Title of report:	*Workforce Enabler – Wellbeing Practitioner Project Extension – Note to board*
Date of meeting:	10.12.20
Lead Officer:	Laura Sharpe (OOH Workforce Enabler SRO)
Author:	Stewart Weller (OOH Workforce Enabler and Training Hub Programme Manager)
Committee(s):	City and Hackney Workforce Enabler Board – September 2020 – For Approval (Proposal was approved)
Public / Non-public	Public

Executive Summary:

Following initial discussion at the September 2020 Workforce Enabler Board it was agreed Dr Deborah Colvin as clinical lead for the project would submit a written proposal for a 6 month extension to the WBP project. This was submitted in the week following the meeting and approved virtually then ratified at the November board.

Recommendations:

There is no recommendations for this paper. It is intended as a note for the board following direction from Sunil Thakker.

The **City Integrated Commissioning Board** is asked:

- To **NOTE** the report;

The **Hackney Integrated Commissioning Board** is asked:

- To **NOTE** the report;

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	As little as 10% of a population's health and wellbeing is linked to healthcare access, the other 90% is influenced by wider factors; people's housing, relationships, benefits, social engagement, disability, unemployment all have a greater impact on physical and mental health. This project aims to address that.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	Following referral, the WBP will contact the patient to arrange a home visit and use various tools including wellbeing (care) plans, motivational interviewing techniques and goal setting. (WBPs are able to work remotely and have laptops, mobile phones and personal alarms).
Ensure we maintain financial balance as a system and achieve our financial plans	☒	Cost was considered by the workforce enabler board as part of the approval process.

Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	The WBP work across community, primary and voluntary sectors as part of an integrated model.
Empower patients and residents	☒	Feedback from our service users has been overwhelmingly positive, showing that this service has not only been essential but has acted as a much-needed safety net for these patients at a time when feelings of uncertainty and anxiety are high

Specific implications for City

[Please make the specific implications of the proposal for City.]

This paper is not a proposal but intended as a note to the board

Specific implications for Hackney

[Please make the specific implications of the proposal for Hackney.]

This paper is not a proposal but intended as a note to the board

Patient and Public Involvement and Impact:

[Please set out how service users have been involved in the development of proposals. Please also state whether/how the content of the report is likely to impact on public and patient perceptions of service providers.]

This paper is not a proposal but intended as a note to the board

Clinical/practitioner input and engagement:

[Please set out how clinicians have been involved in the development of proposals. Please also state whether/how the content of the report is likely to impact on clinicians/practitioners.]

This paper is not a proposal but intended as a note to the board

Communications and engagement:

[Does this report, or the work described in the document, require communications and/or stakeholder engagement with patient groups, the public or integrated care partners? Yes/No. If yes, please explain what communications and engagement has been undertaken or will be undertaken. If no – please state why not.]

No – The paper is a note to the board.

Comms Sign-off

[Which Communications and Engagement team member has contributed to the communications and engagement thinking which underpins this work? If not applicable - please state why this is not applicable.]

Not applicable. Paper Is a note to the board.

Equalities implications and impact on priority groups:

[Please set out any equalities issues and particularly in relation to impact on priority groups; e.g. young black men]

None

Safeguarding implications:

[Please set out any safeguarding issues or implications emerging from the report]

None

Impact on / Overlap with Existing Services:

[Please state how proposals in the report will impact on existing service provision, considering inter-relations between NHS and Local Authority, acute, GP and community services.]

This paper is not a proposal but intended as a note to the board

Main Report

Background and Current Position

[This section should include a brief explanation of the context, including reference to previous committee decisions, and an outline of the current situation, key issues and why the report is necessary.]

This report is intended as a note to the ICS board in order for members to note the approval of a 6 month project extension to the WBP project that was originally commissioned in 18/19.

Proposals

[This section should explain in more detail and justify the recommended course of action, setting out clearly what beneficial outcomes are expected.]

This paper is not a proposal but intended as a note to the board

Conclusion

[This section should draw together and summarise the key points of the report.]

This paper is not a proposal but intended as a note to the board

Supporting Papers and Evidence:

Appendix 1 – 'WP First Quarter Review' PDF. Appendix 2 - 'WBP 'Request for funding extension paper' PDF

Sign-off:

The extension was signed off by the City and Hackney Workforce Enabler and Training Hub Board

Title: *Workforce Enabler – Wellbeing Practitioner Project Extension – Note to board*

Purpose: *Note to ICS Board for information*

Date: *29.11.20*

Author: *Stewart Weller (OOH Workforce Enabler and Training Hub Programme Director)*

SRO: *Laura Sharpe (GP Confederation CEO – OOH Workforce Enabler SRO)*

Appendices: *1 - 'WBP Quarterly Report' 2 - WBP 'Request for funding extension paper'*

Note to Board

The ICS board are asked to note a 6 month extension to the Wellbeing Practitioner piolet project following approval from the City and Hackney Workforce Enabler and Training Hub Board.

This project is the pilot whereby there are 8 wellbeing practitioners based with practices – they support the most complex patients who have high needs and high use of services system wide.

Background

The Wellbeing Practitioner (WBP) project started in October 2019 and was scheduled to end in December 2020. The project was awarded £371,866k as part of the second tranche of workforce enabler bids managed by the City and Hackney CEPN (Now called the Training Hub). This funded was awarded in three instalments of £148,800, £111,553 and £111,553 based on milestone achievements.

Since February 2020 quarterly project reports have been submitted to and reviewed by the Workforce Enabler and Training Hub Board as part of our governance and reporting process.

See attached appendix 1 – 'WBP Quarterly Report'

Current Position

In the September 2020 Workforce Enabler and Training Hub board Dr Deborah Colvin raised under AOB that one of the Wellbeing Practitioner pilot project commissioned by the previous CEPN board was at risk of not running for a sufficiently long enough period of time to demonstrate the full benefits, because of Covid predominantly.

