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NHS North East London

"Making a difference"

An evaluation of Health and Wellbeing Coaches in North East London

Professor Richard Griffin

Executive summary	5
Foreword	6
Introduction	7
The approach taken in this evaluation	9
The Health and Wellbeing Coaches questionnaire results	12
Stakeholder self-completion questionnaire results	17
The findings from the semi-structured interviews	19
Other information	25
Discussion	26
Recommendations	32
Appendix 1: HWbC's questionnaire – all answers to the question asking them to describe the difference their role made to clients and patients	33
Appendix 2: HWbC's questionnaire – all answers to the question asking the difference coaches make on other healthcare staff	35
Appendix 3: Activity data	36
Endnotes	40

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'I have worked with people who have not slept for years and after sessions they sleep, people have managed to begin to leave the house to walk, incorporated mindfulness practice into their daily life, given up smoking, returned to work after a long absence, taken up meditation, now understand the way their physiological self-works and developed healthier relationships' (Coach, questionnaire)

'I believe the role has huge potential to expand and become well known in the NHS as the leading non-clinical role' (Coach, questionnaire)

'...patients are being seen quicker, health coaches are offering support one to one and group sessions, patients are happy with their care, I am happy there is a health and wellbeing coach within the practice to support our patients and...myself to give the patients help when needed' (GP, questionnaire)

'Patients feel heard for the first time and understood and then they are motivated...they understand that they set the goals...which I support... sometimes it is light touch and sometimes it's more structured – how to fit in time for that extra walk or cycle ride or batch cook so they don't get a takeaway every night. If a client gets really into it, you can see those results quite dramatically. Sometimes it's small steps but then it's like a snowball' (Coach, interview)

'They are competent and capable...we feel the role is a positive thing for our Primary Care Network' (GP, interview)

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"Making a difference"

An evaluation of Health and Wellbeing Coaches in North East London

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Note on terminology

Some participants in this evaluation described the people coaches support as "clients", others called them "patients". The term "client" is used in this report, for people referred to Health and Wellbeing Coaches for support. References to "coaches" are to Health and Wellbeing Coaches unless otherwise stated. The word 'system' is used to describe the collective stakeholders in North East London with an interest in personalised care.

Abbreviations

ARRS	Additional Roles Reimbursement Scheme
HWbC	Health and Wellbeing Coach
GP	General Practitioner
ICS	Integrated Care System
NEL	North East London
PCN	Primary Care Network
SPLW	Social Prescribing Link Worker

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Executive summary

• Whilst health coaching is an established practice, Health and Wellbeing Coaches (HWbCs) are a new NHS role that assists supported self-management as part of the personalised care agenda. Funding has been made available by NHS England to Primary Care Networks (PCN) to deploy the role if they choose to. In March 2022, twenty-five coaches were in post in North East London (NEL).

• Commissioned by The Shoreditch Trust and the NEL Integrated Care System (ICS), this mixed methods evaluation investigated two key issues. Firstly, what is the impact of the role on clients and other primary care staff, and secondly what is the coach's experience of work? The evaluation considered the role across NEL, but focused in particular on the City of London and the borough of Hackney.

• HWbCs improve health and wellbeing outcomes for people experiencing a wide range of issues including diabetes, weight management, poor mental health, pain management and social isolation.

• Just over half of the people supported by coaches presented with more than one issue. Nearly one in ten presented with five issues.

• HWbCs not only work with clients setting health and wellbeing related goals, they also referred and/or signposted clients to an extensive range of services; in the case of coaches employed by The Shoreditch Trust over 280 organisations and services (ranging from ACAS to the Young Women's Trust).

• This evaluation found a consensus amongst those participating that the coaches are reducing the workload of General Practitioners, and other staff, in the practices they support. The full impact of the HWbC role will be seen in the longer term, for example, through less hospital admissions and overall improvements in population health. The improved health and wellbeing outcomes coaches support are likely to save the NHS money. For example, it is estimated that the NHS spends £6.1 billion a year treating illnesses related to overweight and obesity.[1] There is a need to capture the long term impact of the role.

• Generally, the HWbCs who participated in this evaluation were positive about their experience of work, although some issues were identified. These were the variable quality of induction and on-boarding, a sometimes lack of supervision, poor access to training, and pay levels. A need was identified to provide coaches with more professional support and consistency in terms of their scope of practice. Furthermore, there was evidence of inappropriate referrals.

• Participants were clear that HWbCs played a distinct role within the personalised care team complementing other roles particularly Social Prescribing Link Workers.

• Although this evaluation found widespread support for the principle of personalised care, only a small proportion of NEL primary care employers utilise HWbCs at present. As a result, there is a need to promote and explain the role – including the impact it can have – across NEL. To enable this a personalised care strategy with a long-term vision for the role needs to be developed by partners.

• The evaluation suggests that thought needs to be given to how the role might evolve and be sustained over time including the creation of specialist coaching roles and career progression opportunities. This will help retain staff.

Foreword

I am delighted, on behalf of the Personalised Care programme at North East London Health and Care Partnership to introduce this evaluation, undertaken by King's College London, on the experience and impact of Health and Wellbeing Coaches in North East London.

It is well documented that populations and people have improved experiences and better health outcomes when they are empowered to actively participate and self-manage their health and wellbeing.

Personalised care involves new ways of working and new models of care to address health inequalities and support better outcomes for local people and communities. This is about early intervention and prevention, and, at its core, it is person-centred, using quality conversations, giving time, and taking strengths-based approaches.

Health and wellbeing Coaches are an integral part of this holistic way of working, bringing vital specialist coaching skills, expertise and behaviour change methods in to primary care settings to enable people to be **active participants** in physical and mental health.

The findings of this evaluation and its recommendations have highlighted the tangible and positive difference that our coaches are making; a sustainable impact on people living with long term conditions, anxiety, pain management and social isolation.

This is proof of concept as well as evidence for growth and expansion of the Health and Wellbeing Coaching workforce. The report also cites additional emerging evidence of impact of GP workload through the more detailed work with our commissioning partner The Shoreditch Trust.

These are next challenges as a call to action alongside taking forward the recommendations in this evaluation, in support of our local populations. We will achieve this only as a collective endeavour in partnership with clinicians, managers, PCNs, Training Hubs and of course by listening to our workforce.

Gita Malhotra
NEL Personalisation Strategic Workforce Development Lead

At the Shoreditch Trust, we support people to make positive life choices and take up opportunities to improve their emotional, physical and social wellbeing. Supporting people to flourish using strengths-based frameworks and coaching conversations is integral to our approach.

Developing Health and Wellbeing Coaching for City & Hackney Primary Care Networks has been an invaluable opportunity to increase access to holistic support, with the client in the lead, developing the skills, knowledge and confidence to take charge of their health.

We are immensely proud of the team in City & Hackney, all the coaches across NEL and our NEL ICS partners for their persistence and commitment to a way of working that is seeing some really positive gains for clients and for the wider system, with huge potential for consolidation and growth into the future.

Jacqui Henry
Director of Wellbeing Practise & Partnerships, Shoreditch Trust

This evaluation was jointly funded by NEL HCP and City & Hackney PCNs.

Introduction

This report sets out the findings of an evaluation of Health and Wellbeing Coaches deployed in North East London. Coaches "support a personalised care approach and help individuals to make positive behaviour changes based on what is important to them" (Howarth et al, 2021: 140)[2]. Alongside Social Prescribing Link Workers (SPLW) and Care Coordinators, the role is "essential in securing the over 26,000 additional staff needed to support the existing [primary care] workforce" (ibid: 140).

Personalised care is based on 'what matters' to people, taking account of their strengths and needs, rather than 'what is the matter' with them. The objective is for personalised care to benefit up to 2.5 million people by 2024 (Personalised Care Institute, 2022).[3] The six universal components of the personalised care approach, within the Personalised Care Model, are:

1. Shared decision making.
2. Personalised care and support planning.
3. Enabling choice.
4. Social prescribing and community-based support.
5. Supported self-management.
6. Personal health budgets and integrated personal budgets.

NHS England and Improvement's (n.d.) H*ealth Coaching. Implementation and Quality Summary Guide* points out that personalised care – …represents a new relationship between people, professionals and the health and care system. [4]It provides a positive shift in power and decision making that enables people to feel informed, have a voice, to be heard and be connected to each other and their communities (page 3).

Box 1: Definition of health coaching

Health coaching has been described as a practice that aims to help "people gain and use the knowledge, skills and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals. (NHS England and Improvement, n.d,: 6).

The Personalised Care Institute (2022) describes the Health and Wellbeing Coach role as comprising the following features:

1. Coaching skills are used to establish one-to-one relationships with individuals to improve activation.
2. Coaches support people to develop their knowledge, skills, and confidence to become advocates for their own care so that they can achieve their health and wellbeing goals.
3. Coaches have "strong" communications and negotiating skills which are deployed to help people to understand the implications of their own decisions around their healthcare.
4. Coaches link with other roles, such as SPLWs, and services to support people.

The Shoreditch Trust (2022) describe the role as working "alongside people who need additional support".[5] The organisation provides the following examples of who may benefit from supported self-management enabled by coaches:

- People with or at risk of a long-term condition who struggling to adapt their lifestyle.
- People concerned about a recent health test result.
- People managing chronic pain.
- Individuals who are living with depression and anxiety.
- People who may need support managing their weight.

Access to HWbCs is via a referral, most frequently from a General Practitioner (GP). Clients normally have up to eight sessions each of which last for around 45 minutes[6]. NHS England and Improvement guidance states that "Health and wellbeing coaches may also wish to consider setting up facilitated support groups or encourage the set-up of peer led support groups for people who have completed coaching or self-management courses but would benefit from some light touch support to stay on track" (n.d:2).

National training is available for coaches who are expected to undertake a minimum of four days training endorsed by the Personalised Care Institute.[7]

Funding for the role comes from NHS England's Additional Roles Reimbursement Scheme (ARRS), which provides support to PCNs for several additional posts such as SPLW, Pharmacists, Dieticians, Occupational Therapists, Care Coordinators, Nursing Associates as well as Health and Wellbeing Coaches.[8] Primary care employers decide which ARRS roles they choose to employ and which they do not. The aim is to build capability and multi disciplinary ways of working.

