the council to ensure wide understanding of pathways and processes in addition to their required training above. Finally, the Care Navigators are provided with most of their training in-house by East London Foundation Trust ensuring they're able to meet their responsibilities and respond to arising issues.

Skills and Responsibilities

Reviewing job descriptions, the action group created a table to present key findings and comparisons between the required qualifications and knowledge/skills of the personalised care roles and similarities and differences in how the people working in the roles are supervised/managed. The group noted that the overlapping training requirements, responsibilities and interests of the roles would offer the opportunity to do training together which would also improve the roles' ability to work together and consistently.

Role	**Qualifications**	**Supervision / Management**	**Knowledge / Skills Required**
Social Prescribing Link Workers	NVQ level 3 or equivalent relevant qualification and / or extensive experience	Clinical Lead (Primary Care Network)	• Ability to identify, assess and manage risk • Ability to work from a strengths based approach
Health and Social Care Navigators	No specific qualifications needed	Regular 1:1 supervision	• Ability to interface between primary and secondary care providers as well as social care and voluntary organisations. • Up to date knowledge of local services and be able to use available resources effectively • Ability to support, navigate, sign post and link patients, and their carer's to other services that would benefit the patient's quality of life

Health and Wellbeing Coaches	No essential qualifications – but willingness to attend training with a non- clinical SSM health coaching skills programme (minimum 4 days) qualification essential	• Ongoing regular supervision from a health coaching mentor • Access to relevant GPs to discuss patient related concerns	• Skills in supporting behaviour change and specialist coaching methods • Ability to apply health coaching in group settings • Skilled in active and reflective listening, building trust and rapport quickly
Community Connectors	University degree and/or professional qualification	Primary Care Network Lead (ELFT)	• Demonstrable knowledge of local services and provisions • Newham and/or East London specific knowledge of the common thread issues faced by people suffering from mental health • Strong understanding of what factors influence health and wellbeing and the social determinants of health • The ability to assist service users in setting goals and making changes that are meaningful • An awareness of the barriers faced by people suffering from mental health concerns
Care Coordinators	NVQ Level 3 in adult care - advanced level or equivalent qualifications or working towards		• Knowledge of the personalised care approach • Understanding of the wider determinants of health • Strong organisational skills • Knowledge of how the NHS works • Strong foundation in enabling and communication skills
Community Neighbourhood Link Workers	No specific qualifications needed	• Regular supervision inc. wider adult social care and peer • Regular 1:1	• Budget management • Specific community contacts and knowledge

The skills and training action group had to rely heavily on job descriptions and online material to review the skills, knowledge and experience of the six roles, resulting in gaps and difficulties in making comparisons. Direct engagement with employees in the roles would help fill some of the gaps by capturing some of the more personal, unique skills and training people in the roles have, such as; local knowledge, behaviours and attitudes, lived experience, career development and aspirations.

In addition to skills and training, the importance of career development and support was noted during the project, with particular emphasis around staff retention. Anecdotally, it was noted that

high turnover in these roles, in part due to the stress and lack of capacity in the system, results in challenges for the workforce, professionals who work with them, and residents. For example, in relation to the community connectors the impact has resulted in key people leaving, difficulty recruiting, low morale, and an increase in internal conflict.

This is also seen in primary care networks where the variation in how the roles are embedded result in differing levels of support, supervision, and multi-disciplinary team membership. Adding to these challenges regarding funding for these roles which is either short term or unknown for many of them.

Mapping and Pathways Action Group

To help map where the personalised care roles are positioned in the wider system, the action group found out where the roles are physically located/based, who the roles are employed by, who the roles are funded by, average case load, number of people in the roles, and when the roles were available to residents' in Newham. Any blanks in the table below are pieces of information the group were unable to find, as of November 15th 2022.

Role	Physical location / base	Role employed by	Role funded by	Average case load per worker	Number of people in the role	Available in Newham since
Social Prescribing Link Workers	GP Practice	Primary Care	NHS		21	2020
Health and Social Care Navigators	East Ham Care Center (EHCC) - ELFT sites	ELFT	NHS (ELFT)	20-30	8	2014
Health and Wellbeing Coaches	GP Practice	Primary Care	NHS		4	2021
Community Connectors	VCSE & ELFT Sites	VCSE	NHS (ELFT)	15-20	9	2020/21
Care Coordinators	GP Practices	Primary Care	NHS	Approximately 5 cases a week	8	2020/21
Community Neighbourhood Link Workers	In the community (Libraries for e.g.)	Council	Adult Social Care	Currently 40 (as of Nov 2022), but target is 10 residents with 1-1 support every month	8	2012

Healthy London Partnership have produced an interactive map showing the geographical location of the Social Prescribing Link Workers, how many there are, and what PCN they operate in. We intend to create a Newham specific map for all the roles. A screenshot of the Healthy London Partnership map, showing the location of provision is below. For more information visit - The London Social Prescribing Map - Healthy London Partnership

