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Supporting High Frequency Users (HFU) through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators

This guidance note sets out the principles and recommended approach for offering proactive, personalised care for those at higher risk of hospital admissions due to psychosocial needs, as part of a broader strategy for ICBs and PCNs to tackle winter pressures and reduce unplanned admissions. These are patients who use services more frequently than usual, including A&E attendances or unplanned hospital admissions and may be identified as being vulnerable, where lifestyle, behavioural or social risk factors are impacting on primary and secondary care service usage. Through the offer of proactive, personalised care, and in particular maximising the support offered through social prescribing link workers, health and wellbeing coaches, and care coordinators, they can be supported to uncover and address psychosocial support needs, improve their symptom and condition management, and to access a broader range of support options in their communities, resulting in reduced unscheduled use of primary and emergency care.

18 October 2022

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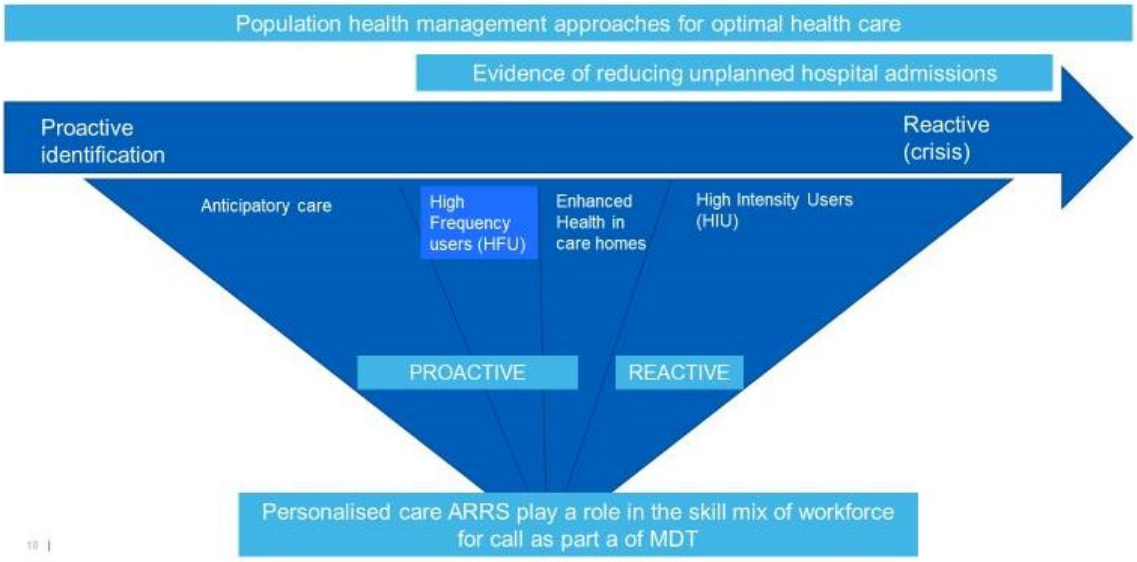
1. Introduction

1.1 In order to prepare for the pressures and increased demand on services during the Winter period, ICBs and PCNs need to consider how to address issues around access and more flexibly meet the needs of patients, ranging from people who become ill and use services infrequently, to those with more complex needs who require multidisciplinary support to offer more proactive and personalised care.

1.2 One particular cohort of patients who may benefit from more proactive support, relates to those who use services more frequently than usual, including A&E attendances or unplanned hospital admissions, and may be identified as being vulnerable, for example complex, frail, or patients with multiple long term conditions or patients where lifestyle, behavioural or social risk factors are impacting on primary and secondary care service usage. Through the offer of proactive, personalised care, they can be supported to uncover and address psychosocial support needs, improve their symptom and condition management and to access a broader range of support options in their communities, resulting in reduced unscheduled use of primary and emergency care.

1.3 This guidance note sets out the principles and recommended practical steps for services to offer proactive, personalised care, delivered via multidisciplinary teams (MDTs) and in particular maximising the support offered through social prescribing link workers (SPLW), health and wellbeing coaches (HWBC), and care coordinators (CC), with the aim of increasing individuals' knowledge, skills and confidence to better manage their health and wellbeing, and thus reducing the risk of unplanned admissions, called High Frequency Users (HFU).