NEL ICS provides dedicated support for HWbCs including the establishment of a dedicated network for the coaches with a forum that meets every six weeks, access to accredited training and supervision support through an accredited supervisor.

The approach taken in this evaluation

Introduction

This evaluation used self-completion questionnaires and semi-structured interviews to address the impact of the HWbCs and their experience of work. Detailed anonymous quantitative data was gathered by The Shoreditch Trust on the issues clients referred to coaches wished to have support with, along with activity levels and the demographic data.

Objectives

The evaluation sought to address the following questions:

1. What impact have Health and Wellbeing Coaches had on clients who have received support?
2. How has this role impacted on the work of the wider primary care team?
3. What are the challenges being faced by the Health & Wellbeing Coach workforce in their places of employment?
4. What progress has been made in integrating personalised care roles into primary care settings?

Methods, participants, data collection and analysis

A mixed methods approach was adopted to meet the evaluation's objectives. Individual methods deployed were:

- An on-line self-completion questionnaire was distributed to the coaches.
- An on-line self-completion questionnaire was distributed to the stakeholders including GPs.
- Semi-structured interviews, undertaken using Microsoft Teams or through phone calls were conducted with a sample of coaches and stakeholders.
- Content analysis of data held by The Shoreditch Trust.

To capture the 'voice' of participants, extensive use was made in the questionnaires of free text questions to allow respondents to express, in their own words, their views of the role. This allowed for richer insights to be gathered. To measure coaches' experience of work, measures were constructed, with statements drawn from research (see below) as well as insights from the commissioners of this evaluation. A Likert scale was deployed. Both questionnaires were designed on Microsoft Forms. Feedback was sought from the commissioners of this evaluation on the questionnaire design.

Table 2.1 shows the participation rate for each method. Further details on the characteristics of the participants are set out in the analysis sections of this report. Data from each of the methods was analysed and presented independently, with common findings, insights and observations being bought together at the end. For both the free text answers and interviews thematic analysis was utilised to review the texts to identify recurring and salient points.

Table 2.1: Participants

Method	Response (n)	Response rate (%)	Notes
Coaches' questionnaire	17	68%	Total 25 HWbC employed
Stakeholder questionnaire	19	20%	GPs, PCN Managers & Clinical Directors
Semi structured Interviews	16	N//A	Coaches = 5 ICS staff=3 GPs= 2 PCN managers=2 Support agency=2 Social Prescriber=1 Other

Theoretical underpinnings

The evaluation was guided by three theories to ground findings within an analytical framework and address the four evaluation questions.

Realistic Evaluation

Realistic evaluation[9] is an approach to evaluation that seeks to increase validity and utility through an understanding that interventions, in this case the introduction of HWbCs, are shaped by the following:

Mechanisms + Context = Outcome

'Mechanisms' refer to how an intervention should work, or in other words what is expected of it. In this case this means evidence showing that health coaching can improve client activation for example. Evidence, mainly from overseas, shows that health coaching can result in a 12% reduction in hospital admissions, for example.[10] 'Context' recognises that what 'actually happens' is contingent on local circumstances, which will not be fixed across location or time. Context can enable or inhibit the effectiveness of the intervention; its 'Outcome'. The qualitative methods deployed in this evaluation allowed Context to be explored with participants, such as the extent of support or training coaches received in their workplace.

"Good Work"

An objective of the evaluation was to assess the experience of HWbCs of work to see whether, as a Context factor, this had an impact on the role's Outcomes. There is a growing body of evidence showing that employer approaches to people management, such as access to training and job design, can have a positive impact on organisational outcomes, including in healthcare. Ogbonnaya and Daniels (2017) , for example, found that NHS trusts with good people management were:

- More than twice as likely to have staff with high levels of job satisfaction.
- Over three times more likely to have staff with the highest level of engagement, compared to trusts with less extensive talent management practices.
- Over three time more likely to have the lowest level of sickness absence.

Reviewing the wider non-NHS literature, Ogbonnaya and Daniels (2017) report that "high quality work is characterised by job security".[11] The authors identified the features that characterise "good work". These were that staff:

- Are able to input into decisions that affect how, when and what work is accomplished.
- Have reasonable work demands and working hours.
- Clear role descriptions.
- Are able to use their skills and access to learning.
- Can perform a variety in tasks.
- Have support from coworkers.

Drawing on the insights of this research and from discussions with the evaluation commissioners, the HWbC's questionnaire included measures to assess the extent to which they might be said to experience "good work". This issue was also explored in interviews through an open question — "Can you tell me about your experience of employment?"

New roles

Although health coaching is an established intervention, not just in the UK but internationally the HWbC role is a new one in the NHS.[12] In 2017 Kessler and colleagues published an article in the Human Resource Management Journal setting out a three stage model associated with the development of new roles in the NHS.[13] In the first stage, which is called 'Emergence', old ways of working dominate, but the initial need for the new role is established.

Next comes a 'Legitimacy' stage when the new role begins to be fitted into established structures, processes, and systems but only with isolated examples of new ways of working. The old ways still dominate. Finally comes 'Acceptance' when the role is 'taken for granted' and routinely used, (although the authors make the point that roles can stall at either of the first two stages and not progress to this stage). This model can be applied to the HWbC role to consider its degree of acceptance and what might need to occur to embed it further.

Limitations

This evaluation took place over a three-month period (January-March 2022) for a role that has only recently been introduced into the NHS.

A full assessment of its impact will need to take place over a longer time scale, for example to see the extent to which coaching interventions reduced hospital admissions or GP visits and lead to sustainable changes in client behaviour. It was not possible to gather full quantitative data on impact (in fact it is a recommendation that such data is gathered), although activity data was gathered (see Appendix 3).

Finally, the evidence gathered for this evaluation was limited to a small sample of potential personalised care stakeholders in NEL; those who might have an interest in the role. Views from the majority of PCNs that chose not to employ the role was not available.

The Health and Wellbeing Coaches questionnaire results

Introduction

This section sets out the results of the questionnaire of HWbCs. In total 17 coaches completed the questionnaire – 68% of all those employed in NEL at the time of the evaluation.

Who are HWbCs?

The questionnaire gathered anonymous background information about the HWbC workforce. Fifteen respondents identified their gender as female, one as male and one preferred not to disclose their gender. In terms of age:

- 1 coach was aged between 16-24 years old
- 6 coaches between 25-35
- 6 coaches between 36-45
- 3 coaches between 46 and 55
- 1 coach between 56-65

Eight of the sample were White/White British, seven Asian/Chinese/Asian British and two Black/Black British. In terms of hours of contracted work:

- 1 coach worked between 9-16 contracted hours a week
- 4 coaches worked between 17-30 hours
- 11 coaches worked between 31-40
- 1 coach worked over 40 hours a week

The HWbCs were asked to state what the highest level of qualification they possessed was when they began working as a coach. Fifteen responded and the qualifications they had acquired prior to employed are set out in Table 3.1. These range from Regulated Qualification Framework level 3 qualifications, those equivalent to A Levels, up to level 7, equivalent to master's degree. Most (n=13) held qualifications at degree or above level. Only five of the sample possessed a coaching qualification prior to employment, the rest did not.

Table 3.1: Highest formal qualifications held by coaches

Qualification	Number	Subject detail (where specified)
A Levels	1	
Coaching diploma	1	Level 4
Degree	8	Psychology (n=2), French and Portuguese
Postgraduate diploma	2	Equal Opportunities/ Public Health & Nutrition
Masters' degree	3	Neuroscience

Employment arrangements

Nine HWbCs worked and lived in the same borough, eight did not. Nearly half (n=8) used a language, in addition to English, in their work. The questionnaire also asked the coaches who employed them. HWbCs reported a variety of arrangements. The majority (n=9) were employed directly by a PCN, six were employed by an external agency (such as The Shoreditch Trust) and two by GP Federations.

Respondents were further asked whether they worked closely, or not, with a number of other roles. They were also provided with the option to include other roles if they worked with them. The results below combine those saying that they worked "very closely" and "closely" with a role identified in the questionnaire:

1. SPLW – 94% of HWBCs surveyed stated they worked closely of very closely with this role
2. GPs – 71%
3. Receptionist – 65%
4. Care Coordinator – 49%
5. Healthcare Assistant – 47%
6. Practice Nurse – 29%
7. Health Trainer – 6%

The other roles and services that HWbCs identified that they worked with were:

- Health Coach (n=1)
- Family Wellbeing Practitioner (n=-2)
- Occupational Therapist (n=1)
- Dietician (n=2)
- Talking therapies (n=1)
- MIND local area teams (n=1)
- Public health (n=1)

HWbCs experience of work

Respondents were asked to state the extent to which they agreed or disagreed with a series of statements related to their experience of work. They were given the option to choose "neutral" if they did not have an opinion. The statements were drawn from research into the people management interventions that characterise "good work" (discussed in section 2.4.2).

The results are set out in Table 3.2. The table combines those stating that they "strongly agreed" or "agreed" with each statement.

With the exception of supervision, induction and access to training, it can be seen that the HWbCs who responded to the questionnaire had a positive experience of work. Asked whether they would recommend becoming a coach to other people, 13 said "yes", four said "maybe" and no one said "no" (see the answers to the open questions for further information).

Table 3.2: HWbCs experience of work

Statement	% Who Agreed
I received a welcome pack on employment	53
My efforts are recognised	82
I am able to input into discussions	82
I have been able to attend appropriate training courses	35
My post's roles and responsibilities are clear	65
The need for my role is understood	75
I feel supported by my practice	65
I feel supported by my employer	65
I feel I am part of my PCN/practice team	70
I am able to access accredited coaching training	88
I am regular supervised	18
I receive positive feedback	59

The impact of the role

HWbCs were asked whether they agreed or disagreed with a series of statements linked to the potential impact of their role. Table 3.3 shows how many respondents (%) either "strongly agreed" (SA) or "agreed" (A) with each statement.

The results show that respondents had a clear view that their support was having a positive impact on clients, assisting them to make health and well-being related behaviour changes through goal setting, onward referrals, and signposting. The majority also strongly agreed or agreed that their role had a positive impact on other primary care staff.