At the meeting there was general support for the GP Confederation, which runs this pilot, to pull together a short background to this pilot and the costs if we were to extend the pilot for 6 months as a proposal.

Total cost for 6 month extension **£139 973.89.**

See appendix 2 – WBP 'Request for funding extension paper'

Below is an extract from the September meeting minutes;

'DC made a request to the board for an additional funding from the enabler budget line to extend the Wellbeing Practitioner project in City and Hackney. DC fed back that the project had so far produced great results and been beneficial for the system. In principle the group agreed to the extension however it was agreed DC would produce a short paper with specific details around timeline and funding.

Action – DC to produce and circulate 1 page requesting additional funding for virtual sign off from board'

Board members were given 2 week to feedback on the proposal.

The following responses we received;

- Catherine Pelley (Homerton) emailed in support.
- Jayne Taylor (City and Hackney ICS) emailed in support.
- Liz Hughes (Voluntary Sector) emailed in support with some really helpful points on integration with HCVS at neighbourhood level which we will pick up at the meeting.

This request has come from the GP Confederation and therefore no one has replied from the GP Confed because they are conflicted.

Following the discussion at the September board and feedback received virtually the extension was granted.

This decision was ratified in the November board under a review of previous meetings actions.

City & Hackney GP Confederation
A community interest company

Name of Contract	Wellbeing Practitioner Pilot
GP Confederation Lead & Job Title	Julie Vázquez – Project Lead
Report Title	Wellbeing Practitioners - First Quarter Review
Covering Period	January 2020 – April 2020 (4 months)
Authors	Mine Aslan, Olivia Henry, Zoe Horton, Rosie Lisser, Natasha Middleton, Barbara Reissner, Julie Vázquez, Anna Weedon
Date	8th June 2020

1. Purpose

This report provides an update of the activity of the first quarter of the Wellbeing Practitioner Service and summary of learning, findings, and the impact of the service on patients and staff. It also contains some options for potential development of the service.

2. Background and aims – Wellbeing Practitioners (WBPs)

We know that the biggest determinants of health aren't what happens in the Doctor's surgery but what happens outside. As little as 10% of a population's health and wellbeing is linked to healthcare access, the other 90% is influenced by wider factors; people's housing, relationships, benefits, social engagement, disability, unemployment all have a greater impact on physical and mental health (Social determinants of health model: Healthy Lives for People in the UK, The Health Foundation, August 2018).

City and Hackney GP Confederation (GPC) wanted to support frustrated GPs, unable in a 10-minute consultation to 'unpick' the issues adversely influencing the health of their patients with the most need - the complex, the vulnerable and those failing to thrive.

3. Pilot setup and operating model

3.1. Research and engagement

Prior to launching the service, we looked at projects which have proved successful in other areas of the country and organised some visits. Manchester's Focused Care Practitioners http://focusedcare.org.uk/ and Health Connections Mendip https://healthconnectionsmendip.org/ of note. Here the success stories are incredibly positive and statistically there were significant decreases in unemployment, social isolation, anxiety and depression, alcohol and cocaine use.

A plan was then developed from what has worked well and adapted for City & Hackney residents.

The GPC clinical lead met with interested GPs to share findings from visits to Mendip (Frome) and Manchester and to ensure commitment to the pilot as this was found to be a critical success factor in other models. Practices had to commit to provide necessary clinical space, inclusion in practice meetings and MDTs and day to day line management for the WBP to be integrated into the practice team.

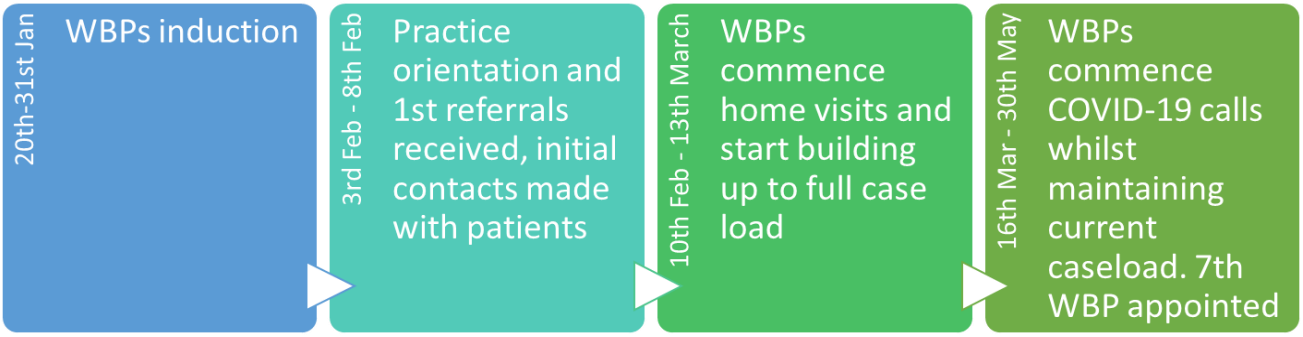
The project lead engaged with other statutory services and voluntary sector organisations to introduce the pilot and to ensure that the WBPs could meet with front line teams once in post, raise

awareness of the service, engage with the wider support systems and smooth joint working and community navigation for their mutual patients/service users.

3.2. Recruitment and launch

The GPC received pilot funding from the City & Hackney Community Education Provider Network's (CEPN) workforce transformation fund for a 12-month period commencing in January 2020.

We identified initially 6 practices in Hackney who would 'host' a WBP and their lead GPs were involved in recruitment and interviews during November 2019. We had a very strong field of applicants and successfully recruited 6 practitioners who underwent an intensive 2-week induction period in January 2020. The service became fully operation on 3rd February this year. A final WBP was recruited in March 2020. The diagram below shows a timeline of the WBP service.