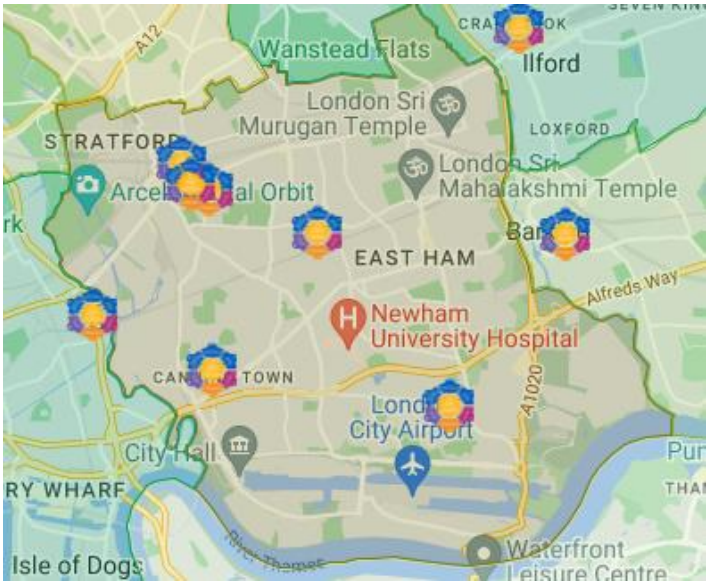

Figure 32 Healthy London Partnership: London Social Prescribing Map

To further develop an understanding of where personalised care roles engage with residents, who refers to the roles, and where they refer on to, detailed pathways for each of the six roles have been produced. Not only do the pathways map resident's support journey, they also show which needs the roles support, the data collection systems used, and give detail on the type of support the roles provide. The pathways reveal that most personalised care roles do not typically refer residents to other personalised care roles, the exceptions being Social Prescribers refer some patients with mental health needs beyond practical support to Community Connectors, and Care Navigators refer to Community Neighbourhood Link Workers.

Showing the needs each personalised care role support illuminates the wide variety of health and wellbeing issues the roles in Newham support. The roles vary in the level of need they support from complex to moderate, encompasses mental and physical health, and includes children, adults and those at end of life. The action group only identified form filling as a gap in the provision.

In addition, the pathways show that Social Prescribers and Health and Wellbeing Coaches have the most overlaps, with resident point of access, need, and data systems being the same. Both roles receive referrals from GPs, support people with long-term health conditions, and use EMIS data software.

In the course of reviewing the roles, the action group raised that if the project was to research how effectively the roles empower people to improve their health and wellbeing, it would be beneficial to create detailed models of what residents want from personalised care but isn't currently available.

Furthermore, the action group shared that patients often have multiple referrals into roles which results in duplicated assessments and sometimes duplicate referrals due to lack of coordination and inappropriate referrals.

The personalised care pathways have been summarised below.