1.4 HFU as a model builds on the approaches that PCNs will already have underway to proactively offer and improve access to social prescribing to an identified cohort of patients with unmet needs, in line with the Personalised Care service requirements in the Network Contract Directed Enhanced Service. This service model encourages a broader approach, making use of a range of roles funded through the Additional Roles Reimbursement Scheme (ARRS), and with a specific focus on supporting patients with psychosocial needs through coaching and connections to wider support services. This cohort will have different characteristics to those patients with complex clinical needs who may require intervention through an alternative programme of support e.g. Falls Response service, or a virtual ward.

1.5 Similar models, including a study of a complex population health intervention in Frome (see Case Study), have shown “highly significant reductions in unplanned admissions to hospital” as a result of patient-centred goal setting, community development and social prescribing. Over the period of April 2013 to December 2017, unplanned hospital admissions decreased by 14% for the identified cohort, at a time when emergency admissions more generally had increased by 28.5%.

1.6 As outlined in Dr Claire Fuller’s Next Steps for Integrating Primary Care, supporting the growth and development of integrated neighbourhood teams and reorienting our existing workforce to support our most vulnerable and complex patients to stay at home and access care in the community will, over time,

contribute significantly to efforts to reduce growth in hospital demand. Health and wellbeing coaches, care coordinators and social prescribing link workers provide an excellent opportunity to address health improvement, and to provide connections to local communities and services, reducing reliance on primary, community and secondary care.

1.7 NHS England is supporting ICBs and PCNs to take action to boost capacity outside of acute trusts to support general practice, primary care networks and their teams through winter, which includes the scaling up of additional roles in primary care and increasing the flexibility for primary care networks (PCNs) to do this. ICBs can provide business analyst support to support interoperability between systems and linking of system data based on population health management approaches.

1.8 Social prescribing link workers, health and wellbeing coaches, and care coordinators are all included in the Additional Roles Reimbursement Scheme, with a specific aim of supporting patients based on what matters to them, and helping to address their holistic needs through advice, guidance, and connection to wider support services, including social, practical and financial support. These roles can help to identify and address unmet social needs and health inequalities through targeted work with specific groups identified through proactive approaches. Focusing on individuals' wider health and wellbeing and supporting them to stay well can free up clinical time and capacity, avoiding the need for A&E attendances and unplanned admissions.

2. Principles and recommended approach

2.1 This example service model is based on learning from systems who are already offering proactive approaches to support patients at highest risk of unplanned admissions, or those experiencing health inequalities, with caseloads being managed by existing ARRS roles. Where systems are already offering this type of approach they should build on their exiting work and expand as appropriate; systems who have yet to develop proactive approaches should start small and expand over time. ICBs and PCNs will have their own processes in place for

stratification, segmentation and prioritisation of needs based on population health management data, however, the approach outlined below provides some guidance on how the service model could be designed to support patients with psychosocial risk factors who may benefit from proactive support to manage their health and wellbeing.

2.2 The model is based on the following steps:

Step 1: Cohort identification using risk stratification approach

- Using population health management data and risk stratification tools (including the health inequalities dashboard), identify a cohort of patients at highest risk of unplanned admissions, where psychosocial and condition management issues are key factors in admissions, who would benefit from a proactive offer of personalised care to help them increase their knowledge, skills and confidence to manage their health and wellbeing. It is up to local areas to decide which cohorts they wish to focus on, but potential inclusion criteria are set out below or may draw from the High Intensity Use programme.

- Potential inclusion criteria:

  - Patients who have had 2+ unplanned admissions AND been prescribed 10+ medications in the last 12 months AND where professional judgement has identified individuals requiring additional support that may be provided through a SPLW, HWBC or CC in addition to a registered health professional or partners such as pharmacies, VCSE services etc.