Table 3.3: Perceptions of the impact of the role

Statement	SA (%)	A (%)
Able to support changes to health-related behaviours	88	12
Help people to reflect on their health-related behaviours	65	18
Deliver long term changes to health-related behaviours	53	29
Reduce GP workload	53	29
Reduce the workload of other practice staff	35	35
Support changes to wellbeing related behaviours	82	18
Help people to reflect on their wellbeing behaviours	88	12
Deliver long term changes to wellbeing related behaviours	76	6
Increase access to wellbeing opportunities	65	29
Improve access to care	31	50

Free text answers

To explore in more detail HWbC's experience of work and the impact of supported self-management, the questionnaire included a number of free text questions.

HWbCs experience of employment

HWbCs were asked whether there were any issues that they wished to raise in respect of their experience of work. The only issue raised by more than one person (n=3) was about role clarity:

The role of the health and wellbeing coach is haphazard. The role I was employed to undertake was not clarified nor thought through - there is still a great deal of underpinning knowledge required for GPs and other medical practitioners.

I think the role is not clearly defined and with most practice staff there is an assumption that coaches should attend to patients in the same time (10 mins or 20) as the clinicians which does not do justice to my role as a coach. I would like 30-40 mins, but I have managed to make a case for 30 mins now during a PCN meeting and am doing much better consultations now.

I have complete autonomy of my role which I appreciate, however there has been a clear lack of clarity over what the role of a H&W coach is so my focus has been to establish this structure and communicate this to all practises and set a precedence moving forward.

Further insights into how the employment of role might be improved were provided by the answers given to a question asking HWbCs why they would – or would not - recommend the role to someone else. It should be noted that the majority of the responses to this question were positive (see Box 2), however four respondents stated why they would recommend the role:

Only if the infrastructure was sustainable and the role was protected in terms of supervision and training.

If the appropriate induction and training is done prior to allocating patients along with supervision, I would strongly recommend the role.

I think that the majority of patients referred in are in quite challenging life situations and can present as distressed - this kind of work is not for everyone. You need to have a stronger motivation than just to get paid to do this kind of work; it needs to align with your values and the direction you want to go.

If the person valued working with people closely by encouraging and inspiring others then yes for sure.

Box 2: Why coaches would recommend the role to other people

The majority of HWbCs completing the questionnaire were positive about their role and said that they would recommend it to others. Below are the explanations each gave for why they would recommend being a HWbC to others:

It's a satisfying job role I find it fascinating and very rewarding mostly

It's the best form of preventative and integrated medical approach and we can make a huge difference to the lives of our patients and reduce the load on Doctors and NHS in general. It's the way forward for personalized and quality care. It's a very fulfilling job. I would recommend it to all those who like to coach/counsel and are happy to work with people in their community

It is a diverse role and would fit anyone from any background

I am very enthusiastic about the role. I think we could affect positively people's life

It is a very rewarding role that has a direct impact on clients

I have already talked fondly about this role and two of my friends from my Master course have become Health and Wellbeing coaches for the NHS in the last 6 months

I have on-boarded many friends, family and colleagues into the HWB role across different areas of the country I have a wide network of allied health professionals

There is very much a need for more HWBCs

It is a very fulfilling role, working with people and making a positive difference in some way

It is a rewarding post to work in

The impact of supported self-management on clients

Asked to explain the impact they had on clients, HWbCs were able to clearly articulate the effect their role was having, (the full set of answers given to this question are set out in Appendix 1):

I have worked with people who have not slept for years and after sessions they sleep, people have managed to begin to leave the house to walk, incorporate mindfulness practice into their daily life, give up smoking, return to work after long absence, take up meditation, understand the way their physiological self-works and develop healthier relationships

I have helped hundreds of people achieve weight loss and thereby reduce/manage their elevated lipids, blood glucose, bp and prevent CVD, DM and many other health conditions related to obesity (mental health, back pain, OA, cancers) Encouraging them to eat healthily and be physically active it helps control their fatty liver and risk of CHD

One patient above 50, obese, OA, hypertension (taking medication) was able to lose weight, started including exercise in her daily routine as well as healthier meals, and after 12 interventions her blood pressure was normal - not taking medication - and decided to start studying to open doors for her professional life. Also, this patient was able to improve her mobility in the upper body, and her pains decreased

We have been tracking outcomes from the wellbeing service Year 2020/21 delivered lifestyle interventions to 300+patients 100% reported excellent patient experience 87% of patients said the interventions were effective and have improved their health and wellbeing, confidence, 90% of patients were able to get the help they needed (holistic service)...For example, patients who have suffered trauma 2-3years ago did not have access to therapies. Having attended the service patients were introduced to effective coping techniques that initiated the healing process

Patients who were unsuccessful at weight loss programs have shown improved weight loss through the service because they feel supported and motivated, also empowered. Patients with IBS who have had trouble with coping with symptoms have reported improvements through dietary changes Patients suffering from grief and loss have reported transformation through the coaching experience. Many patients who chose lifestyle interventions over medication are referred to me. I have a 100% success rate

Furthermore, the HWbCs were clear that it was a health coaching approach that helped people, reinforcing the principles underpinning personalised care:

Patients have a space to first talk and feel listened too, once a rapport has been established, patients feel more confident to open up and try the coaching model once it has been understood

I enable people to reflect and understand their anxiety related behaviours and make changes. Coaching involves step changes and I use many tools to do this

It also helps them see the link between food and mood & improve their mental health by giving them a safe space & time to speak re: their health concerns and feel 'heard'

My patients report feeling heard, finding out about relevant and helpful services, finding new techniques to manage stress, having some accountability for the actions, thinking about what they want/their goals and feeling supported

The role provides a safe space and dedicated time for patients to share an overview of their life and what areas are contributing to the pressures that impact their wellbeing. Patients have commented how they have felt heard, supported, and not judged for feeling the way they do

The impact of the HWbC role on other primary care staff

There was a clear consensus amongst respondents that their role had a positive impact on other staff, particularly GPs (see Appendix 2 for the full answers to this question):

[We are] taking the pressure off them

Reduces returning interaction with patients where prescriptions are not needed to treat health

[We are] Reducing their workload

The HWbCs felt that the role created new options for GPs to refer clients who would benefit from the supported self-management approach. As one coach explained:

They [GPs] feel they can refer those patients to me who they are not able to give more time to but who need more attention and hand holding where change in lifestyle is concerned as it's not very easy to just advice in 10 mins and get someone to lose weight or change their eating habits which are poor since many years or all their life

Another said:

My role has reduced the 'headaches' GPs tend to deal with which medication fails to address. such as the lifestyle or social and housing issues that contribute to a person's wellbeing. We have demonstrated that the roles are reducing the work pressure load on the system Nurses feel supported. Practice managers have commented the roles are adding value to patient experience The PCN is overall extremely impressed with the wellbeing team – I am the longest-standing employee since its conception

Barriers to the full utilisation of the HWbC role

HWbCs were asked to list any barriers they felt inhibited their role's full deployment. These are listed in Table 3.4. It should be noted that some of these are linked. It was felt that lack of awareness of the role led to inappropriate referrals, for example. The issue of inappropriate referrals was explored further in the interviews and is discussed later. 'Incidence' in Table 3.4 refers to the numbers of times the issue was raised.

Table 3.4: Barriers to deployment identified by coaches

Barrier	Incidence
Inappropriate referrals	8
Workload	4
Awareness of the role by GPs and patients	6
Lack of sufficient time to support clients	2
Lack of leadership	2
Supervision	1
Funding	1
Lack of mental health training	1
Lack of Social Prescriber in PCN	1
Lack of space	1

HWbCs were asked if there were any other points that they wanted to raise in respect of their employment and deployment. Several reiterated issues that had previously been mentioned, such as supervision (n=3) and awareness of the role amongst GPs (n=3). One coach felt that there was a need for:

Clear communication on what the role is, and more communication with doctors at the practises to feedback from both sides. At present no communication with doctors, only referrals

Other issues raised were:

MUCH better induction - e.g. systems such as EMIS, coding, diagnostic tools (which ones to use), standardised health Coach referral pathway, time of sessions clear, funding

Focus on sustainability in terms of managing caseload numbers. -Expanding the number of coaches which allows us to share caseloads and frees up time to accomplish other parts of the role such as networking and outreach opportunities

Lack of career progression - and financial remuneration based on experience and delivering outcomes experience is not taken into consideration as this is 'new' and 'alien' to the NHS Lack of ARR leadership - people have been appointed roles [without] adequate experience

Stakeholder self-completion questionnaire results

Introduction

A self-completion questionnaire was sent to individuals, including GPs and PCN managers, with a potential stake in the employment of HWbCs, to gather their views on the role, including from settings that had chosen not to deploy them. In total 19 people completed the questionnaire (a 20% response rate).

Eight respondents were from Tower Hamlets, four from City and Hackney, two each from Redbridge and Barking and Dagenham, and one each from Newham, Waltham Forest and Havering. Of the respondents thirteen came from settings that employed coaches and six from those that did not. Of the six who did not currently employ them, three indicated that they would like to and two that they "might". One respondent had sought to recruit a HWbC but had "no takers".

Reasons for employing a HWbC

Respondents were asked to state why they had decided to either employ or not employ coaches. The answers are shown below:

Reasons for employing

1. To improve patient care (n=4).
2. Funding was available (n=1).
3. Wanted to provide more personalised care to local population (n=1).

Reasons for not employing

1. Lack of clarity about how the role could be used (n=1).
2. Perceived challenge of integrating the role with the team (n=1).

Respondents provided further insights into the role when answering an open question asking them to explain why the role would have a positive impact on client's health and wellbeing[14]. The most frequently cited (n=7) reason was that coaches improve health outcomes, as the following quotes illustrate:

...patients are being seen quicker, health coaches are offering support one to one and group sessions, patients are happy with their care, I am happy there is a health and wellbeing coaches within the practice to support our patients and supporting myself to give the patients help when needed

Most chronic diseases and mental health burdens can be reduced through lifestyle choices

If we approach healthcare from a holistic point of view, health and wellbeing coaches would enable patients to improve their personal health which would have greater outcomes overall

Enhancing the contribution of HWbC

Respondents were asked – 'What do you think is necessary to ensure Health and Wellbeing Coaches can fulfil their potential to assist people change behaviours that are affecting their health and wellbeing?' All stakeholders responded to the question (n=19) although one stated that they felt there was "no need for the role".

The areas identified are set out in Table 4.1. A third (n=6) of respondents felt that a key issue was awareness of the role, lack of which meant that practices were not always engaged with it and that referrals were not always appropriate.