3.3. How the service works

WBPs have day to day line management and GP supervision from the practice. They are employed by the GPC and from here have 1:1 and team support for management, professional development and reflective practice.

An operating model was developed and finalised with input from the WBPs once in post.

A simplified process is as follows:

- WBPs accept patients onto their caseload following a discussion with the patients GP regarding their concerns and perceived need for intervention to support complex patients to achieve improved wellbeing. There are no referral criteria other than 'failure to thrive'

- WBPs also attend the practice multidisciplinary team (MDT) meetings on a regular basis where referrals may be made.

- Following referral, the WBP will contact the patient to arrange a home visit and use various tools including wellbeing (care) plans, motivational interviewing techniques and goal setting. (WBPs are able to work remotely and have laptops, mobile phones and personal alarms).

- WBPs record data using a specially designed EMIS template, spreadsheets and the Warwick/Edinburgh wellbeing scale.

- WBPs will then meet or speak to the patient regularly to seek to 'unpick' the issues they face and help them in any way needed for as long as is needed.

3.4. Ethos and approach

Our dedicated WBPs have a 'never give up' philosophy and will often visit individuals and their families in their home away from the sometimes overwhelming bureaucratic settings which we know exist in both health and social services. The Wellbeing Practitioners in Hackney are highly experienced and skilled individuals drawn from a variety of allied health professions with several years of experience working with vulnerable children, young people, adults and the elderly. They are compassionate, non-judgmental and approachable individuals who readily embraced the Manchester ethos and commitment to 'Unrelenting Kindness'. They approach their work in a person-centred way with a clear understanding of the wider effect on the whole family when an individual's medical and social needs are unmet.

Our WBPs support people with the social, emotional and practical problems they are facing, with flexibility and no limiting referral criteria, remit, or timeframes. As such, they are in a key position to try to fill the gaps that people experience in the health and social care (H&SC) system.

They have described their guiding intentions as follows:

We are guided by a particular set of intentions as a framework underpinning all our work. These can be summarised (a working outline) as follows:

- Meeting people where they are at. We understand that people are all different in how they prefer to be supported, and we are interested in being flexible to when and how they wish to consult with us in the way that best fits for them.
- Safety and dignity of the person is at the centre of our work. We aim to be attentive to how we cultivate trusting and respectful relationships with people through interactions of care, compassion, openness, reliability and accountability; and we know this can take time.
- Each person is the expert in their own life. We are led by the person we are working with, as to how we can be useful alongside them towards their hopes and preferences for their lives. We use a strength-based approach and are interested in their skills, knowledge, and values.
- Contextualising people's lives helps to understand a person's 'way of being'. We set out to understand the many ways people have responded to the problems they have faced. We do not pathologise people or individualise problems.
- We acknowledge our influence in people's lives. We have knowledge, skills, and we are part of the professional network which brings power to influence, that we want to be open about, be accountable to, and utilise it in being useful alongside people.
- Building community helps to address problems. We collaborate closely with people by building links with others in their life including family, friends, community and the professional network in order to support people through the problems they face.
- We are passionate about supporting people in their struggle against poverty, inequality, injustice and all forms of discrimination. We endeavour to support people towards their hopes for their lives and preferred ways of being.

A day in the life of a Wellbeing Practitioner: Example 1

9:30am Home visit to a 58-year-old man, Raul along with interpreter. Raul is living with multiple sclerosis and is mostly bedbound. He has 'disengaged' with physio and OT and has been rude to carers at times. Spent some time discussing Raul's daughter who he is estranged from and this has him feeling 'what is the point?' He agrees to me liaising with OT and Physio and coming to see him again next week.

10:45am Time at the GP practice writing up notes and making calls to two new referrals to introduce myself, explain what I do and arrange time to meet with them.

11:30am Attended a Health and Disability assessment with Michael, a 43-year-old man. I met him at the surgery and we travelled together by tube to Marylebone. Offering emotional support along the way as he wasn't sure what to expect and was quite anxious. Whilst we waited nearly an hour for his appointment, I took the opportunity to check in (we discussed things that he felt comfortable talking about in a waiting room). How was he feeling emotionally and mentally and what coping strategies were working well for him? What furniture did he need for his new flat and what would be a priority to apply for in a grant? During the assessment I ensured that everything was clear and understood. I bought a coffee for Michael on the way back to the station, de-briefed the experience for him (the assessor was supportive, helpful and understanding. It seemed to be a positive experience and hopefully meant Michael could receive the appropriate benefits). I travelled back with him and then he went off to carry on with his day. (He texted me later in the afternoon to thank me for going with him).

2:30pm Home visit to a 64-year-old woman, Miriam, who has severe liver issues and has had 4 strokes. She has asked to meet to discuss some letters received in the post as she is not sure what they are all about and she is also worried about possible debt. We go through the mail together, sort it out into different piles and we contact Christians Against Poverty together to make a referral. I arrange an appointment for them to do a home visit.

4:00pm Home visit to a 79-year-old man, Mr Chowdry, who is housebound. Mr Chowdry hadn't eaten all day and was hungry. His carers usually bought food for him but something seemed to have gone wrong as there wasn't any fresh food in the house and he didn't have any money. He asked me to buy some chicken legs from the local fried chicken shop which I did. With his permission I then raised a safeguarding concern regarding the conditions he was living in and some other issues. (He was subsequently visited by a SW and moved from the flat very soon afterwards).

A day in the life of a Wellbeing Practitioner: Example 2

9.15am John arrives early for his 9.30 appointment and I say 'hello' to him and check if he can wait till 9.30. Since losing his parents he has become completely socially isolated and has become more dependent on the surgery, booking frequent appointments with his GP.