  - Further validation via MDT professional judgement of risk of admission based on additional significant risk factors e.g. age >75, frequent 999 or 111 contacts, and/or multiple LTCs. In addition, anyone identified to be clinically of concern by the discharge liaison team, the practice team, the district nursing team, a community hospital ward doctor, a discharge summary review, through recent contact, or by ambulance or out-of-hours contacts and include carers.

- The Process of cohort identification could include:

  - Application of risk stratification tools to search patient records and identify individuals who meet the inclusion criteria

- Review of existing disease registers held by practices
- Proactive searches by acute services to identify patients who make frequent use of services or where reasons for attendance are recorded as non-clinical factors
- Segmentation based on clinical and psychosocial factors
- Reviews of patient discharge letters
- Local intelligence and/or referrals from local partners e.g. pharmacies, social services, voluntary and community services
- Referrals from other Winter Pressure programmes.

Allocation of caseloads

- MDT meetings can be used to review the identified list of patients to ensure the appropriate clinician or professional is allocated to each case. This will take into consideration the clinical and non-clinical risk factors for each individual. Consideration also needs to be given to existing caseloads and capacity of the workforce.
- For those with significant psychosocial risk factors, caseloads may be allocated provisionally to care coordinators, social prescribing link workers, or health and wellbeing coaches.
- For those with significant clinical or pharmaceutical risk factors, caseloads may be managed by a GP, nurse, pharmacist, advanced nurse practitioner, or physician associate.

Step 3: Proactively contacting patients to invite them to discuss their needs

- ICBs and PCNs will want to consider a sensitive communications approach for onboarding patients, ensuring they understand the reason for being contacted, what support is available, and that their participation is voluntary.
- Patients will be invited to have a ‘What Matters to Me’ conversation about the issues they are experiencing and what type of support might be most beneficial to them, in order to more proactively manage their health and wellbeing. For those patients with clinical risk factors, this conversation will be facilitated by an appropriate clinician,

and for those with non-clinical, psychosocial risk factors, care coordinators (or other personalised care roles) will facilitate the conversation. Through shared decision making, referrals to relevant interventions, and/or the development of personalised care and support plans, the patient can be directed to the appropriate support.

- Health and wellbeing coaches can work with patients to provide coaching on symptom and self-management, mild depression, and anxiety.
- Social prescribing link workers can discuss and offer help with wider social support issues and can direct people to non-clinical support services, including benefits and financial advice, employment support, lifestyle advice and social networks.
- Referrals to other specialist roles within primary and/or community services might also be required.

Step 4: Regular check-in points

- Following the initial 'What Matters to Me' conversation, and any subsequent interventions, there should be a period of check-ins with the patient to check how they are doing with making any changes, and whether there have been any issues in terms of access or the suitability of interventions. This may result in changes to personalised care and support plans, alternative referrals, or assistance with making contact with services. These check-ins can be initiated by care coordinators or other roles within the team.