Table 3.4: Barriers to deployment identified by coaches

Factors	Incidence
Better understanding by PCNs/ practices of the role	6
Coaches to have more time with clients	2
More training	2
More supervision	2
Greater community engagement with community assets (e.g., gyms)	2
Coaches should be embedded in PCN strategies	2
Practices within PCNs to work more closely together to support coaches	1
More space for coaches to work in	1
Create formal wellbeing teams	1
Additional resources and training	1
Coaches to provide more feedback to other PCN staff	1
More peer support	1
Incentives for GPs to recruit coaches	1
Ability for Practice Nurses to refer to coaches	1

What needs to happen to expand the deployment of HWbCs in NEL?

Perhaps not surprisingly the proposal most frequently mentioned (n=9) was the need to promote the role. Two respondents suggested that impact evidence was needed. Other proposals mentioned (all by one person each) were:

- HWbCs to work more closely with the wider health team, such as Occupational Therapists and Health Visitors, so that they are more aware of the role.
- Increase the number of HWbCs employed to increase their impact and visibility.
- Create formal wellbeing teams.
- Improved leadership.
- Provision of incentives for employing the role.

One respondent, whose PCN already employed a HWbC, made the point that in their case it was important that there was a period of stability, rather than expansion, to allow the role to embed.

Client support

Respondents were asked to list the conditions and issues that, in their opinion, HWbCs could effectively support. Respondents (n=17) identified the same range of conditions, such as Long-Term Conditions (particularly diabetes), anxiety and mental health issues, that coaches were already supporting (see Box 2 and Appendix 3 for details of the full range of conditions supported).

The point was made by three respondents that there was value in earlier interventions by coaches to avoid conditions becoming acute:

The patient doesn't always have to be diagnosed with one or two LTCs before working with a HWBC, the patient requires support before the issue becomes a lifelong problem

Other points

Respondents were asked if there were any other points that they wished to raise about the role. No new points were raised by the seven stakeholders who answered this question.

Most used it as an opportunity to make positive comments about the role – "[HWbCs] Improves the quality of service to our patients' for example. It should be noted though that one GP answered that they thought coaches were a "waste of time" and that "we don't need more nonclinical staff".

Given the number of stakeholder respondents it is not possible to know whether this is a minority view rather than one reflecting GPs more widely in NEL. It is worth noting though that, in contrast, another GP stated that "there are not enough of them". The first GP who made the negative comment did not employ HWbCs, the second one did.

The findings from the semi-structured interviews

Introduction

Semi-structured interviews were conducted with a number of HWbCs and personalised care stakeholders including GPs and Personalised Care NEL ICS leaders. The objective of these interviews was to explore in greater depth the evaluation questions.

For HWbCs the key questions asked were:

- What impact, if any, is your role having?
- Can you tell me about your experience of work?
- How would you like to see the role develop in the future?

Discussions were allowed to flow to enable respondents to raise issues and insights that were important to them. Prompts were used, where necessary. For example, HWbCs were asked, if they did not raise the issue unprompted, whether they felt other primary care staff were clear about the difference between each of the personalised care roles. Issues such as these were identified from the questionnaire responses.

Personalised care stakeholder respondents were asked - (1) why their PCN had decided to employ the role (if relevant), (2) what impact – if any - they thought the role was having, (3) what steps could be taken to improve the impact and, (4) what was needed to raise awareness of HWbCs and increase their deployment across NEL.

Thematic analysis was used to identify common issues, although all relevant points were recorded even if mentioned only by one participant. Five common themes were identified:

1. HWbCs are having a positive impact on outcomes and primary care workforce capacity .
2. HWbCs are generally positive about their experience of work.
3. People understand the difference between the various personalised care roles and why each is needed.
4. The referral process should be reviewed.
5. There were lots of ideas about how the role could – and should develop and scale in the future but also that there were also some risks raised.

A number of sub themes were identified with the broader five themes.

Theme 1 – HWbCs are having a positive impact on outcomes and primary care workforce capacity

All the HWbCs and personalised care stakeholders interviewed were clear that the role, and indeed personalised care more generally, was having a positive impact, and the reasons for that impact:

...in order to reduce any kind of long term condition: diabetes, heart disease, cancer, you've got to change your life style. So, you have got to eat more healthily, be more active. Find ways to reduce your stress...the clients being seen by coaches would have previously been seen by GPs...GPs will say that someone needs to manage their diabetes (that is what is a matter with them), but that doesn't fit in with what matters to you, you need to identify factors that do matter to them...they may not be happy at work which is acting as a barrier to their management. By supporting the little things that will have an impact on their diabetes (PCN Manager)

As a coach you come across to patients/clients from a different perspective, from a different angle...and yes there is a reason why they have been referred to us and sometimes a reason is a symptom in itself but you need to get to the underlying issues...I give them a lot of time and space and options. They always have options with me (Coach1)

Yes, there is a need [for the role] ...there are competent and confident...We feel the role is a positive thing for our PCN (GP2)

There's overwhelmingly lots of positives in how [the coaching role] has played out, particularly in terms of how the role has impacted on clients, I can just see this by talking to the coaches...this is a role that is making a real difference (SupportAgency1)

We're making a huge difference...Building that relationship with a patient is really important. When that patient is open to change its amazing...basically the doctors do not have a lot of time. A lot of the things that the patients need is not medication, it's behaviour (Coach 5)

All respondents felt that coaches were increasing primary care workforce capacity and reducing the workload of GPs (and other staff):

The role is a response to a shortage of GPs…they mean that there is someone who is helping manage demand (ICSstaff1)

Sub theme 1.1: Additional client needs are identified

The point was made by several respondents that HWbCs frequently identified other issues, beyond the original presenting one(s). These had not been initially identified on referral and represented potentially unmet need. GP2 made the point that HWbCs might, in fact, increase activity, or at least not reduce it, in the short term. They went on to make the point that without HWbCs demand would most likely be greater in the future, as the unmet needs became more acute.

Why was it that coaches were able to identify additional need? One HWbC thought she was able to identify additional need because people were not always willing to share information with a GP:

A lot of people don't want to come to a GP due to connotations of, you know, I am going to a GP, and I have to admit to this or that problem (Coach1)

Sub theme 1.2: There is a need for a long-term impact data

There was a clear consensus amongst the people interviewed (echoing the questionnaire results) that HWbCs were having a positive impact, even though it was "still early days" (ICSStaff1). Respondents recognised the need for robust data to be gathered on health and wellbeing and that there was a need to bring together existing quantitative impact data, for example that held by PCNs, to share and develop a longer-term outcomes metric.

This later point reflects the point already made that the impact of the role will unfold over the long term, for example manifesting in fewer GP appointments and hospital admissions, as well as improved population health:

It needs more time, [and] an evaluation framework that supports the workforce (ICSStaff1)

Furthermore, it was recognised that success might look different to different stakeholders. This was why, respondents said, there was a need to bring people together to agree outcome measures, particularly given that supported self-management represented a different approach to care. It was pointed out that primary care outcome measures were not always geared up to personalised care:

[Primary care] is not about a personalised approach but often about monitoring activity not outcomes…it's all about measuring efficiency targets…no one cares about patient experience or staff satisfaction. [HWbCs] are about doing something different, around, I guess, patient experience linked to wider determinants of health…Thinking about making a difference has to be at the core of it… then its not just about numbers of people…it's about the relationship between people" [ICSStaff1)

I would like everyone to be on the same page in terms of outcome measures…I think there are different expectations across the piece (SupportAgency1)

Theme 2 – HWbCs are (generally) positive about their deployment and employment circumstances

Sub theme 2.1: There are different views on why the PCNs adopted the role

PCNs through the ARRS had discretion as to whether they chose to deploy a HWbC or not. There were mixed views on why those that did, did. Discussions with PCN representatives suggested some were motivated by the rationale of personalised care and recognised the added value of the role:

Clinical practitioners will find out what's wrong with you, whereas a personalised care role will find out what matters to you. You need that balance of staff (PCN Manager)

Others felt that the availability of the role through national funding drove its adoption:

Because they are fully funded it was low risk: 'why not? We can take a punt (ICSStaff3)

This though had consequences:

Being 'additional' funded roles suggests an impermanence (ICSStaff4)

The stakeholder questionnaire results also suggested a range of reasons why organisations chose to deploy HWbCs.

Sub theme 2.2: HWbCs engagement with practice staff and practices can be variable

In an example of good practice, one PCN had set up monthly meetings with all their staff and the 'additional' roles they employed through the ARRS, including HWbCs. The reasons for this were the PCN Manager said, "so that they would feel part of the team". This approach was further seen as a means to raise awareness of the roles with other staff such as Physiotherapists, which in fact it did.

Following the establishment of the monthly meetings referrals to HWbCs increased within the PCN's practices. This level of awareness and engagement was not, however, universal. Some HWbCs reported that it was difficult for them to formally meet other staff to discuss their roles. One, for example, had sought unsuccessfully to speak at their weekly PCN GP meetings, for a year, despite repeated requests.

Two HWbCs reported that they experienced different responses to their role in different practices within their PCNs. Some practices referred clients, but some did not, although in one case the coach said this was changing. "Word about the impact of my role seems to be getting around", she said.

One participant noted, talking about the personalised care agenda more generally, that some GPs "get it" and some do not (ICSStaff1). The SupportAgency respondents noted that practices within PCNs and different PCNs "all have their own ethos and culture of working which can be very different".

In all cases, the HWbCs interviewed reported that they felt it was their responsibility to be "proactive" in promoting their role:

...at present it feels like the coaches are holding the weight of the role (SupportAgency1)

I'm being almost like a sales agent (Coach 5)

It has felt that the burden of responsibility has fallen on the roles to prove their worth (ICSStaff3)

Sub theme 2.3: HWbCs are generally content with their employment

All the HWbCs interviewed were specifically asked about their experience of employment and what, if anything, could be improved. As reflected in the questionnaire responses, the coaches were on the whole positive, including specifically about the support they received from The Shoreditch Trust:

Clinical supervision by The Shoreditch Trust has been really useful. I have learnt a lot (Coach2)

The issues that were raised are set out in Table 5.1.