9.30am In the session with John we discuss and plan a referral to the community kitchen on Wednesdays. I call the practitioner at the community kitchen and John feels reassured that he knows who is going to meet him when he arrives there. We book an appointment to meet at the surgery same time, same day next week. I encourage John to call me before the session if he would like to speak to someone. He says he will

10.45am Sheila is surprised to see me although I have called her yesterday to remind her. She says she had forgotten but welcomes me. She has also forgotten what we planned to focus on today so I gently remind her. She apologises for being so forgetful. I call the hospital patient transfer booking line and write the details down in big letters on a piece of paper which she sticks on the board in her kitchen. She says she hasn't spoken to anybody in days and asks me if I'd like to have a cup of tea with her. Only if I can help make it as she is quite frail. Whilst we enjoy our tea, she tells me about her childhood memories during the war when they were evacuated and had to live outside London and life in and out of shelters. Her long term memory impresses me and I acknowledge that with her as well as her strength, her resilience and how she coped with trauma and loss in her life. We plan to meet again in 3 weeks' time and I write the date and time down for her.

11.50am I see the GP in the corridor and give her a quick feedback about John and Sheila. The GP tells me that John has not booked appointments with her in the last 2 weeks. I write my notes on EMIS.

12:00 *Lunch break. I have some time to chat to the receptionists and practice nurse*

1:00pm I have been meeting regularly with Peter and his housing problem is now less pressurising so he feels able to focus on his next 'agenda item'. I call him to confirm that we are meeting at the 'Recovery College', he arrives 10 minutes after I do and he tells me about his bus journey and how he has been feeling anxious recently. There is a service user in the corridor shouting at the police and asks Peter if he has any weed. Peter manages to avoid the situation. We then meet the 'Recovery College' tutor and Peter signs up on one of their courses. Peter wants to become a co-tutor at the 'Recovery College'.

2.30pm I attend the MDT meeting at the surgery and give feedback on the recent home visits I have made. I check the progress of a referral I have made to the OT and we plan to make a joint home visit to Sarah next week. I receive two new referrals from one of the GPs

4:00pm Samuel phones me to say he would like to reschedule his appointment with me today at the surgery as he feels too nervous to leave the house. We plan to meet next week but he is happy to speak on the phone and updates me on the conversation he had with the Job Centre regarding his benefits after our call to them to appeal their decision. Samuel says he has no money for food this week. I suggest sending him a Foodbank voucher, he says he'd be grateful for that.

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A day in the life of a Wellbeing Practitioner: Example 3 (COVID-19 specific)

9am Check tasks from GPs on EMIS, text message and emails.

9.15am Check-in call with Arthur to see if he needs any shopping and whether he has received his medication. He tells me the District nurses will be visiting to give him an injection. Make a referral to the Good Gym for help with shopping

9.30am Contact Daniel, adult carer for his mother, Diana, following a referral from the GP. Daniel has decided he will continue to get the shopping, and doesn't need a volunteer, but said he would like his mother to have more social contact. Diana is housebound and has dementia. I asked if he would like me to refer to Alzheimer's in Hackney. Explained they usually did organise activities, and if I refer now, hopefully she would get the support she needed, when services got back to normal.

10am Make a referral to get a Hackney foodbank delivery for Jack who I called yesterday.

10.15am Text contact with Mark to let him know that Core Arts had received the referral and had left messages. Text him the telephone number to call, if he was still interested.

10.20am Email CAB worker for Samantha, to see if there has been any progress on getting the help she needed to complete the ESA.

10.40am Contact with Jessica, I have been trying to get her laptops, to help her children study at home. She has 4 children who are sharing a laptop. The mutual-aid group had said they may be able to help, but it seems that the laptops they had donated need repair. Contact the children's school to see if they can help, as the Learning Trust have said this support was being co-ordinated by the schools.

11:00am Text catch up with Mags, positive news that family are really engaging with Alive and Kicking programme, and she has started jogging too.

11.05am Phone call to Molly, who I have been in contact with over the last few weeks. She sadly lost her husband, and has found living in 'their' house very difficult. Listen to how she is feeling, talk about times when she did feel a little bit better, and what support she had found helpful.

12:00pm Phone call to Dexter, who I had spoken to last week. He was managing an appeal regarding overpayment of ESA, and due to not having any benefits had previously stopped taking his medication, as he was not able afford it. He informed me that he had taken it last week has started working in customer services. I check with him whether he would like more support to manage his mental health (from a service such as The Wellbeing Network or Mind). He said he would like to think about it. I text him the information.

12.40pm Phone call from Paul, he has had issues trying to sort out his pension, as he is unable to fill in the necessary forms. He had eventually been able to make a claim by phone, but this meant his ESA has stopped before his pension started. Paul said he had received a letter from Hackney housing benefit, about his ESA stopping. He has called the number, but he said he did not feel that the person he spoke to was listening. He didn't know if he should put something in writing. I said I would contact housing benefit, as I had a good contact, who had been supportive of someone else, I was working with. I would ask that they did not make any changes to his housing benefit, as it should be that his pension would be sorted soon.

2.15am Emailed Iceland customer services, as Doris's dad, had contacted me to let me know that she had not been given priority to get into the store, despite a letter form the learning disability team.

2.30pm Phone call with Harry. His voice sounded much clearer, and more confident. Last week he has found out he had been successful with his PIP appeal. I noticed this change, and he says when he is feeling anxious, he feels he can hardly talk, as he has so little breath. He tells me that he told Hackney council he no longer needed the food, as the food did not really support his diet, however he was still happy to be getting a Made in Hackney dinner Monday-Friday.

3:00pm Phone call from Kay, feeling very anxious, because of paperwork she has been sent, we talk it through, what is important to look at now and what she could wait to look at later.