SOCIAL PRESCRIBER / SOCIAL PRESCRIBING LINK WORKER

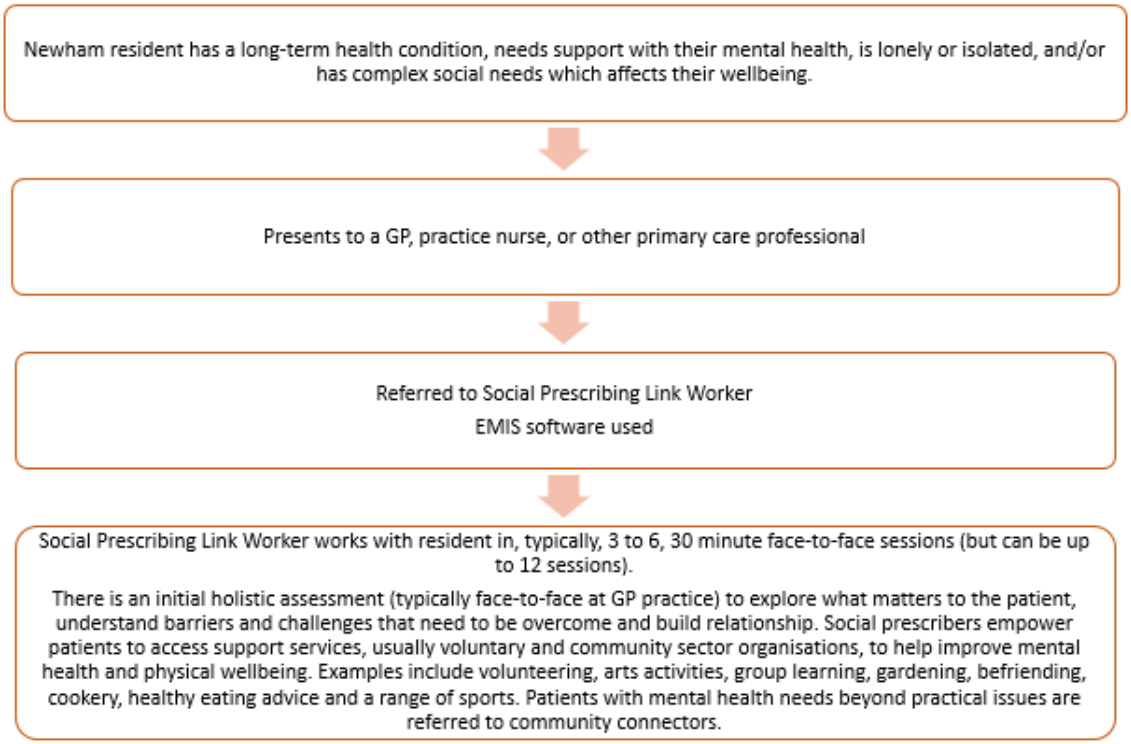

Figure 33 Social Prescribing Link Worker Pathway

HEALTH AND WELLBEING COACH

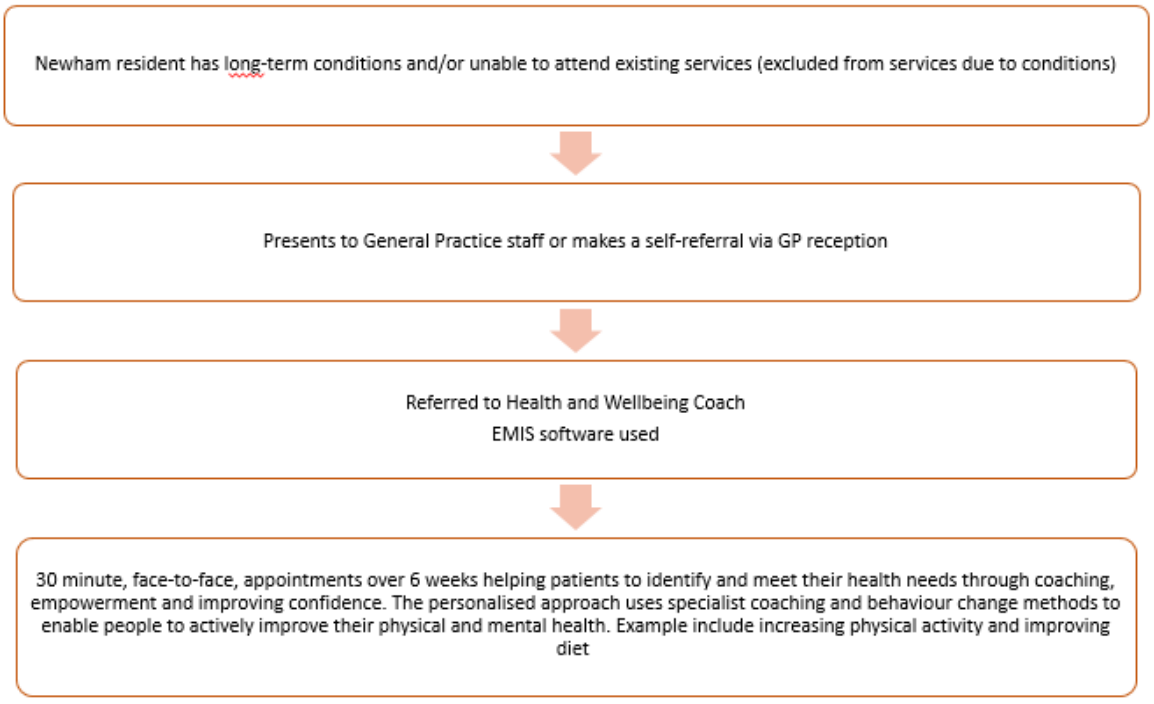

Figure 34 Health and Wellbeing Coach Pathway

COMMUNITY CONNECTOR

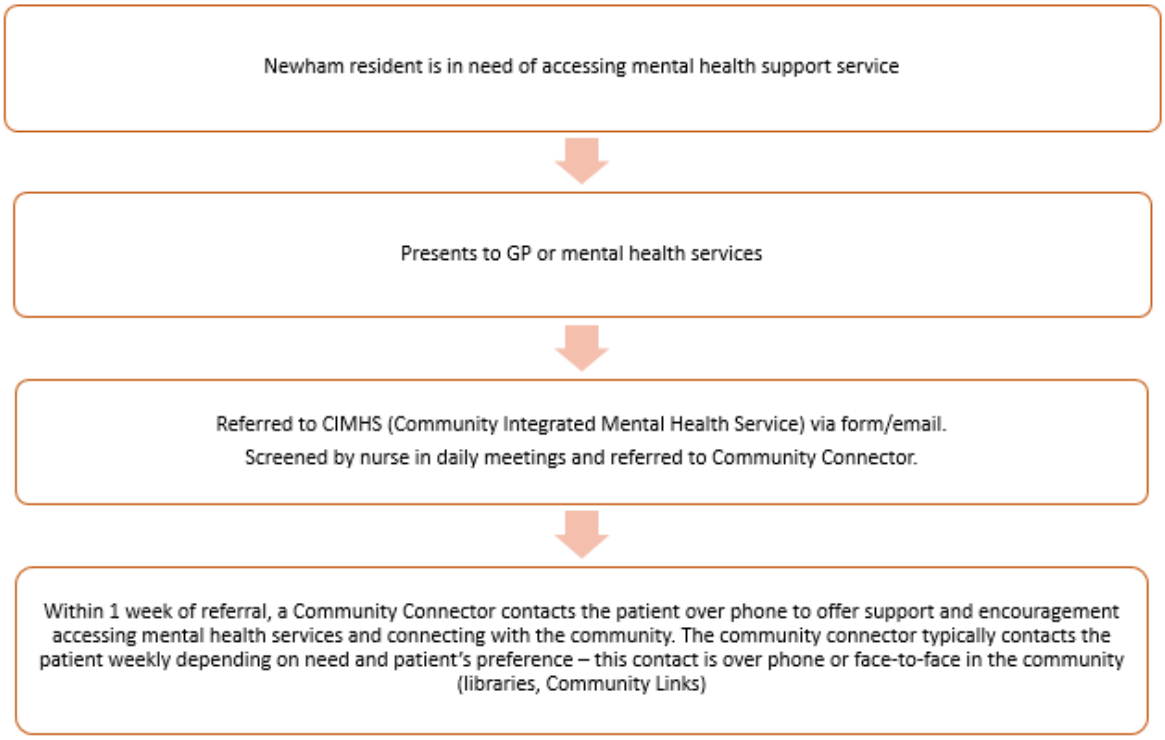

Figure 35 Community Connector Pathway

CARE COORDINATOR

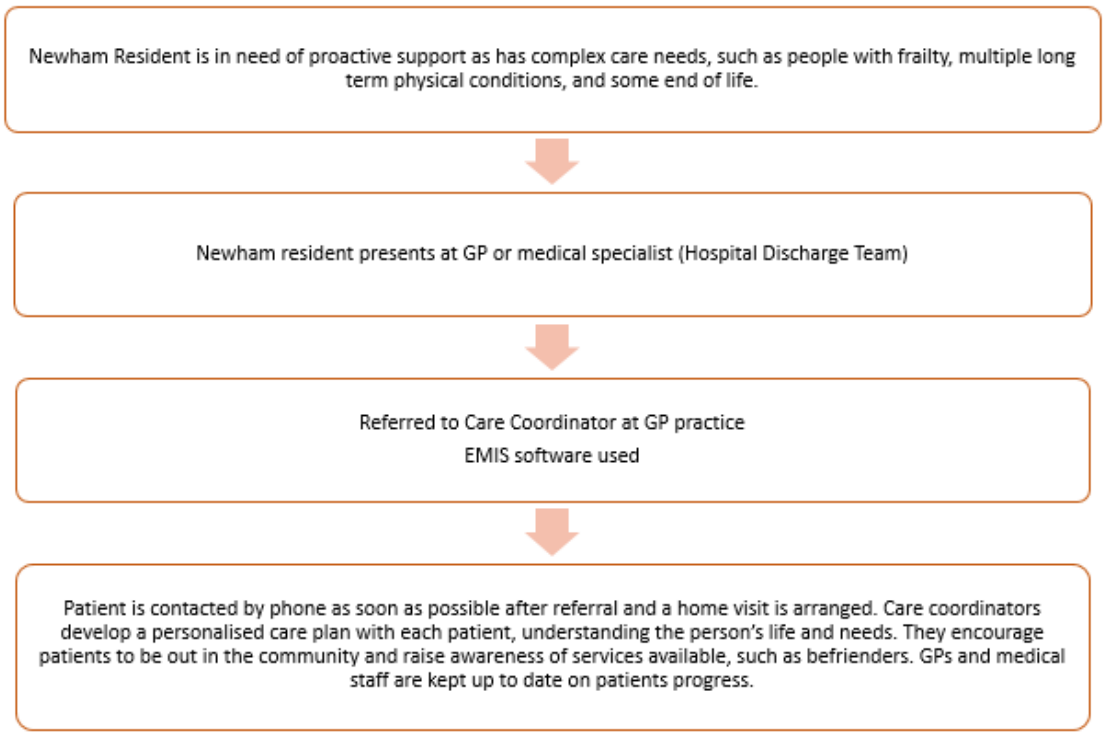

Figure 37 Care Coordinator Pathway

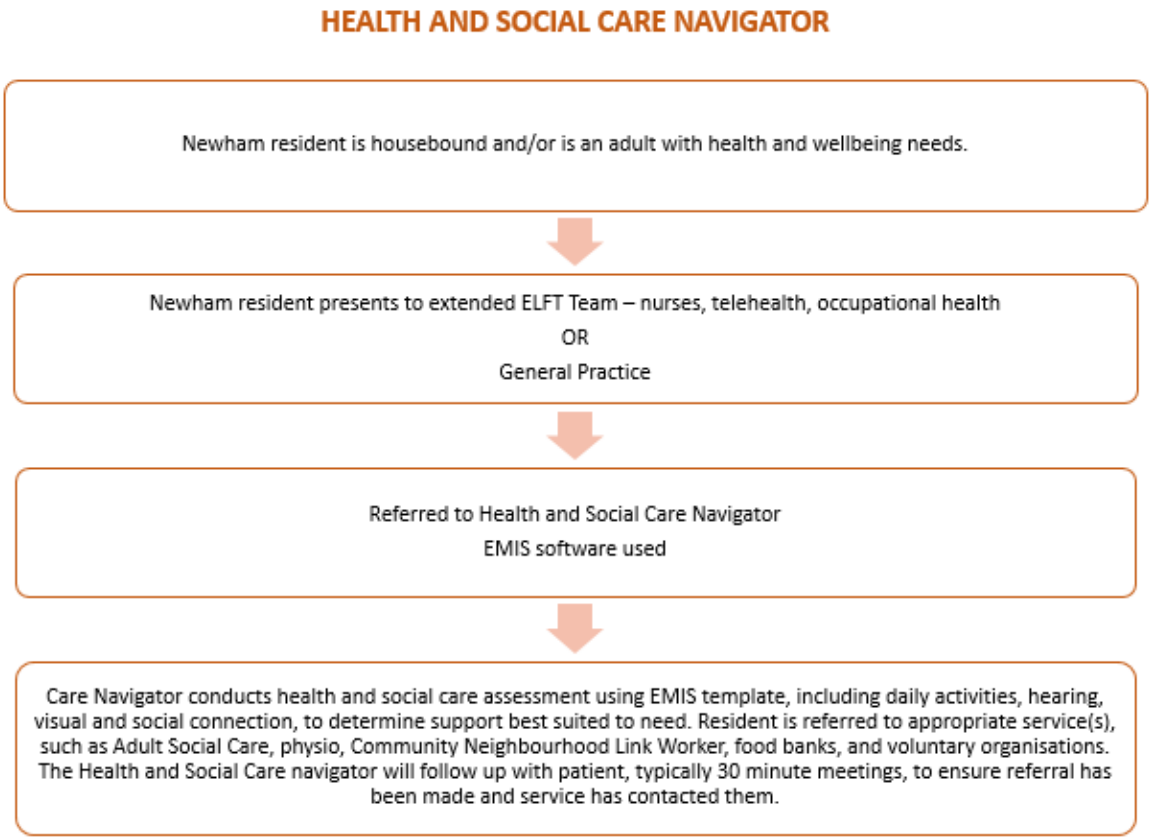

Figure 38 Health and Social Care Navigator Pathway

Models and Evidence Action Group

The models and evidence group reviewed 52 documents describing various models, approaches and studies of personalised care from within and beyond the UK. The key findings of the group were:

- There is a lack of strong evidence about the benefits of social prescribing and similar personalised care support, however the studies and evidence so far do show a range of positive outcomes for beneficiaries
- The majority of studies and documents found were about social prescribing with the other five roles having little written about them
- Most studies found that a social prescribing approach provided economic benefit through reduced need and attendance at GPs or hospital
- Models that seemed to work well often referred to principles or 'magic ingredients' that guided the approach such as supportive and collaborative conversations[8]
- The evidence supported a flexible approach depending on the population of interest
- There is no published research or service evaluation measuring the long-term outcomes of social prescribing. Any data on long-term effects of social prescribing, particularly health system usage, have been impacted by the COVID-19 pandemic. Therefore, to measure long-term outcomes of social prescribing, the group suggested a project would have to be conducted when the data is no longer skewed by the impact of the pandemic.