Table 5.1: Employment issues raised by HWbCs

Issue	Details
Pay	"Pay scales should be at least Band 5. We carry our own case-load" (Coach1).
Feedback	HWbCs would like to be observed in practice by another coach to get professional feedback – "you have to assess your own impact" (Coach3). This was seen as particularly important because the coaches were "beginners" (ICSStaff2).
Terms of employment	The need for more consistency in terms of contracted hours of work, holidays and management of sickness absence.

An ICS lead described why they thought deployment could be an issue in some settings, saying that this might be due:

Partly due to poor understanding of the role, partly Covid, partly lack of management time and support...and that this is a new role and there isn't a well-defined national criterion for what a Health and Wellbeing Coach could be, what is the top and what is the bottom of their expertise (ICSStaff2)

Theme 3 – There are clear differences between the personalised care roles, and each is needed

There was no evidence from the interviews that stakeholders or HWbCs were confused by the different personalised care roles. Overlap between

roles did exist, with, on occasions, HWbCs taking on a social prescribing role and vice vera, but this was not seen as an issue in most cases.

...whilst there are distinct differences between the different roles, there is also a grey area, which I am fine about...Health and Wellbeing Coaches have different skill sets, different strengths [to other personalised care roles] (PCN Manager)

The same PCN Manager said that they saw the coach as existing "under an umbrella" of a number of roles centred on providing personalised care roles. Their PCN was about to employ a Mental Health Practitioner as it was perceived that there was a gap in the team to support people with severe mental illness who did not need secondary care.

The SPLW interviewed contrasted the limited time SPLW had to see clients compared to HWbCs. They saw the coach role as an opportunity to additionally and more deeply help clients. The example of a coach supporting someone to ensure that they followed-up a benefits request was cited. Coach3 reported that when her PCN lost their SPLW, her workload rose. This shows, at least in this case, that refers were able to distinguish different client needs on the basis of presenting issues, but also a workload risk when vacancies arose. The SPLW said they were clear of the complementary benefit of both roles:

[They] are a great support for our role [and] greater support for our patients. They are another support mechanism for our role and vice versa. (SPLW)

HWbCs were also positive about SPLWs:

The Social Prescriber role is just as important as the coaching role (Coach2)

Theme 4 – The referral processes should be reviewed

A persistent theme raised by the HWbCs was that they could sometimes be referred clients whose circumstances required greater support than they could provide. Sometimes it was felt this was because GPs were not fully au fait with the role, and at other times because there was nobody else available to see these clients:

We are not an acute service. Our clients should be stable, enduring and long term...the wellbeing team can be seen as a 'dumping ground' (Coach1)

We are not meant to see people in crisis, but because the NHS, primary care in particular is in firefighting mode at the moment and a lot of people who do present at GPs are in a really difficult life situations...they are the people the GPs think 'where can I send this person' who clearly needs more support that I can give (Coach2)

More than one coach described being referred people who were experiencing a crisis. The coaches did their best to support such individuals:

It's a case of everybody pitching in and everybody doing the best they can...sometimes it's not the coaching, but just being there for someone (Coach2)

GP1 raised that it was the responsibility of GPs to risk assess clients prior to referral. They made the point that it was important that coaches had the appropriate training to assist people with particularly mental health issues, which they thought "can be a little overwhelming".

The issue of referral processes is complicated, however. The HWbCs were not keen to unduly limit the people they saw. They recognised that whilst a 'symptom' like hypertension might be clear, it was possible, and indeed desirable, that coaching sessions identify further issues that may need addressing.

However, in saying that it was apparent that some referrals were clearly not appropriate, placing pressure on the HWbCs and limiting the impact of their intervention (due to the individual's circumstances). To address this the coaches felt that:

1. GPs (and others) should be clearer about the type of client HWbCs can and cannot support. This is linked to raising awareness of the role.

2. HWbCs should receive more information when referrals are made about the client. Currently, one said, "we get a few words with a task" (Coach2).

The referral issue also touches on the related issue of the autonomy of the role anad its newness. HWbCs acknowledged that they could refuse referrals they felt were inappropriate but felt that it was hard to do so in a new role that was seeking to 'prove its worth':

That's the hard thing about starting a new role and being a pilot, having the confidence to set boundaries…I could have rejected more referrals than I did but being in a one-year programme, I really wanted to make it work. I really wanted to help the GPs when they wanted help, rather than say 'it's not appropriate' (Coach2)

Theme 5 – There were lots of ideas about how the role should develop and scale in the future but also that there are some risks

Sub theme 5.1: The need for a strategy

Perhaps reflecting the enthusiasm for the role from those interviewed, there were a large number of suggestions about how HWbCs could develop in the future (see Box 3). There was a strong view amongst stakeholders about the need for a long-term personalised care workforce strategy for NEL. This needed, the PCN Manager said, to set out "what they are doing and where we go from here".

All but one participant felt that this should be co-produced jointly by NEL ICS, PCNs and employers such as The Shoreditch Trust, with coaches and service users. One participant, though, believed the strategy, should be London-wide. Such a strategy could include a consistent approach to training and the role's broad scope of practice, although allowing for local flexibility.

Aligned to this strategy[15] it was also proposed that guidance should also be provided by NEL ICS on the personalised care roles, including HWbCs, for PCNs who have not yet deployed the role:

… [there is need for] a bit of education, back to basics, explain what the role can do…'here's the scope of practice we think is appropriate for east London. Its not mandatory but it's a starter for ten', then let them [PCNs] run with it, let them go and decide what they want…to meet local needs (ICS2)

Whilst there was support for an overarching strategy and vision, there was a strong feeling that this should be "bottom-up" and allow a degree of flexibility to allow local population health needs to be reflected in the coach's role:

There is a need for an overarching strategy, but that strategy needs to be flexible…there is a need for some consistency and standarisation across the whole piece and some support externally to set the tone for how these roles are embedded and senior buy-in. At the same time what people don't want to see is a rigid approach…people bring different things to the role…people need to be able to react and adapt to local circumstances (SupportAgency1)

Box 3: Future development of the coaching role

- Greater use should be made of virtual group consultations.
- Coaches should be given the opportunity to rotate between different PCNs across NEL.
- Consideration should be given to designing 'specialist' coaches alongside 'generalist' ones. This was already developing informally. In one PCN where there were a number of coaches employed, one had begun to specialise in supporting people with mental health issues. In another PCN, one coach specialised in nutrition (here three coaches were employed). This could be expanded to other areas (with education support) such as children and young people and health and fitness.
- Coaches should take a more active role in prevention, for example supporting people who are pre-diabetic.
- Formal wellbeing teams should be created.
- There is a need for formal career progression routes.
- Longer should be taken to prepare new employment settings for the role to help embed it.

Participants supported the expansion of the role across NEL. This included PCNs investing in larger teams:

…one coach in a PCN…seems like a drop in the ocean (SupportAgency1)

One person believed that a greater distinction should be made between the "health" and the "wellbeing" elements of the role:

Health and wellbeing are two potential roles that are wrapped up in one, and the assumption that this skill set resides in one individual is problematical (ICSStaff3)

Sub theme 5.2: There are risks to the role's sustainability

Risks were identified that could inhibit the further development and expansion of the role, most notably the lack of sustainable funding, which was mentioned by almost all participants:

The very fact that this contract that we have has to be renewed on a yearly basis is not conducive to a good programme delivery because you are putting people under tremendous stress for no reason. Let us be fixed for three, six years, let us do evaluations and then tell us 'If you guys are doing a good job' (Coach1)

Other risks mentioned were:

- A lack of a stable workforce infrastructure in primary care.
- Lack of system's leadership to promote the role.
- Lack of "firm" impact data.

Other information

Introduction

Anonymised exit interview information and feedback gathered at a network meeting of the NEL coaches in 2021 were reviewed. Insights from both support the wider findings of this evaluation.

Exit interviews

Information was provided anonymously from five individuals who had left their coaching role. Whilst the amount of information provided about their experience of being a HWbC varied, most were positive about the role and employment.

For example, they felt valued by their team. The issues that were raised varied by individual, underlying again the importance of local context. Issues raised in the questionnaire and interviews also appeared in exit interviews, for example the lack of awareness of the role:

The most challenging part came from NHS/PCN side. With this being pilot, having to get GPs on board. The workload and how GPs referred and unrealistic expectations. There is a culture of dumping patients that aren't appropriate, outside our remit. This is time-consuming. (Staff2)

One leaver raised issues about on-boarding and training:

I didn't know anything about PCNs, this was the most mysterious part, this was the gap in my knowledge. It may help to have one other line about mental health knowledge, this is an important issue and skill needed from practitioner.

The demographic we work with there are a lot more social and mental health issues to address in order to address physical health issues…The 3-day training wasn't always relevant, too picture-perfect. That training didn't acknowledge the complexity of population and work. (Staff2)

Staff1 reported in their exit interview that they had received no training, mentorship, and very little supervision.

Workload pressure was also raised by two leavers. Staff1 mentioned another HWbC had left the role "due to burnout". Another said:

Time can get very booked up and is out of your control. There aren't that many opportunities to have informal chats/support with colleagues. Rare to get together with people face-to-face in office, informal, unstructured time together. (Staff4)

Staff4 reported that they were leaving because they felt that "I have learnt what I need to and the role won't deliver new challenges". This points to the need to consider future career development and progression.

Feedback from the coach's network

Feedback was gathered by the NEL ICS and The Shoreditch Trust in 2021 from HWbCs who attended the first dedicated HWbC network meeting about the issues that they faced. Issues raised, with one exception, were the same as those that have emerged from this evaluation (see below).

The new issue was about language differences between coaches and clients, which it was felt could inhibit the efficacy of support. Given the rich diversity of communities in East London, this issue may warrant further investigation. The full list of issues raised at the network meeting were[16]:

- *"A big gap in understanding of what coaching is and a clash of cultures - the language of wellbeing vs language of health/medicine, which can lead to GPs not understanding what coaches do.*
- *Actual language difference is also a big issue. Coaches work in massively diverse communities - sometimes even with an interpreter it can be difficult to meet needs fully and this impacts on equal opportunities.*
- *It has been challenging to negotiate the different ways of working across practices- each practice operates differently and has its own culture and expectations of the role.*
- *Appropriate supervision specific to the needs of coaches has been a key challenge- although there are national guidelines it's not always clear where and how to access locally and provision of supervision is inconsistent across the piece as a result.*

  For some coaches, clinical supervision has been available, but this doesn't reflect an understanding of the role and its holistic approach - it's useful to discuss complex clients with clinicians/clinical supervisors, but specific coaching supervision is missing.