4.00pm Urgent referral from GP, regarding couple, Ellen and James, Ellen has just come of hospital, and James has dementia. Ellen is not able to go shopping, and her daughter is limited in what she can do, as her partner is self-isolating. Ellen really wants to be able to shop online at Sainsbury's. However, they are not going to be able to get priority, as they are not considered high-risk. Ellen did not want a volunteer to do some shopping for her, as it is important for her to be able to choose. She says that she is very tired, and it is hard to cook every day. I suggest she might like to have a meal delivery - a restaurant in Hackney is delivering cooked meals 4 days a week, I speak to Kemp Kitchen and they can deliver cooked food, Thursday, Friday, Saturday and Sunday.

5:00pm The GP had said that Joe preferred a call later in the day. Joe had been experiencing noise issues from a neighbour, and was finding it very hard to get the support he needed during this time. Listened to what steps he had already taken, and suggested that he may be able to get legal advice from Shelter (gave him the London number – as the local office is not open). He has received a response from the council regarding his complaint, but finds reading this quite overwhelming and is finding it exhausting to keep going. I suggest, if it was helpful, that he could email me the response. He also discusses benefit issues, I contact CAB to see if they could answer his questions, and they respond to say that they can

3.5. Changes during the pilot

As the service developed and refined there were some changes to process and to data capture with amendments to the EMIS template. One of the WBPs had to move to another practice due to an unforeseen lack of space.

3.5.1. COVID-19 pandemic

Just 5 weeks into the pilot the WBPs had to change working practice due to the COVID-19 pandemic. During this time, the WPBs have been working from home and are able to support people via phone calls. For the majority of people, the pandemic has meant that the support they previously had - whether from family, community or the service sector has lessened or even ceased completely leaving them feeling more isolated and vulnerable.

Crucially, the WBPs have been flexible and creative and find alternative ways of getting patients the support they need. They have found IT and virtual options, e.g. mental health apps, mindfulness apps and online courses. They have sourced alternative options for people who do not have access to the internet via the COVID-19 mutual aid voluntary groups

The WBPs have been researching, negotiating and co-ordinating the existing and new services that have emerged. The Hackney Support Services map has proven particularly useful as this has reflected changes in how services run in real time. There has been close team working between the WBPs, GPs, Social Prescribers, volunteer and statutory services. WBPs have been an invaluable service during COVID 19 as the role is highly practical and very responsive. The WBPs have been able quickly to support patients to get access to emergency food and medication drop offs as well as other services that they might not have been aware of.

There has been a change in the work and the needs of patients during this time. The WBPs have adapted their practice to manage much more crisis work - getting people food and/or emergency support, regular 'check in' calls and emotional support, communicating with family who cannot support elderly parents as they would normally, and arranging community support to shop for food, pick up prescriptions and carry out other errands.

The WBPs have been working with much larger numbers of people for shorter periods of time, alongside their longer term complex work. Over 500 new patients have been referred. Some of these people will need longer term support and will be added to the WBP caseload.

The importance of very good listening skills has been even more important, and to have the focus and resilience to remain open and committed to every person, even after many phone calls. Their relationship-building skills have enabled patients to build trust and to feel safe sharing information about other areas of their life that they need support with. The WBPs have needed to spend time understanding and strengthening what people are able to do alone within the confines of their home, e.g. exercise and tools to help cope with anxiety.

Some patients on the existing WBP caseload (prior to lockdown) have not wanted to be in regular phone contact and have preferred to wait until it is possible to have face to face support; some have asked for a regular call to check in and have a chat; whilst for others the need for support has greatly increased during this time with people facing isolation, confinement, postponement of appointments, delays in getting their problems addressed, a loss of hope for addressing problems, bereavement and fears about the virus itself.

4. Community engagement and work with local agencies

The WBPs are based in 3 neighbourhoods (2 or 3 in each), in this way they 'buddy up' to share knowledge, support each other and are building a sense of the local population in terms of need, social demographics, and community systems.

In the last 3 months, the WBPs have built up an impressive knowledge of the range of services locally available - from birth to end of life. They have done some targeted outreach to introduce themselves to teams and organisations so that others can understand the role, and know when a person may need support from a WBP. Other connections have been made as collaborative links are formed specifically around a particular individual's needs.

The WBPs have also attended other organisation team meetings and visited services, e.g. the CAB, Family action and Age UK, and been present at system-wide events relating to community navigation across the borough. The WBP team attended an open day run by Ground Work, to find out how they support refugee and asylum seekers in Hackney, through their Circles project.

The voluntary sector in Hackney is very rich and referrals have been made to local organisations for many reasons as varied as:

- applying for sensory aids
- arranging food parcels / foodbank
- adult autism assessment
- counselling
- grant applications
- befriending services

- support for carers
- community garden projects
- IT literacy / IT equipment
- community lunches
- training courses
- adult literacy
- sourcing volunteer support to help with activities of daily living
- benefits advice
- energy advice

Joint visits have been undertaken with professionals such as a dementia nurse, health visitor and the high intensity user team (so far). The WBPs are also regularly in touch with the voluntary sector programme manager for neighbourhoods and have used this contact to raise awareness of their service and widen their reach.

The WBPs have developed constructive working relationships with statutory services and the voluntary sector - notably Engage Hackney, Frampton Park Baptist Church and the Friendly Society - and liaise closely with these professionals regarding the WBP patients.

The WBPs also act as advocates for people, e.g. helping other professionals to understand points of view and experiences of people they had not considered. This advocacy proved invaluable when encouraging a domestic violence (DV) support service to continue and keep a WBP patient on their caseload even though the person had not been in touch with them. In this way the support services case was kept open through WBP intervention. The WBP was able to inform the DV worker that the patient's situation had changed – that the patient still needed support it just hadn't been safe for her to talk to them.