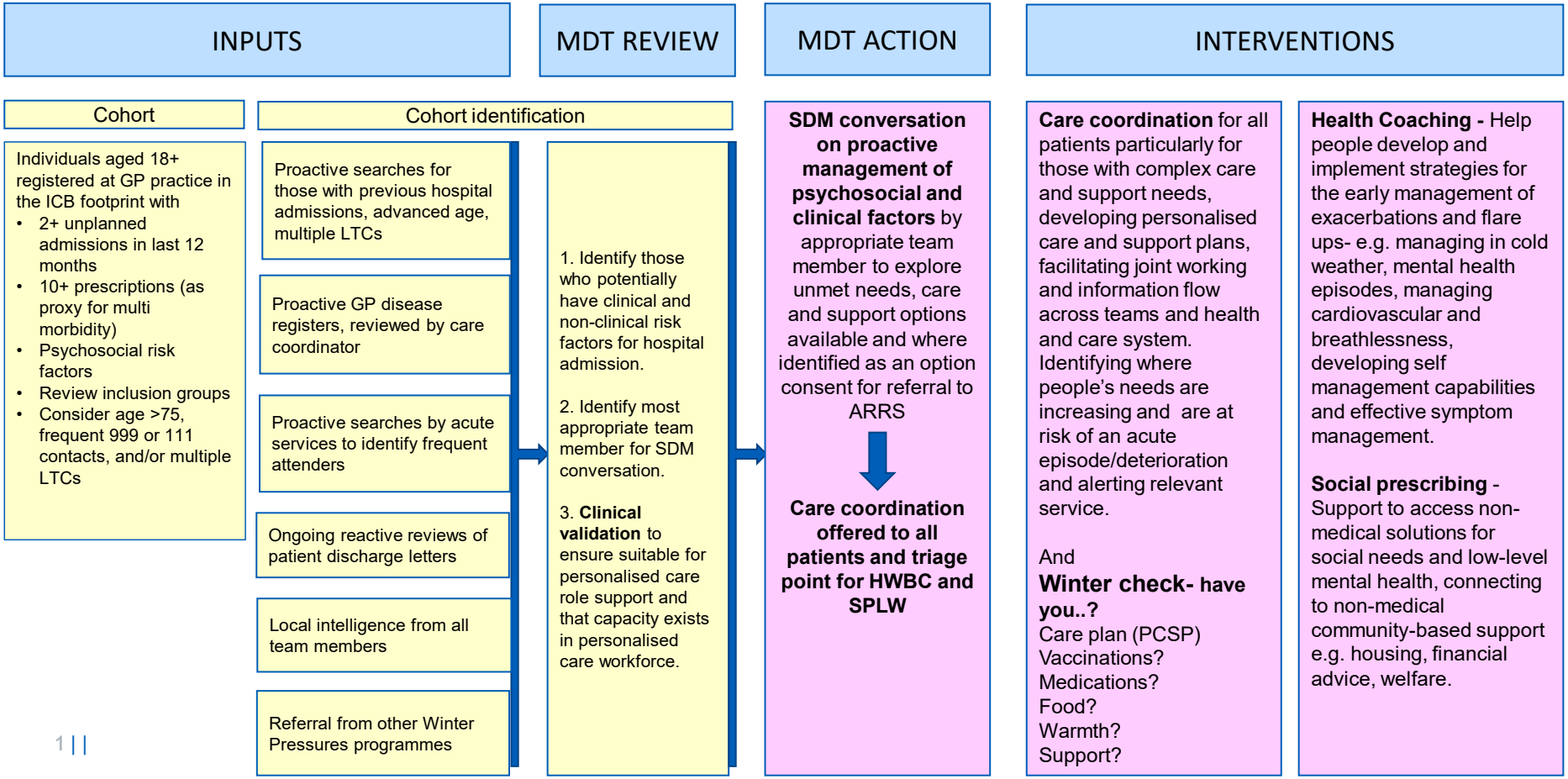
Step 5: Review and refresh caseload

- Following conversations with the appropriate clinician or professional, and on completion of interventions, patients can be discretely discharged or stepped down to relevant community support, but with the potential for re-entry to the list should a change in circumstance occur.
- Cohort identification will need to be refreshed at regular intervals to ensure a rolling programme of support as cases are closed and/or workforce capacity increases or decreases.
- ICBs and PCNs are encouraged to consider the deployment of their current ARRS roles to meet increased pressure and demand during the Winter months, and plan for additional recruitment via ARRS and/or System Development Funding (SDF) for primary care to strengthen their capacity to meet the needs of different patient

groups. Recruitment may be required to backfill roles to allow current staff to prioritise more proactive work, or to recruit for specific skills and experience to provide targeted support for particular population health needs.

3. Example pathway

Example of proactive case-finding for support from social prescribing link workers, health and wellbeing coaches and care coordinators and other ARRS



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4. Governance and risk management

4.1 This service model will rely on ICB support and partnership working between acute services, community and primary care, and wider support services including voluntary and community services, in relation to the identification of patients, ensuring they are connected into the appropriate psychosocial and/or clinical support, and measuring the impact on individual outcomes and service utilisation.

4.2 In order to ensure that individuals' clinical risk factors are fully considered and managed by an appropriate clinician, validation of patient lists by an MDT will be essential.

5. Additional resources

5.1 Workforce development frameworks have been developed to support PCNs to implement and support the three personalised care roles.