- Some evidence referred to the experience of carers and how they can often find it hard to access services due to caring commitments and lack of time

[8] Fullwood Y. (2018). 'Age UK Personalised Integrated Care Programme Sustainability, impact on hospital attendances and admissions, and lessons learned about spreading and scaling the model'. rb_feb19_picp_sustainability_impact_on_hospital_activity_and_lessons_lea....pdf (ageuk.org.uk)

- Overall, the evidence was positive, while acknowledging more needs to be done to provide a strong evidence base

Key examples of the evidence found are below. Overall, it was felt that the evidence supported the provision of personalised care roles, however there were opportunities to improve the offer available in Newham using the lessons learnt from others.

A summary of over one hundred social prescribing programmes conducted by the National Academy for Social Prescribing reported the following health, social and system outcomes[9]:

- Increases in self-esteem and confidence, sense of control and empowerment
- Improvements in psychological or mental wellbeing, and positive mood
- Reduction in symptoms of anxiety and/or depression, and negative mood
- Improvements in physical health and a healthier lifestyle
- Increases in sociability, communication skills and making social connections
- Reduction in social isolation and loneliness, support for hard-to-reach people
- Improvements in motivation and meaning in life, provided hope and optimism about the future
- Acquisition of learning, new interests and skills including artistic skill
- Reduction in number of visits to a General Practitioner (GP), referring health professional, and primary or secondary care services
- GPs provided with a range of options to complement medical care using a more holistic approach.