The WBPs work closely with social prescribers and have developed good relationships, at times co-working on the complex issues people are facing to best provide the level of support required.

With the advent of the COVID-19 pandemic it has been of even more vital importance that the WBPs have demonstrated excellent joint working and consummate communication to undertake crisis co-ordination and provide a quick response to many new referrals.

4.1. Feedback from voluntary and community groups

Frampton Park Baptist Church, Community Work: *The WBPs have been referring patients to us on a regular basis and we have communicated often to find help together and tackle issues.*

I have really enjoyed working with the WBPs during this time, getting to know a bit more what a wellbeing practitioner does. Their work is very valuable to the community and the patients of the surgeries! It is amazing what difference it makes to the patients. Their support is holistic, professional, sees the individual, flexible and has a "can-do" attitude. They are looking at every area of the patients live and putting in a lot of effort to tackle issues. They know their community and where to get further help from.

From patients they had referred to me I have heard only good things spoken and that many of their patients know them by name shows commitment and close regular contact. In the cases we have worked closely together I have seen them compassionately trying to find solutions willingly going the extra mile and thinking outside the box.

The service makes a big difference for the community. Having worked with the surgery trying to tackle some of the issues during our volunteer project a few years ago I can see that having wellbeing practitioners engaging with patients directly will improve lives much more effectively.

The Friendly Society: *Our work lately has been focused on providing essential goods deliveries and welfare checks for families and individuals in East London who are struggling either with financial difficulty or imposed self-isolation due to COVID.*

We've been working with the WBP since the start of the pandemic. Individuals in need are identified and referred to us for a specific service. Further, the WBP acts as an ongoing port of contact between ourselves and our service users so that we're kept updated if and when repeat services are required and for us to provide feedback. Thanks to the WBPs understanding of patients' needs we were able to immediately identify service users at the start of the pandemic and the referral information supplied has allowed us to prioritise our work so that we're able to serve those most at need without delay. To date, we've received over 30 individual referrals from the WBPs and carried out over 70 deliveries of essential food and toiletries to individuals who are shielding with no other means of getting these goods or to families either self-isolating or facing financial difficulties. The WBPs have also identified other more specific requests that we've been able to cater for, including the provision of a mobile phone for an elderly gentleman who had become unreachable by his doctors and regular prescription collections for a number of patients who cannot leave their homes.

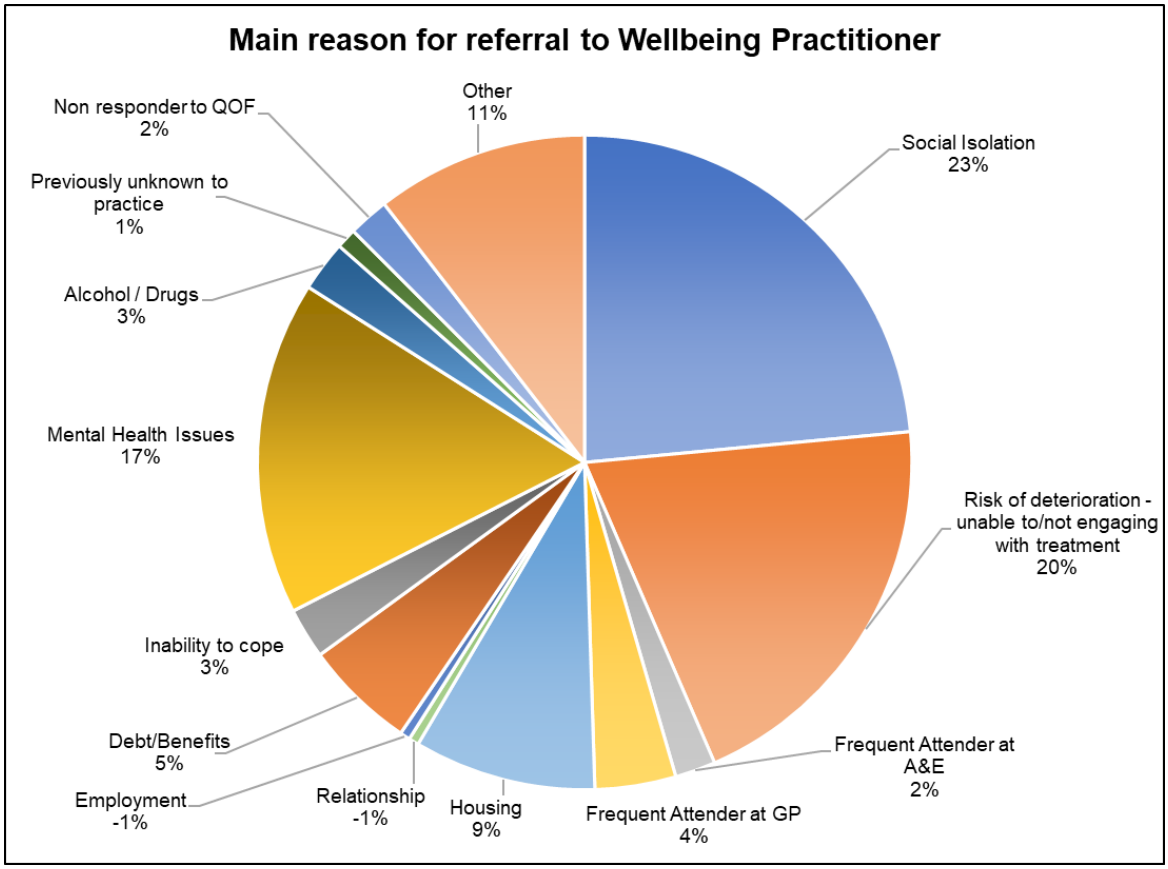
Feedback from our service users has been overwhelmingly positive, showing that this service has not only been essential but has acted as a much-needed safety net for these patients at a time when feelings of uncertainty and anxiety are high. Many of our service users have stated that they would not have known where to look for help had it not been for their connection to the WBPs. We hope to continue to work closely with the service moving forward.