5.2 There are also a number of training courses to support the personalised care roles, including:

- Mandatory Health Education England e-learning for link workers, applicable to all roles here. The course includes a number of different sessions, with the following being of particular relevance:
    - Supporting people with their mental health through social prescribing
    - Social welfare, legal support and money guidance
- The Personalised Care Institute (PCI) also provides further advice, guidance and training materials, including bespoke personalised care training such as the e-learning courses in Core Skills for Personalised Care, Shared Decision Making, and Personalised Care and Support Planning. There are also a

number of PCI accredited training courses covering health coaching, care coordination and social prescribing.

5.3 NHS England have produced a number of resources to support PCNs in recruiting social prescribing link workers, health and wellbeing coaches and care coordinators, and adapting their service offer to support a more personalised and proactive care approach. These include:

- PCI webinar for PCNs on Training, Supporting and Embedding New Personalised Care Roles
- Welcome Pack for Link Workers who are new in role
- Welcome pack for care coordinators and H&WB coaches
- Further key roles and responsibilities are outlined in the PCN reference guide for link workers. The reference guide also includes further information on how to work with key partners locally
- The Summary Guide gives a clear picture of what a good social prescribing scheme looks like. It also includes a Common Outcomes Framework to help measure the impact of social prescribing on people, the local system, and the voluntary and community sector.
- Social Prescribing Collaboration Platform – a network for news, resources, and discussion. Email england.socialprescribing@nhs.net to join.

6. Case study

Summary

Frome Medical Practice[1] reduced emergency admissions to hospital through a proactive systematic intervention over a 44 month period. The complex intervention in Frome was associated with highly significant reductions in unplanned admissions

[1] Abel, Kingston et al (2018) *Reducing emergency hospital admissions: a population health complex intervention of an enhanced model of primary care and compassionate communities*, British Journal of General Practice, Vol. 68, Issue 676

to hospital, with a decrease in healthcare costs across the whole population of Frome.

The model built on interventions that had already shown some success in delivering improved health outcomes. In relation to primary care, the model included person centred consultations, development of self-management plans, care coordination and social prescribing.

Background

Frome Medical Practice is a single general practice in Frome, Somerset, in the South West of England. The practice provides comprehensive primary care for 28,510 people. The practice embraced the House of Care model of person-centred care planning and modified the national template to enable all care plans to be undertaken using principles of personalised care planning. Through the combination of targeted identification of people at risk of unplanned admission, systematic care planning for this group and referral to the social prescribing scheme, and proactive community development, the practice has been able to demonstrate an increasing trend of reduction of emergency admissions to secondary and tertiary care.

Aim

To evaluate a population health complex intervention of an enhanced model of primary care and community development on population health improvement and reduction of emergency admissions to hospital.

Design and setting

A cohort retrospective study of a complex intervention on all emergency admissions in Frome Medical Practice, Somerset, compared with the remainder of Somerset, from April 2013 to December 2017. Patient-centred goal setting and care planning combined with community development and social prescribing was implemented broadly across the population of Frome.

Method

Patients were identified using a variety of methods. A mixture of databases were searched, such as the Quality and Outcomes Framework long-term conditions

database, along with specific searches by diagnosis on the practice database, and by clinical impression. The clinical impression identification was open to all health professionals and was not limited to doctors. Some patients who would not necessarily be picked up by database searches benefit from the use of the models of care due to the limits of predictability of care using screening tools. Patients were identified using broad criteria, including anyone giving cause for concern.

In addition, anyone identified to be clinically of concern by the discharge liaison team, the practice team, the district nursing team, a community hospital ward doctor, a discharge summary review, through recent contact, or by ambulance or out-of-hours contacts was eligible. This included carers, and the practice has a coding system to specifically identify carers.

Results

There was a progressive reduction, by 7.9 cases per quarter (95% confidence interval [CI] = 2.8 to 13.1, P = 0.006), in unplanned hospital admissions across the whole population of Frome during the study period from April 2013 to December 2017, a decrease of 14.0%. At the same time, there was a 28.5% increase in admissions per quarter within Somerset, with a rise in the number of unplanned admissions of 236 per quarter (95% CI = 152 to 320, P<0.001).