In support of this, quantitative and qualitative data from a Mind mental health pilot in Bexley suggests that social prescribing had a beneficial effect on quality of life, wellbeing and social capital of participants as well as fewer A&E attendances, fewer non-elective admissions and reduced hospital stay six months after their social prescribing referral. On average, client's mental wellbeing scores increased by 4 points after social prescribing – the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) describes this as a meaningful increase in wellbeing.[10] However, it is worth noting that Bexley and Newham vary greatly in demographic background. As of 2021, Bexley is 72% white compared to 31% in Newham, with big differences in age too, with Newham having a higher proportion of younger, working age population.

The pilot in Bexley also illuminates some key learnings around access to service. Coordinators identified that there were barriers to attending social prescribing assessments at GP surgeries primarily due to mobility. As a result, home visits and assessments in community locations were included at the assessment stage. This also had the added benefit of being more attractive to those groups who were less keen to attend GP surgeries such as younger clients or those who are carers or have young children. Furthermore, follow up calls three months after clients originally refused the service originally refused the service helped increase acceptance rates as the call was an opportunity to review their appetite for the scheme and also reassess their needs.[11]

In addition, there are learnings from the Age UK Evaluation Personalised Integrated Care report that can help inform models in Newham. The report found that applying certain eligibility criteria across

[9] Polley M, Chatterjee H, Asthana S, Cartwright L, Husk K, Burns L, Tierney S. [On behalf of the NASP Academic Partners Collaborative]. (2022). 'Measuring outcomes for individuals receiving support through social prescribing'. London: National Academy for Social Prescribing

[10] Palmer D, Wheeler J, Hendrix E, Sango PN, Hatzidimitriadou E (2017) 'Social prescribing in Bexley: pilot evaluation report'. Mind in Bexley.