5. Activity analysis – pre COVID-19

Across the 7 practices, the majority of patients referred to the WBPs are female and under 60 with 'pockets' of older men. Very few children have been referred as the main patient although the WBPs will work with the entire household/family if needed.

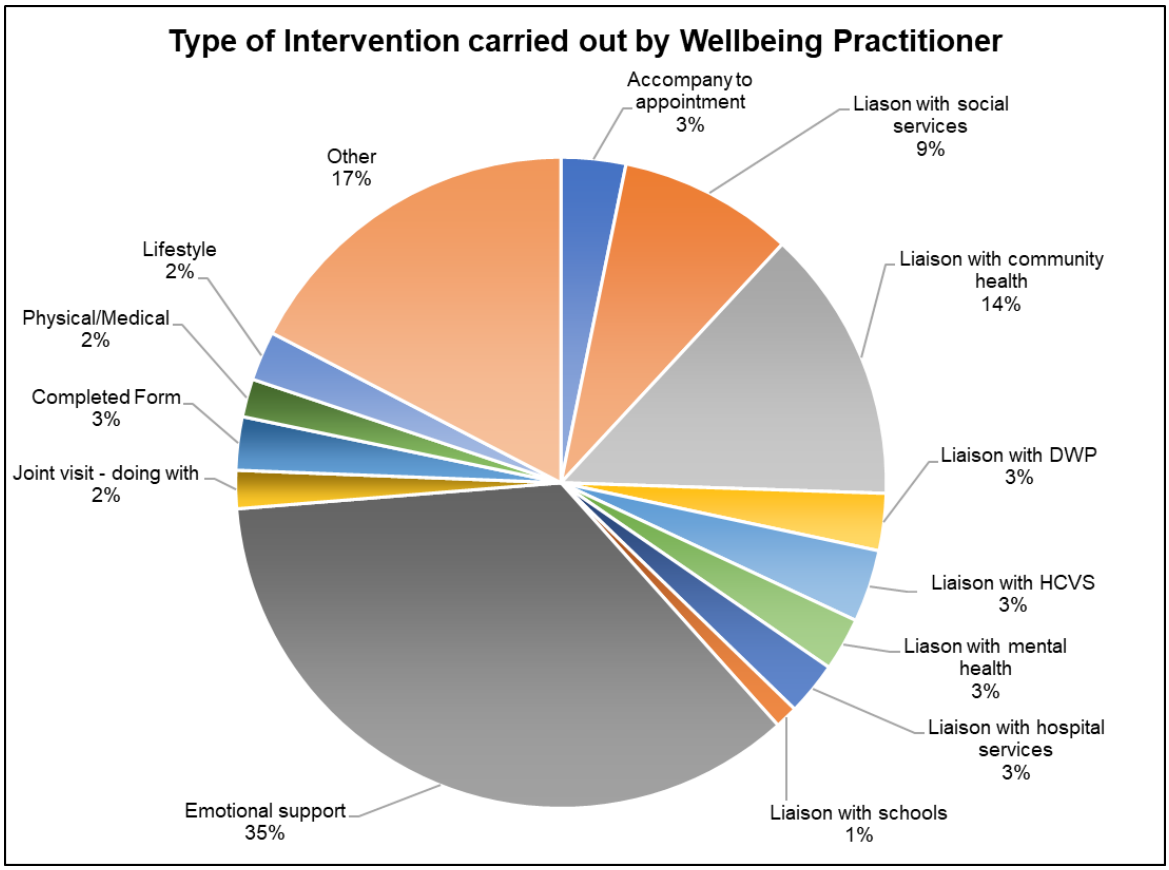
The patients on the WBPs caseloads typically have a number of problems and issues requiring expert assistance and 'unpicking', however, there is usually a main reason for referral to the WBP service and these are shown in Graph 1