Conclusion

The complex intervention in Frome was associated with highly significant reductions in unplanned admissions to hospital, with a decrease in healthcare costs across the whole population of Frome.

Worked Example of proactive case finding

Practice with approximately 5,000 registered patients using SystmOne

Step 1: Identify workforce capacity at this practice

3-4 hours of social prescribing link worker or health and wellbeing coach time/week and up to 30 mins GP time/week

Step 2: Cohort identification – 30 minutes

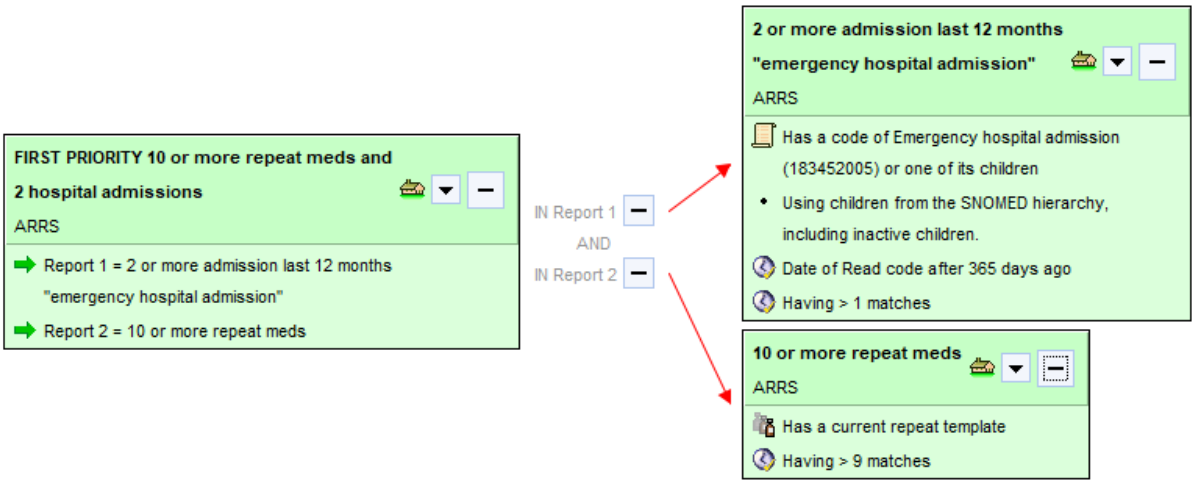
1. Searches set up in SystmOne to identify people with previous hospital admissions and other risk factors for admission including advanced age, multiple LTC and polypharmacy.

2. Thresholds for the searches adjusted to yield a cohort size that can realistically be targeted with the time available (e.g. thresholds for age, number of admissions, number of repeat meds). Aiming for around 1/1000 patients in the top priority group.

3. Final cohorts agreed:

    a) FIRST PRIORITY: Those with 10 or more repeat medication items and 2 hospital admissions in the previous 12 months – 7 patients

    b) SECOND PRIORITY: Those with 10 or more repeat medication items and 1 hospital admission in the previous 12 months – 29 patients



Step 3: MDT discussion 1 hour

GP, SPLW and HWbC meeting to go through the list, confirm that these individuals may be suitable for SPLW or HWbC intervention. Most patients already well-known to GP due to frequent attendance. Several patients had medical needs identified such as an overdue medication review – addressed through clinical team member input.

Step 4: Implementation

SPLW or Care Coordinator proactively calling patients on the list, starting with first priority cohort, for a SDM conversation about whether to proceed, then onwards SPLW input.

Weekly 10 minute meeting with GP to discuss important matters arising, quality improvement and consider targeting broader cohorts in the coming weeks.

Appendix 1 - Health and wellbeing coaches

Health and wellbeing coaches (HWBC) focus on improving health related outcomes by working with people to set health related goals and to make changes in their health related behaviours. They offer people support to increase their self-efficacy, motivation and commitment to make changes to their lifestyle, improve their health and manage symptoms.