- *There has been a mix of levels of general support for the role from very little to a lot - some coaches did not receive clear guidance on what to expect, based on real understanding of the role and remit. Support has ranged from a good induction and a good level of support and training, to starting in role with no JD, no support or training and being the only coach in a borough with no other HWBCs to relate to.*
- *A lot of referrals have caused challenges in managing capacity and maintaining role remit. "*

HWbCs also highlighted what they thought was working well about their role:

- Support from other HWBCs- sharing the load and sharing expertise and the wider multidisciplinary and wellbeing team.
- The variety of the role.[17]
- High levels of satisfaction in the context of difficult challenges in establishing role remit and identity.
- Feedback from clients.
- "Showcasing stories in the context of presenting the role at key PCN/practice meetings has worked well for bringing the role to life".

Activity data

The Shoreditch Trust gathers data on the background of clients seen by the coaches they employ, the nature of presenting issues, goals set and signposting/onward referrals. This data is summarised in Appendix 3 and provides an insight into the breadth of activity undertaken by HWbCs.

Discussion

Introduction

This evaluation sought to address the following four questions:

1. What impact have Health and Wellbeing Coaches had on the clients who have received support?
2. How has this role impacted on the work of the wider primary care team?
3. What are the challenges being faced by the Health & Wellbeing Coach workforce in their places of employment?
4. What progress has been made in integrating personalised care roles into primary care settings?

This section brings together the evidence from the evaluation to address each of these questions.

What impact has Health and Wellbeing Coaches had on clients who have received support?

All the participants in this evaluation believed – and could demonstrate – that the role was making a positive difference to client's health and wellbeing. In fact, numerous participants used the phrase "making a difference" when describing coaches and health coaching. The case study in Box 4 is a good example of how supported self-management is having a positive effect on clients.

Box 4: Case study

Coach4 in an interview explained that a GP might tell a patient "*You have diabetes, you need to lose weight*". That patient might be referred to a diabetic programme where they would get *"loads of information, but how do you translate that into your life?*

That is what I do as a coach. I look at what you are already doing … 'let's look at where you are, what you can do'. It's very much incremental changes to your life. People from the BAME community might be told to eat more vegetables of a type that they don't eat like cabbage and carrots. Coaches can adjust to client groups, for example, by being sensitive to particular diets, cooking methods, recipes".

For one session Coach4 walked around a supermarket with her client to help her make the "right" choices, but choices that were relevant to her lifestyle, religion and diet.

More generally talking about the impact of coaches and health coaching, Coach4 said:

Patients feel heard for the first time and understood and then they are motivated…they understand that they set the goals…which I support…sometimes its light touch and sometimes it's more structured – how to fit in time for that extra walk or cycle ride or batch cook so they don't get a take away every night. If a client gets really into it, you can see those results quite dramatically. Sometimes its small steps but then it's like a snowball.

A persistent issue raised by HWbCs was that on occasions they were referred clients who required more or different support and care than they could give. Whilst it was not possible for the evaluation to gauge the magnitude of this issue, further thought needs to be given to referral criteria and information.

Linked to this is the fact that clients frequently present multiple needs linked to the wider determinants of health and well-being. Less than half of the clients supported by Shoreditch Trust HWbCs presented with just one issue (see Appendix 3).

As one participant said, "*complexity feels like such a key issue that I wonder if we should be acknowledging more clearly the impact of health inequalities, clients who experience multiple levels of need and often challenges to basic essentials of life- food, income, housing, connection that are feeding into risk and management of long-term conditions*" (SupportAgency1).

Looking further ahead, a number of participants argued that the biggest impact the role could make was in prevention rather than management of existing conditions.

As one system lead put it: "*Helping those on the trajectory to poor health outcomes, whilst noting that those who already have poor outcomes need support as well*" (ICSStaff2).

Box 5: Co-creation outcomes

Between 2007-2011, the Health Foundation led a programme to support people with long term conditions to self-manage.[18] The evaluation phase of this programme's pilots identified the following outcomes arising from the approach which included supported self-management:

- People with depression in one area used significantly fewer consultant appointments and bed days and had reduced anxiety and depression. In another locality people were less likely to have consultations with specialists at the mental health trust.
- People with diabetes had improved clinical outcomes (glucose control, lipids, and renal function).
- Several sites reported reduced "did not attend" rates for appointments since the programme was introduced, particularly where individuals had received agenda-setting prompts prior to their appointments.

How has this role impacted on the work of the wider primary care team?

Whilst data on the actual number of GP and hospital visits saved because of the interventions of the HWbCs has not been collated, participants felt that the role was indeed reducing the workload of GPs and also building primary care capacity and improving access to care. It is not difficult to get a sense of the potential magnitude of the impact of the role.

One of the main Long Term Conditions coaches provide support for is diabetes. Diabetes UK estimates that the disease costs the NHS £14 billion per year[19], mainly due to complications such as sight loss and amputations. Around 4.7 million people in the U.K. have diabetes. Very roughly, diabetes costs £3,000 a year for each person.

HWbCs help people to manage their condition (and with early intervention could help people who are pre-diabetic). NHS England estimate that every visit to a GP, in 2019, cost the NHS £30.[20]

Box 5 provides evidence of the potential impact of supported self-management interventions including for clients who are diabetic. Another common issue coaches work with clients on is weight management, which costs the NHS an estimated £6.1 billion rising to a projected £9.1billion by 2050.[21] One PCN was using coaches solely to address weight management.

As noted already HWbCs reported that their work with clients had resulted in new needs being uncovered, for example – for physiotherapy, talking therapies or social prescribing.

Whilst this represents an increase in demand, the meeting of need, which would not have happened if the coaches had not been in post, is likely to reduce demand in the long run, as well as, of course, improving the quality of life for clients.

What are the challenges being faced by the Health & Wellbeing Coach workforce in their places of employment?

Section 2.4.2 set out the features of employment that constitute 'good work'. The results from the questionnaires, HWbC interviews and the exit interviews suggest that coaches do feel valued and that they have a positive experience of work (see Table 7.1).

This is not to say that there are not some people management issues – supervision, access to training, induction and pay levels were all raised – which need to be considered, but generally coaches are satisfied with their job.

Almost all would recommend becoming a HWbC to someone else, for example. The level of satisfaction is particularly striking given the precarious nature of funding for the role and its newness.

Given the small numbers of coaches in post it is not possible to discern the extent to which there may be a 'halo effect' operating from recruitment of an initial cohort of staff. It was certainly clear from the interviews that the HWbCs are extremely dedicated and committed to making a difference.

A number of coaches said that they would like more professional feedback on their performance, perhaps through peer review. Whilst they felt valued members of their team, all of those interviewed were frustrated that they could not engage more with the GPs in their PCNs.

The questionnaire suggested a high level of connection with GPs so this issue may be more about the quality of contact rather than frequency, although evidence was found of HWbCs who were unable to meet with their GPs.

An issue for the near future is likely to be the need to address the current lack of career development opportunities for HWbCs. This was cited explicitly by one leaver in their exit interview who said, "I have learnt what I need to, and the role won't deliver new challenges". Ideas to develop the role included formal creation of specialist coaching roles (which are informally emerging), more senior coaching roles and the opportunity to rotate.

The recent (June 2022) production of the Workforce Development Framework for HWbCs which includes career stages (based on experience) and a competency framework provides an opportunity for a focused discussion on the future development of the role and its learning needs.

Table 7.1: Evidence that coaches experience "good work"

Characteristic of good work	Evidence
Staff can input into decisions that affect how, when and what work is accomplished.	Yes
Reasonable work demands and working hours.	Yes
Clear role descriptions	Yes (although some issues around scope of practice)
Use of skills	Yes
Access to training	No
Staff perform a variety in tasks.	Yes
Staff have support from coworkers.	Yes
Job security	No

What progress has been made in integrating personalised care roles into primary care settings?

Even assuming that the attitudes expressed towards the HWbC role are a proxy for attitudes towards personalised care more widely (and if they are this would suggest positivity from those who participated in the evaluation), it was not possible to answer this question comprehensively for NEL, due to lack of data from the wider primary care workforce.

Just one GP responding to the stakeholder questionnaire was opposed to the role, describing it as "a waste of money", however the small response rate (20%) means no wider conclusions can be drawn from that source.

It is clear, though, from the coach's questionnaire and the interviews that, in the words of one system lead, many primary care staff "get it" but also that "...some people need to be convinced of the principle [of personalised care]" although "most don't" (ICSStaff2).

It was striking how many HWbCs reported that not all the practices within their PCN made use of the role – at least initially. "I still get no referrals, not one" said Coach 5, talking about a practice in her PCN.

This suggests that even where coaches are employed, not everyone engages with personalised care, although these practices are a minority. One coach did report that over time, they had been able to demonstrate the value of the role to colleagues who were not engaged at first.

This had led to referrals from practices that previously had not referred. However, this meant that participants felt that the "burden" (SupportAgency1) of promoting the role often fell on the shoulders of the coaches and that this needed to be shared more widely.

Stakeholder participants saw the HWbC as an alternative and necessary option for GPs to assist people, for example with weight management or anxiety, where traditional approaches would not work. Such cases may comprise a fifth of people accessing general practice.[22]

They also understood the role's place and contribution in the context of personalised care more generally and were clear of the distinction between the various personalised care roles, perceiving them collectively as a 'well-being team'.

The word "umbrella" was used by more than one participant to describe this. There were suggestions that more formal teams should be created, and often it had been left to the HWbCs to identify other staff they needed to engage with.

It was recognised that some overlap between the personalised care roles was inevitable, but this was not seen as a bad thing – "an overlap is better than a gap" (ICSStaff3).