[11] Palmer D, Wheeler J, Hendrix E, Sango PN, Hatzidimitriadou E (2017) 'Social prescribing in Bexley: pilot evaluation report'. Mind in Bexley.

all personalised integrated care sites was unworkable. Instead, integrated care works better when the eligibility criteria reflects local context, demand and need.[12]

During the evaluation process the group identified some additional insights and possible further actions:

- It would be helpful to approach the providers of the models reviewed to better understand the challenges and costs to implement their approach which were not included clearly in the documents.
- When reviewing the sustainability and funding models of personalised care roles, it is important to recognise and be sensitive to the capacity of the voluntary sector in delivering social prescribing.

[12] Fullwood, Y. 'Age UK Personalised Integrated Care Programme Sustainability, impact on hospital attendances and admissions, and lessons learned about spreading and scaling the model'.
rb_feb19_picp_sustainability_impact_on_hospital_activity_and_lessons_lea....pdf (ageuk.org.uk)

RECOMMENDATIONS

Formulated from expertise of the roles, research, and group discussions, the five action groups had the task of creating a list of recommendations over the course of the project. The recommendations are a key output of the action groups and have been intentionally framed by the groups in a way for managers of the roles and senior managers from across the system to review and agree, rather than an as an action plan.

The five action groups produced a total of 27 recommendations, with some action groups generating the same recommendations. The recommendations have been categorised into four themes; communication, training and development, systems and processes, and data. We have also included information about which groups developed each recommendation in order to show which were identified by multiple action groups and in an attempt to provide some context.

Key

M&P - Mapping and Pathways Action Group; M&E - Models and Evidence Action Group; Qual D - Qualitative Data Action Group; Quan D - Quantitative Data Action Group; S&T - Skills and Training Action Group

Communication

	Recommendation	Action Groups
1.	Further raise awareness and understanding of the roles for both residents and workforce via available channels including but not limited to VCS, faith sector, carers and Training Hub • will need to be ongoing because people's needs are changing and the roles are developing • Raise awareness for referrers e.g. GPs, hospital staff, social care ○ Create simple, easy to understand guides to each role (staff versions may require more detail but should still be simple)	M&P, Qual D, S&T. M&E
2.	Develop ongoing engagement structures / processes to get continuous feedback inc. focus groups (utilising existing settings/groups where possible)	Qual D

Training, Development and Responsibilities

	Recommendation	Action Groups
1.	Add an advocacy responsibility to role descriptions e.g. communicating challenges residents have with services such as online only access or location to service providers / commissioners	M&P
2.	Develop system-wide training so all roles have consistent baseline training / common induction across roles to help develop understanding and connections • Co-develop the 'magic ingredients' - principles and culture that all Newham roles use as their foundation	M&E, S&T
3.	Share / communicate opportunities to do (joint) training consistently across roles • Open training up to other roles • Share wider training/support services e.g KeepingWellNEL to all roles (especially those not within / connected to training hub)	S&T
4.	Ensure roles have dedicated time to access training: • Work to ensure management recognise the importance of having protected time for training • Consider what minimum participation in training and skills development is	S&T

5.	Identify investment to ensure the sustainability of Personalised Care Community of Practice e.g. resourcing capacity and enabling wider participation	S&T

Systems and Processes

	Recommendation	**Action Groups**
1.	Identify synergies and improve connection between roles with goal of avoiding duplication of work • Work together to provide wider, collaborative offer e.g. events to meet needs of local population • Consider centralised administrative support / management functions • Identify opportunities to work with other existing programmes/roles e.g. Family Hubs, LBN family navigators, ICB programmes (frailty) where possible,	M&P, M&E
2.	Develop a shared strategic and consistent approach to the personalised care system across Council, NHS and VCFS to be more effective • How is the offer structured, connected and provided? • How do we protect against turnover of people in strategic roles? • Co-develop system principles and approach • Increased accountability within system regarding where roles are placed and their scope, ensuring they complement each other, consistency and accessibility with intention of preventing inequity	M&P, M&E, Qual D
3.	Streamline / simplify pathways and referrals e.g. single point of access • Don't rule out option of bringing all the roles together into one role/one central programme • Should explore how specialist expertise and training is retained	M&P, S&T
4.	Maximise use of people who could identify possible beneficiaries e.g. libraries, repairs, hospital staff	M&P
5.	Continue to gather an understanding of barriers to access and create open referral process • Connect to inequalities programmes and consider outreach to black and minority ethnic groups to overcome access barriers and challenges • Review how carers receive support and is it accessible to them • Remove need to be referred by a medical/social care professional where possible	M&P, M&E
6.	Explore opportunities to increase partnership with/involvement of volunteers alongside paid roles, as seen in some personalised care models	M&E
7.	Develop processes to identify issues that are playing out at family level which brings additional complications and feedback loops helping to support the family as a whole rather than treating people as stand-alone individuals	Qual D
8.	Address system challenges (e.g. data sharing and confidence in data held) that affect ability to perform roles as fully as possible and for residents to engage completely	Qual D
9.	Provide a specific form filling support offer	M&P

Data

	Recommendation	**Action Groups**
1.	Work as a system to ensure consistent minimum referral data capture for all roles • Explore using a universal data collection template for all the roles	Quant D