Examples of where HWBC can support: Respiratory, cardiovascular (T2 diabetes, hypertension), new diagnosis, stress/low mood		
Prevention and staying well	**Deterioration/acute episodes**	**Discharge and recovery**
Supporting people to self-manage, increase activation levels and sustain behaviour change.	Help people develop and implement strategies for the early management of exacerbations and flare ups- e.g. managing in cold weather, mental health episodes, managing angina and breathlessness	Support people to come to terms with new situation/diagnosis, including limitations and change of life. Support people in problem solving and working through strategies towards independence on discharge where appropriate.
Improving patient outcomes e.g. weight reduction, improved blood pressure, improved blood sugar, increased activity. Potential reversal of T2 diabetes.	Be confident in knowing when to self care and when to seek medical attention.	Support people to become active in management of new conditions e.g. Long Covid.
Support people with improved medication adherence.	Where appropriate improve people's confidence in medication titration in response to triggers e.g. use of inhalers.	Support behaviour change needed in response to recent discharge e.g. smoking cessation, weight loss, activity levels.

Developing and linking people to peer support e.g. group coaching.
Time and capacity to explore clinical and non-clinical needs and set goals to improve quality of life.

Appendix 2 - Care co-ordinators

Care co-ordinators co-ordinate and navigate care across the health and care system, helping people make the right connections, with the right teams at the right time. They can support people to become more active in their own health and care and are skilled in assessing people's ongoing needs.

Examples of where CC can support: Multiple long-term conditions, frailty, discharge, anticipatory care, cross team/organisational working (MDTs), care homes		
Prevention and staying well	**Deterioration/acute episodes**	**Discharge and recovery**
Capacity for people to have a named contact to go to who can assess and respond to their changing needs.	Facilitating joint working and information flow across teams and health and care system.	Provide support to people who have been discharged, to ensure all necessary arrangements in place e.g. following a non-elective admission.
Support people to get the most out of clinical consultations, reducing the need for follow-ups and increasing capacity for choice and shared decision making.	Facilitate referrals and ensure timely access to right professionals and teams.	Supporting people to access the right services and resources for their long-term health. For example personal health budgets.
Facilitating joint working and information flow across teams and health and care system.	Support with the development of coordinated treatment escalation plans	Empowering and enabling people to self-manage their own care and support as much as they can (supported self-management {SSM}). Including through NHS @home

Reducing the risk of deterioration/ exacerbations/admissions through PCSP and regular contact.	Spotting where people's needs are increasing and they are at risk of an acute episode.	Facilitating joint working and information flow across teams and health and care system.
Making Every Contact Count and taking opportunities to ensure routine reviews, vaccinations (e.g. Covid, flu) and screening are booked in.		
Supporting people to access services in new ways e.g. virtual wards, NHS @home. Reducing unnecessary appointments.		

Appendix 3 - Social Prescribing Link Workers

Social prescribing link workers (SPLWs) connect people to community-based support activities to improve their health and wellbeing. They are well placed to support people experiencing social and economic challenges.

The roles can be deployed to work collaboratively across the health and care system, targeting those with greatest need; leveraging community assets to support the management of care and wellbeing needs.

Examples of where SPLWs can support: Low level mental health needs including loneliness, isolation, anxiety, support with housing, financial and welfare concerns.		
Prevention and staying well	**Deterioration/acute episodes**	**Discharge & recovery**
Proactive targeting of cohorts at risk of social issues affecting potential admission to hospital	SPLW as part of admission & discharge pathway to enable post-discharge support	Proactive targeting of at-risk groups recently discharged from hospital
Connect people to non-medical, community-based activities and support to build networks and resilience, tackling loneliness and isolation.		Connect people to non-medical, community-based activities and support to build networks and resilience, tackling loneliness and isolation.
Supported referral into services offering help on social determinants of health e.g. housing, energy, debt, welfare.		Support people to access community-based activities that will support recovery.
Help carers of people at risk of admission to access support and		Help for carers to access community-based support

advice to help them sustain caring role.		and advice to help them sustain caring role.
Time and capacity to explore non-clinical, social, emotional and practical support needs that affect health and wellbeing and empower people to take action to stay well.		

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