More generally, participants felt that it was appropriate and efficient that, for example, SPLWs undertook some coaching within the context of their role, and coaches performed some sign posting. Fundamentally though participants were clear of the difference between the roles:

I *think there is enough distinction between them, they all have a different skill set to apply (ICSStaff2)*

One participant saw the value of all the personalised care roles, but perceived the HWbC as central:

I can absolutely see why you would put the three roles together. I think they work really well…the reason I would put Health and Wellbeing coaches central rather than a Social Prescriber link worker is because it's about taking ownership and control. It's about patients deciding what they want to do (Other1)

It was felt that expanding the number of personalised care posts, including HWbCs, would help sharpen distinctions further because with more staff in post:

…you can refine the scope of practice…to take them to the top of their skill set so they can do the most of what only they can do (ICSStaff2)

The fact that staff could be employed by a number of different agencies was seen as a potential barrier to team working, and, coaches reported, they often had to "find" other staff, like AHPs, to support their clients.

One further issue – referrals

HWbCs (and others) were clear that it was important not to be too restrictive about referral criteria and that many clients would have multiple issues they needed help with, some of which may only become apparent after the initial sessions. This is borne out by the data presented in Appendix 3.

In fact, addressing the initial symptom or presenting issue may be something addressed later in coaching sessions, not at the start, HWbCs reported. This 'wide' approach to health coaching was seen as a positive.

However, in saying this it was clear from the interviews that coaches could - (1) receive very little or insufficiently detailed information about referred clients and (2) sometimes did have inappropriate, (in the sense that the client's circumstances fundamentally required different interventions to health coaching), referrals made to them.

Regarding the later point, it was not possible to gauge the magnitude of such referrals, but each interviewee (without prompting) cited examples.

Coaches said that they could have said 'no' to these referrals but did not want too, because the client would have then had no support or in one case because they thought it important that they could demonstrate the value of the role.

It was also thought that lack of awareness of the role sometimes resulted in inappropriate referrals. A GP participant made the point that it was the job of GPs to risk manage referrals.

Conclusion

Drawing on the NHS new roles model discussed in section 2.4.3., it would seem clear that HWbCs are firmly within the 'Emergence' stage, because:

- Old ways of working still dominate primary care, but…
- The rationale for the role is clear, however…
- Not only is its deployment limited to isolated examples, but…
- It is not yet fully integrated into systems and processes. (For example, the barriers coaches experience trying to engage with individual practices or PCN senior teams and the lack, in some cases, of induction).

The emergent nature of the role was captured by a GP and a system lead participant in this evaluation who said:

We are still finding our feet, which doesn't mean the need isn't there once we find out how to use [the role] (GP2, interview)

…they are so new; nobody knows what to do with them (ICSStaff2)

Continuation of the current cohort and expansion in a planned way into new PCNs would most likely move the role into the 'Legitimacy' stage, and over time to 'Acceptance'. A clear conclusion of this evaluation is that the role has proved that it is needed and that it can be appropriately employed and deployed.

However, the point where the role pivots from Emergence to Legitimacy is a critical one and not guaranteed, which is why it would be timely for stakeholder to work together to promote, expand and embed it.

When considering the impact of the role on health and wellbeing outcomes and capacity in primary care the question – 'what would have happened if the coaches had not been there?' - can be asked. In fact, one participant asked this very question in an interview:

It does make me wonder where the patients currently being seen by the Health and Wellbeing Coaches were going before, how were they being supported for what does not require medical interventions (ICSStaff3)

The evidence of this evaluation is that an absence of HWbCs would have had a detrimental effect on hundreds of NEL citizens, not only on their health and wellbeing, but more widely. Coaches were clear that their GPs would only be able to provide limited support to their clients and that they (GPs) welcomed the opportunity to refer clients to staff who could appropriately meet their needs (which also reduced the GPs workload). In short, coaches are making a difference.

Recommendations

1. The NEL ICS should, as soon as practical, bring together all partners with an active interest in the HWbC role, including the coaches themselves. This meeting should be used as a vehicle to:

- Take stock.
- Share the results of this evaluation.
- Share insights on the impact of the role.
- Seek a consensus on the impact measures (also see recommendation 3).
- Agree a vision and shared strategy that promotes the role and includes a vision of how it will develop in the future. [23]This strategy should be within the context of the expansion of personalised care more generally and link to regional and national developments.
- Consider the implementation of the Workforce Development Framework for HWbCs.

2. Following from the above, all NEL PCNs should be bought together or communicated to within the next six months to raise awareness about the coaching role, its impact and the strategy.

3. A long-term evaluation framework should be developed that tracks the impact of HWbCs on (a) clients, (b) other healthcare professionals and (c) wider healthcare (for example hospital admissions). A Theory of Change should be developed to underpin this.

4. Not all the HWbC possessed a degree and the majority of those answering the questionnaire stated that they did not possess a coaching qualification prior to employment. Specific consideration should, then, be given to what qualifications and/or experience coaches should possess on recruitment. This should be linked to the requirements of the competency framework within the Workforce Development Framework.

5. HWbCs would like greater professional support in the workplace, not just with supervision but also pastoral support, professional development and peer review (observation with professional feedback). Coaches value the network, and this should continue.

6. There is a need to consider how referrals can be better managed. This is likely to require a combination of empowering coaches to say no to clearly inappropriate referrals, raising awareness of the scope of the role (and other personalised care roles) and ensuring better information is available to coaches when a client is referred.

7. Workload was not identified as a significant issue, but concerns were expressed that an undue focus on the volume of clients seen (which was perceived to be an issue for SPLWs) would have a detrimental effect on clients because session time would be constrained and HWbCs.

8. Specialist coaching roles are evolving for example those focusing purely on diet and mental health. There is scope to consider the demand for further specialist roles and also to consider the training required to support them. Other opportunities to develop the role, for example a focus on prevention, should be considered by personalised care stakeholders. The 'flat' nature of the career structure could be a barrier to retention in the future.

Appendix 1: HWbC's questionnaire – all answers to the question asking them to describe the difference their role made to clients and patients

I enable people to reflect and understand their anxiety related behaviours and make changes. Coaching involves step changes and I use many tools to do this. I have worked with people who have not slept for years and after sessions they sleep, people have managed to begin to leave the house to walk, incorporate mindfulness practice into their daily life, give up smoking, return to work after long absence, take up meditation, understand the way their physiological self works and develop healthier relationships

People losing weight. People with depression and anxiety helping them to move forward being more proactive

It helps people in my borough (deprived and full of health inequalities) take control of their health and wellbeing. I have helped hundreds of people achieve weight loss and thereby reduce/manage their elevated lipids, blood glucose, bp and prevent CVD, DM and many other health conditions related to obesity (mental health, back pain, OA, cancers) Encouraging them to eat healthily and be physically active it helps control their fatty liver and risk of CHD. It also helps them see the link between food and mood & improve their mental health by giving them a safe space & time to speak re their health concerns and feel 'heard' .Being from a South Asian background I understand the cultural barriers and can help them overcome those too via coaching in their local language

Patients have a space to first talk and feel listened too, once a rapport has been established, patients feel more confident to open up and try the coaching model once it has been understood

One patient above 50, obese, OA, hypertension (taking medication) was able to lose weight, started including exercise in her daily routine as well as healthier meals, and after 12 interventions her blood pressure was normal — not taking medication — and decided to start studying to open doors for her professional life. Also, this patient was able to improve her mobility in the upper body, and her pains decreased

helping people lose weight and have better nutrition for their overall wellbeing. Helping them with techniques to help them cope with difficulties such as stress and anxiety. Talking to people that feel isolated and/or lonely

Empowering people with information regarding health such as nutrition such as explaining that drinking only pepsi can effect how a patient feels physically and mentally and noticing the difference when they begin to drink water. Teaching patients mindful practises that help with anxiety and stress for example and these practises becoming part of their routine

My patients report feeling heard, finding out about relevant and helpful services, finding new techniques to manage stress, having some accountability for the actions, thinking about what they want/their goals and feeling supported. I would like to say that I see patients really taking control of their lives, and increasing their motivation for health and wellbeing behaviour change, I do see some increase in motivation but I also see a lot of people with an external locus-of control and very challenging life circumstances

We have been tracking outcomes from the wellbeing service Year 2020/21 delivered lifestyle interventions to 300+patients 100% reported excellent patient experience 87% of patients said the interventions were effective and have improved their health and wellbeing, confidence, 90% of patients were able to get the help they needed (holistic service). The role provides a safe space and dedicated time for patients to share an overview of their life and what areas are contributing to the pressures that impact their wellbeing.

Patients have commented how they have felt heard, supported, and not judged for feeling the way they do. For example, patients who have suffered trauma 2-3years ago did not have access to therapies. Having attended the service patients were introduced to effective coping techniques that initiated the healing process. Patients who were unsuccessful at weight loss programs have shown improved weight loss through the service because they feel supported and motivated, also empowered.

Patients with IBS who have had trouble with coping with symptoms have reported improvements through dietary changes Patients suffering from grief and loss have reported transformation through the coaching experience. Many patients who chose lifestyle interventions over medication are referred to me. I have a 100% success rate

It gives patient different perspectives of their lives

We aim to behavioural changes. We help client to become aware of un-healthy behaviour and help them to change and replace them for more helpful and healthier ones.

People feel like they are more in control of their wellbeing journey. I do not tell them what to do, rather, I encourage them to focus on what they would like to work on. Most people find that refreshing and empowering

By helping people learn more about their health conditions and identifying ways to live with it.

Oncreasing awareness of behaviour and lifestyle

Appendix 2: HWbC's questionnaire – all answers to the question asking the difference coaches make on other healthcare staff

GPs are able to refer now through a relatively robust referral system. As we begin to attend practice meetings we can educate a little more - we can hold people so reduce the time taken up with persistent attenders, GPS are able to read notes and activate different care pathways. Becoming a more trauma informed practice will also help

They feel they can refer those patients to me who they are not able to give more time to but who need more attention and hand holding where change in lifestyle is concerned as its not very easy to just advice in 10 mins and get someone to lose weight or change their eating habits which are poor since many years or all their life

Takes off the load for example pt's with mood disorders (mild to moderate) are able to work with the coach rather than going to GP

This enables nurses and GPs to have the time to focus on the pt's symptomatology rather than providing lifestyle advice or support

Takes pressure off them

We help client to take more responsibilities on their health therefore they will rely less on GP and Nurses

Another referral avenue. Somebody who can work on a different way with suitable clients

Reduce workload

Reduces returning interaction with patients where prescriptions are not needed to treat health

Helping with their work load and taking patients that we could work with instead e.g. high BMI, diabetes, hypertension. Helping to check weight and keeping track of weight loss progress

For GPs we are a source of referral for them to offer patients support, patients that may be frustrated at having to wait for other services like IATP

I am really not sure about this - perhaps more contact with their patients through my reporting back to them. And having another staff member to take some of the burden - especially relating to wellbeing rather than physical health

My role has reduced the 'headaches' GPs tend to deal with which medication fails to address. such as the lifestyle or social and housing issues that contribute to a person's wellbeing. We have demonstrated that the roles are reducing the work pressure load on the system Nurses feel supported. Practice managers have commented the roles are adding value to patient experience The PCN is overall extremely impressed with the wellbeing team - I am the longest-standing employee since its conception. Issues are mainly team retention - We now have a new team recruited and lack of space (we are redesigning a hub model)

Appendix 3: Activity data

The Shoreditch Trust collated anonymised data on the background of clients supported, the nature of their conditions and issues, goal setting and signposting and referring. This is summarised in this Appendix and provides an indication of the breadth of HWbCs work.