2.	Gather better insight of GP understanding and experiences of roles	Qual D
3.	Identify and understand how the system uses the data • Explore ways for the data to be more coordinated in its analysis, application and reporting (e.g. Health Equity Board, Primary Care Networks, Local Authority)	Quant D
4.	Integrate primary care roles / all health and wellbeing support roles into NEL social prescribing dashboard • Need to be able to identify data from each of the roles	Quant D
5.	Explore ways to monitor and improve data quality • Identify the best way to communicate with those inputting data and facilitate continuous improvement to build confidence and ensure consistent data capture e.g. induction and training, ongoing feedback. • Work with ICS evaluation group and local communities of practice to optimise processes	Quant D
6.	Explore how data can be collected in the hospital system to provide insights going forward (e.g. new coding)	Quant D
7.	Identify resource to analyse Well Newham Directory of Service data and use it for quality improvement in partnership with primary care.	Quant D
8.	Explore existing, planned, possible and newly procured solutions to improve capture of quantitative data in the future.	Quant D

Some of the recommendations developed are already in progress across the system. However, the action groups felt they still were important to capture to show that they are supported by this project, or may require more work. We have moved these recommendations to the table below to distinguish them from the above recommendations which primarily require new activity.

	Recommendation	**Action Groups**	**Existing Programmes / Work**
1.	Create a single, simple directory of services and contacts for roles, including information about the roles and how they can help.	M&P, Qual D, M&E	Well Newham Directory of Service
2.	Explore how we can meet residents' expectations of holistic care from all health and wellbeing roles they interact with across the system, and the training required.	Qual D	Well Newham Approach (strength-based practice)
3.	Explore ways to provide access to the data from the Well Newham Directory of Services in line with data sharing agreements.	Quant D	Well Newham Directory of Service / Well Newham Case Management System

In addition, to the above other work is underway in the borough that relate to the outcomes of this project, even if they don't directly align with a specific recommendation e.g. the recruitment of a Personalised Care Lead by the Newham Health Collaborative, and a NEL Personalised Care Lead who is developing a framework for personalised care across North East London.

LOOKING AHEAD

The final stages of this project is to review the recommendations from the action groups with the key decision makers and stakeholders who are able to determine if the recommendations are actionable and if so how. This will take place in an in-person workshop in late 2022. As part of this workshop the participants will be asked to take ownership of the recommendations as appropriate. After the workshop, those who have taken ownership of recommendations will be asked to develop an action plan for the recommendations they've taken responsibility for.

There are some pieces of work that were unable to be completed as part of the project, and which would still be worthwhile to complete. These may be picked up by particular stakeholders, as appropriate, or may require the Council's Public Health team to coordinate centrally again. These actions are expected to be as follows.

1.	Observations would help provide more accurate understanding of how roles are enacted and supported
2.	Consider how to do more anonymised recruitment and use non-Council channels to recruit, alongside more targeted and open recruitment to broaden resident engagement
3.	Make requests to NEL insights team for specific, deeper dive data
4.	Look at roles in terms of need - what need is being met by each of the roles
5.	Gather experience and feedback from roles about data collection and reporting
6.	Explore ways to get more data from roles who were unable to provide data
7.	Create a map of all roles in Newham and the areas they cover

In addition to the internal work within the borough, we expect to share the report, findings and learning with North East London (NEL) boroughs and possibly more widely as this project appears to be the first of its kind and may be useful to others. For example, a summary of the project outcomes will be presented at an ADPH webinar about supporting residents around social determinants of health in November 2022.

While this piece of work was conducted for the benefit of those in Newham, the findings and recommendations are in line with work that is happening across Newham, including (but not limited to):

- The implementation of a shared, online directory of service for a wide range of people to use to connect residents to services
- A new Personalised Care Lead in the GP Federation providing support to the ARRS roles
- Training Hub providing webinars and supervision support in partnership with the NEL Personalised Care Team
- The work by the NEL Personalised Care Team including the implementation of the minimum data set, social prescribing dashboard and development of a best practice framework
- The borough-wide health equity work
- The recruitment of a Social Prescriber at Newham University Hospital
- Strengthening the strength-based and trauma-informed ways of working across the borough
- The Personalised Care Community of Practice
- Raising awareness of social determinants of health and the services available so people in all areas of health, care and the council can support residents as much as possible

As well as the borough-specific work, there is work happening across North East London, London and nationally that is aligned with the findings of this project. For example, in October 2022 the Health Foundation released a long-read piece called 'A Framework for NHS Action on Social Determinants

of Health'[13]. The piece set out the following framework which clearly aligns with this project's recommendations regarding data collection, joint planning and making it easier for professionals to connect people with the necessary support services.

Furthermore, the NHS is continuing to emphasise the importance of personalised care and social prescribing as part of their expectations of primary care in particular. Most recently, this was evidenced by the focus on personalised care in the NHS Long Term Plan (published in 2019)[14]; the establishment of the National Academy of Social Prescribing; the funding for the ARRS roles; and requirements within the primary care Network Contract Directed Enhanced Service (also known as the DES) including targets for referrals to social prescribers and the requirement for a 'proactive social prescribing' offer[15].