Of 1,118 clients referred to HWbCs, 71% identified as female and 29% as male. Of those stating their ethnicity:

Ethnicity	%
White	42
Black	31
Asian	10
Other including Arabic	5
Mixed	4
Prefer not to say	3

Clients' age distribution was as follows:

Age	%
16-24	5
25-34	17
35-44	22
45-54	22
55-64	19
65-74	10
Over 75	5

In terms of the economic status of clients 66% were economically inactive (for example long term sick or retired) or did not specify, 17% were unemployed, 11% were employed full time and 2% part time and a small number (under 10) were in education or training, or self-employed.

Clients were referred to HWbCs with a wide range and multiple conditions. Whilst 47% of the sample presented with one issue, 23% presented with two, 8% with three, 4% with four and 9% with five. The Table below groups the issues presented by category. In addition, three individuals were supported by HWbCs to address digital exclusion.

Category	%
Emotional	60
Financial stability	15
Physical health	64
Social relationships	19
Work, leisure, life satisfaction	18

In nearly half of cases (46%) HWbCs set one goal with their clients. In almost a third (31%) of cases two goals were agreed. Three goals were set by 15% of clients, four goals by 6%, five by 3% and six by 1%.

The HWbCs referred or signposted clients on to an extremely wide range of other organisations and services, namely:

(Hackney) Foodbank (Trussell trust)
ACAS
Addictive Eaters Anonymous
Age UK City Connections
Aim4Work
Aim 4 Work
Alive n Kicking
Allerton Road Medical Centre (GP, WW)
Alzhiemer's Society
Ambulance Service
Anxiety UK
Arab Advice Bureau Islington
Arthritis Action
ASAP
Backcare.org.uk
Bags of Taste
Birmingham Asylum Refugee & Migrant Support
Barnardos
Be Active Wellness Programme
BEAT
Better Leisure
Better Together
BHF British Heart Foundation
Bikeworks
Bikur Cholim
Bi-Lingual Health Advocacy and Translations
Biscuit Fund
Blue Badge - disabled parking permit applications
Blue Cross for Pets
Boloh at Barnardo's
Boots the Chemist

Borrow My Doggie App
Bow Food Bank (Tower Hamlets)
British Association counselling and psychotherapy
British Lung Foundation
British Red Cross
British Voice Association
Bromley By Bow Centre
BSIX
Campaign Against Living Miserably
Caravan counselling services
Carer First
Carers First
Castle Food Service
Centre for Better Health
CHAMHRAS
Charity Works
Charlie Burns Foundation
Childline
Choice Homes
Choice in Hackney
Choices Islington
Citizens Advice Bureau
City & Hackney CCG - Wellbeing Practitioner
City & Hackney Mental Health Crisis Line
City & Hackney Sickle Cell and Thalassaemia Centre
City and Hackney Carers Centre/ Hackney Carers
City and Hackney Crisis Pathway Services
City and Hackney Wellbeing Network
City Lit
Clarion Housing
Clissold Leisure Centre
Clissold Table Tennis Club
City & Hackney Wellbeing Network
City and Hackney Mind
Family Action - Social Prescribing
Family Action - WellFamily Plus service
CNCN Riverside Engage Hackney
Colostomy UK
Community Food Hub
community walk
Core Arts
Core Clapton
Crisis
Cruse Bereavement Care
DayMer Turkish & Kurdish Community Centre
Derman Centre
Diabetes UK
Diabetic Nurse
Dial-A-Ride
Digital Buddies
Digital Weight Management Programme NHS
Do-It Volunteering
Drink Aware
East London NHS foundation Trust
ELATT
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Hackney Adult Social Care Services
Hackney Ark
Hackney Bereavement Support
Hackney Carers Centre
Hackney Chinese Community Services
Hackney Circle
Hackney City College
Hackney City Farm
Hackney Community Law Centre
Hackney Council Children's Services
Hackney Council Digital Buddy
Hackney Domestic Violence & Sexual Violence Support
Hackney Herbal
Hackney iCare
Hackney Learning Trust
Hackney Local Offer
Hackney Marshes Neighbourhood Mental Health Team
Hackney Migrant Centre
Hackney Mobility Service
Hackney Neighbourhood Service
Hackney Opportunities
Hackney Parks Volunteering

Hackney Playbus
Hackney Sensory Team
Hackney Shine
Hackney Somali & East African Community Centre
Hackney Stop Smoking Service
Hackney supported employment service
Health and Safety Exceutive
Healthier Together Hackney
Health Watch
Healthwise Hackney
Healthy Hearing
Healthy Lifestyle Hub
Healthy Living Programme
Help4hoarders.co.uk
Home Finder UK
Home Hunt
Homerton NHS Foundation Trust
Hospital for Integrated Medicine
Housing Moves
Hoxton health
Hoxton Trust
Integrated Independence Team
IRIE Mind
Jobcentre Plus
Kingshall Leisure Centre
Kiran Support Service
Latin American Womens Aid
LBH helpline Link Worker
LGBT Foundation
Little Village
Living with Reflux
London Black Womens Project
London Fields Neighbourhood- Mental Health Community Connector
London Friend
Long Covid Support
Love Hackney
LOWES project
Lunch Clubs
Made in Hackney
Metro Charity
Mind Welfare Rights Service
Money Helper
Motability
MRS Independent Living
MS UK
Nafsiyat Intercultural Therapy Centre
National Association for People Abused in Childhood
National Pension Advisors
Neighbourhood office - Hackney Council
NELFT NHS Foundation Trust
New Age Games
New City college
NHS Better Health
NHS Care Coordinator
NHS Dementia Service
NHS Dental Service
NHS Every Mind Matters
NHS Mental Health Apps
NHS Web Page
NHS website
NSPCC
Oddbox
Online Resources
Our Parks
Overeaters anonymous
Pain Clinic
Pain Data
Peabody
Penny Appeal
Peter Bedford Housing Association
Posh Club
Power to Live Foundation
Primary Care Mental Health Liaison Service
Queensbridge Group Practice
Recovery College
Reed CV Builder
Refuge
Relate
Rights of Women
Samaritans
Scope
SENDIAGS
Shaw Trust
Shelter
Shoreditch Trust
Short Breaks Hackney
Shout
Sistah Space
Sleepio
Smoke Free Hackney
South Hackney Recovery Team
Southwark Council
Southwark Law Centre
Spiral Holistic therapy centre
St. Mary's Secret Garden
Step Change
Sunday Care Therapy
Support When It Matters
Talk Changes
Taxicard

Telecare
The Advocacy Project
The Eaton Fund
The Haven
The IBS Network
The Listening Place
The Mix
The New Age Games Programme
The Nia Project Ending Violence
The Sharp End
The Sickle Cell Society
The Sleep Charity
The Sleep Council
The Stress Project
This Girl Can
Toynbee Hall
Trauma Response Network
Triumph Over Phobia
Turning Point - Hackney recovery/ substance mis-use service
United kingdom counselling and psychotherapy
Verity - The UK PCOS Charity
Victim Support
Vodaphone
Voiceability
Volunteer Centre Hackney
Walking Together
Waltham Forest Adult Social Care
Waltham Forest Stroke Association
Women's Aid
Work Coach at Hackney Hillman Street Job Centre
Yoga Home
Young Hackney
Young Mind
Young Women's Trust
Your Covid Recovery

Endnotes

1 https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2 [Accessed 31 March]. The figure is for 2014-2015
2 Howarth M, Mello M, and Kershaw M. (2021) Personalised solutions through social prescribing. British Journal of Nursing, 30(3), page 140
3 Source: https://www.personalisedcareinstitute.org.uk [Accessed 24 February 2022)
4 Source: https://www.england.nhs.uk/wp-content/uploads/2020/03/health-coaching-implementation-and-quality-summary-guide.pdf (Accessed 21 March 2021)
5 Source: https://www.shoreditchtrust.org.uk/health-and-wellbeing/health-and-wellbeing-coaching/
6 The actual number of sessions is based on the needs of clients and may be more or less than eight.
7 There is also a personalised care curriculum - https://www.personalisedcareinstitute.org.uk/plugin file.php/133/mod_page/content/28/PCI-Curriculum.pdf
8 Further information from: https://www.england.nhs.uk/gp/expanding-our-workforce/ [Accessed 25 March 2022)
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13 Kessler, I. Heron, P. and Spilsbury, K., (2017). Human resource management innovation in health care: the institutionalisation of new support roles. Human Resource Management Survey 27(2), pp. 228-245.
14 There was one negative response. One respondent said that they would not employ a coach because their role was too similar to that of a SPLW
15 Since this report was written NHS England was produced a draft Workforce Development Framework for the personalised care roles including HWbCs. This covers some of the points raised in this section, such as information for new employers, but does not replace the suggestion for a local strategy.
16 Source: NEL presentation
17 A feature of "good work" is task variety.
18 Source: https://www.health.org.uk/funding-and-partnerships/programmes/co-creating-health [Accessed 28 March 2022]
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22 Source: NHS England (n.d.) Personalised Care. An induction guide for health and wellbeing coach workers in primary care networks. Available online: https://www.england.nhs.uk/wp-content/uploads/2021/05/HWBC-Welcome-Pack-FINAL.pdf
23 Ideas identified in this evaluation include the potential for early intervention, and the potential for "senior" coaches to allow for a career progression. Consideration should also be given to allowing coaches to rotate between PCNs.

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