Figure 4: A framework for understanding NHS approaches to addressing social needs, The Health Foundation (Oct 2022)

Overall, the project has provided Newham with a starting point to begin the process of working together as a system going forward to ensure residents can access what they need, where they need it. It is clear that due to the complexity of the landscape, the current capacity both in the personalised care roles themselves and the wider system, and financial constraints, it is unlikely to be wholly straightforward or quick to implement all the recommendations and associated changes. However, by working together, the offer to residents can be equitable, relevant, trusted and accessible.

[13] Buzelli L, Dunn P, Scott S, Gottlieb L & Alderwick H. A Framework for NHS Action on Social Determinants of Health. The Health Foundation; 2022. (https://www.health.org.uk/publications/long-reads/a-framework-for-nhs-action-on-social-determinants-of-health)
[14] https://www.longtermplan.nhs.uk/areas-of-work/personalised-care/
[15] Network Contract Directed Enhanced Service – Personalised Care: Social prescribing; Shared Decision Making; Digitising Personalised Care; and Support Planning. NHS; March 2022. (https://www.england.nhs.uk/wp-content/uploads/2022/03/directed-enhanced-service-personalised-care-March-2022.pdf)

SUPPLEMENTARY DOCUMENTS

1) Qualitative Data Report – Interviews and Focus Groups
2) Survey – Residents
3) Survey – Health and Social Care Roles
4) Survey – Health and Social Care Roles
5) Survey Results – Residents
6) Survey Results – Health and Social Care Roles
7) Survey Results – Health and Wellbeing Roles
8) Gant Chart

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Additional resources used to help research health and wellbeing support roles are included in the table below. These are available upon request.

Title	**Format**
A GP Perspective on Social Prescribing and the response to COVID-19 in Merton	PDF
Care Coordinator recruitment pack	PDF
CNLW Training & Pathways Email	PDF
CNLW Training and Pathways	PDF
Community Connector – Mental Health Job description	PDF
Community connectors - personalised care roles: training, job descriptions and referral pathways Email	PDF
Community Connectors Training and Pathways	PDF
Community Neighbourhood Link Worker Job description	Word
Community Neighbourhood Link Worker referral forms and Pathways	Word

Community Neighbourhood Link Worker referral information	Word
Draft SPLW Workforce Development Framework	PDF
Evidence Search Results on Social Prescribing and Obesity	Word
Evidence Search Service Results on Social prescribing: models, impacts and costs	Word
Family Action, 'Social Prescribing in Secondary Care: How to Guide'. (2018)	PDF
Gloucestershire Public Health Models	Word
Good Example: Ealing Guided Meditation for Wellbeing	PDF
Health and Wellbeing Coach recruitment pack	Word
Health London Partnership: 'How to introduce a social prescribing champion model and/or a digital platform to support your social prescribing offer'	PDF
JD Mapping 06/05/2020 - Link Workers Social Prescribers Care Navigators	Word
Job description mapping - Link Workers Social Prescriber Care Navigators 2020	Word
King's Fund - Health in the Community (webinar notes)	Word
London Borough of Barking and Dagenham: Linking Social Prescribing to social welfare	PDF
London Borough of Waltham Forest: using social prescribing to combat loneliness	PDF
London Social Prescribing Link Worker Training and Development Matrix	PDF
Mapping the Personalised Care roles in Newham	PowerPoint
MDT Blank Meeting Template	Word
MDT Diagram 2020	Word
NEL - Guide for new Social Prescribing Link Workers	PDF
NEL - Training & Development Mapping Exercise - Crib sheet	Word
NEL - Training Needs Assessment	PDF
NEL - Training Needs Assessment Datasheet	Excel
NEL NHSE Webinar 6th July 2022	PowerPoint
NHC - Primary Care Network Social Prescribing Link Worker	PDF
PRSB - Referral to Social Prescribing Services	PDF
PRSB - Social Prescribing Standard V0.2	PDF
Roles Mapping - Initial	Excel

Shoreditch Trust - Health & Wellbeing Coach Role Description and Person Specification - Adults	PDF
Skills for Care - Building community capacity through asset and strengths-based approaches – a guide for commissioners	PDF
Skills for Care - Community and person centred working using asset and strengths based approaches: a brief guide for adult social care employers	PDF
Skills for Care - Community, asset and strengths-based approaches: a guide to terminology	PDF
Skills for Care - Person-centred and community based working	PDF
Skills for Care - Using conversations to assess and plan people's care and support. The principles of conversational assessment	PDF
Skills for Care: 'Using conversations to assess and plan people's care and support. The principles of conversational assessment'	PDF
Social Health and wellbeing team update, PCN meeting: 20th January 2022	PowerPoint
Social Prescriber Training & Pathways Email	PDF
Social Prescriber Training and Pathways	PDF
Social Prescribing in Oldham, a case study	PDF
Social Prescribing Link Worker JD NHCv2	PDF
Social Welfare Alliance - Training provided to personalised care roles Email	PDF
Supervision for roles recruited through the Additional Roles Reimbursement Scheme (ARRS)	PDF
Understand Social Prescribing Landscape	PowerPoint
Universal Personalised Care, Implementing the Comprehensive Model (NHS)	PDF
VCFS - Training provided to personalised care roles Email	PDF
Waltham Forest - Personalised Care Roles Slifr Pack Form June 2022	
Waltham Forest - Personalised Care Roles Study June 2022	PDF
Workforce development framework: care co-ordinators	PDF
Workforce development framework: health and wellbeing coaches	PDF