Graph 1. Main reason for referral, February 2020 – April 2020



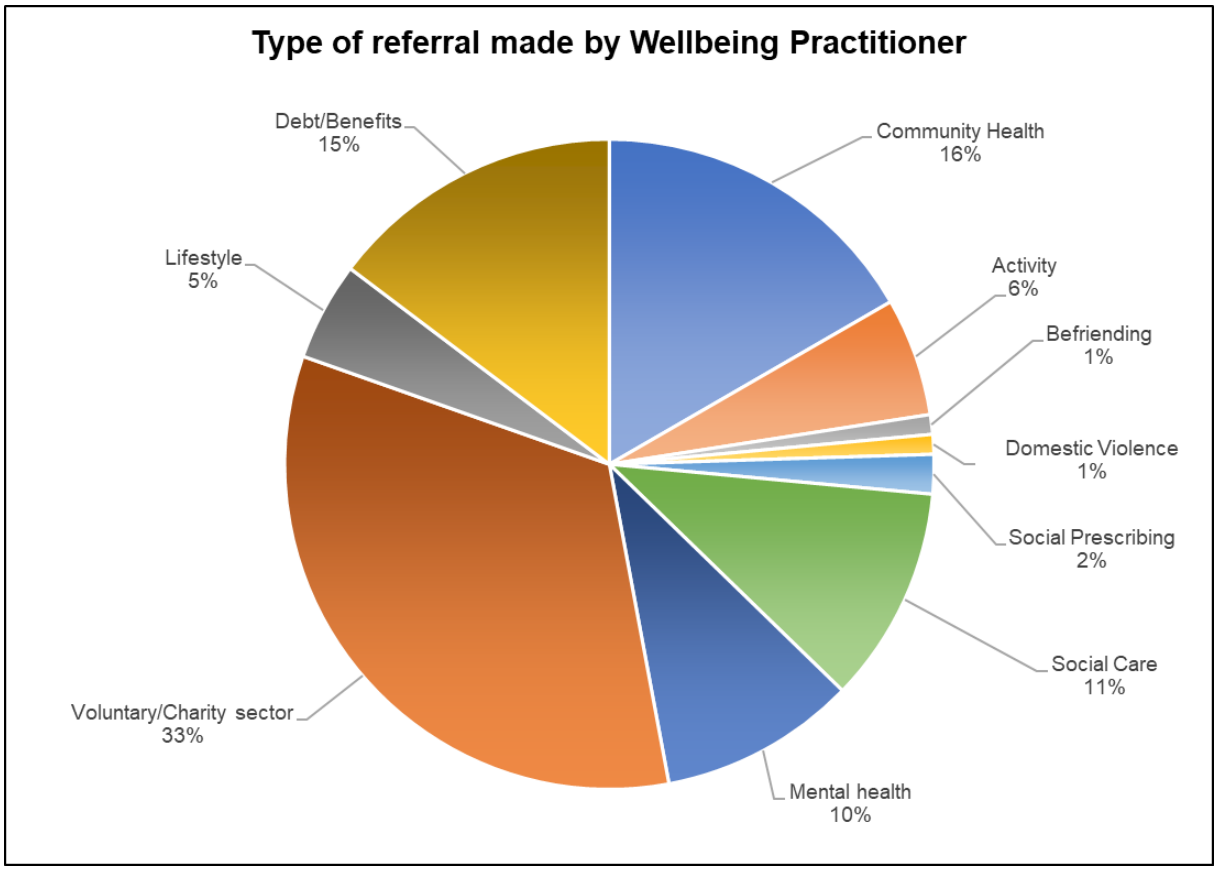
The majority of patients (47) were referred due to issues of social isolation or those at risk of deterioration because they were unable to engage or not engaging with treatment (40 patients). The third biggest cohort was those patients with mental health issues (33). The graph shows issues known to the GP at the time of referral. However, when face to face with the patients, the WBPs were able to identify other (underlying) problems not previously known about by the practice such as housing, unemployment, inability to cope, debt, past life events, mental health issues and social isolation. This would suggest that patients do not always disclose all their problems to health professionals and is also indicative of the multiple factors that people with complex needs are facing on a day to day basis.

Graph 2. Types of Intervention, February 2020 – April 2020



There was significant variety in the types of intervention carried out by the WBPs in supporting their patients (Graph 2), reflecting the bespoke nature of the service. The average number of interventions per patient were 3. The majority of patients requiring emotional support (35% of interventions) and to feel listened to. Typically, during the first visit or 2, the focus is on gaining trust, ensuring that the patient has a secure base and finding out what is important to the them. Emotional support at each stage underpins the ethos of acting always with kindness and going at the patient's pace – it is usually later that interventions would take place. Many patients required assistance in liaising with other agencies, most notably community health services (14%) and social services (9%). Liaison typically would involve making calls, writing letters, chasing outstanding queries, or seeking advice on behalf of the patient. The 17% of 'other' interventions varied in range – from information giving, liaison with family members to advocacy.

Graph 3. Types of referrals made, February 2020 – April 2020



When appropriate, a WBP will make a referral to another service whilst continuing to work alongside their patients. (Graph 3). Patients are not discharged or handed over from the service at this point, even if it is felt that the service referred to will most likely address the patient's needs. Most often referrals have been to a voluntary or charity sector organisation (33%). Section 4 of this report gives some examples of the types of support and services referred to under the 'umbrella' of voluntary/charity sector referrals. WBPs have been instrumental in gaining small grants for patients. They are also authorised distributors of foodbank vouchers for those patients experiencing food poverty.

5.1. CEG Activity report – pre and post COVID-19

The table below shows the data extracted by CEG from the WBP EMIS template. 660 patients in all were accepted by the WBPs, of which 140 were accepted prior to the COVID-19 pandemic. Numbers and complexity has varied across the practices with some patients requiring multiple interventions, visits or calls.

City & Hackney - Wellbeing Practitioners Monthly Report

Practices	PCN	Under care of advanced community care service	Patients entered onto advanced community care service	Patients given support and advice (COVID-19) since 1st March 2020	Risk to vulnerable persons assessed
Lower Clapton Group Practice	SE1 -Hackney Marshes	83	17	72	70
Latimer Health Centre	SE1 -Hackney Marshes	123	38	107	96
The Well Street Surgery	SE2 - Well St Common	201	27	186	181
Elsdale Street Surgery	SE2 - Well St Common	60	15	44	47
The Wick Health Centre	SE2 - Well St Common	70	11	58	56
The Lawson Practice	SW2 - Shoreditch Park	90	30	64	64
The Hoxton Surgery	SW2 - Shoreditch Park	33	2	33	33
Total		660	140	564	547

6. Outcomes and impact

The impact of the WBPs to the service and to patient outcomes has been significant in just 3 months. Already the service is making a difference to staff experience in the practices and the wider system and to patients wellbeing.

The following patient stories have been collected by the WBPs. Further stories can be read in Appendix 1

Ann

Ann lives with her grown up son in a flat. She suffers from ongoing depression but she is a woman who is very resourceful. She has managed to support them both for many years.

When I came to work with her she was really struggling with feeling very low and isolated. She was hoping to move to a new flat that the council had located for her as the current one had neighbours above her who kept her up all night every day. Up until being referred to me she had been receiving regular calls from the GP or a nurse at the surgery.

When we met, we discussed what would be most helpful to her and how I might support her. We talked about her plans for moving and I offered to support her with this journey both emotionally and practically. I also offered to accompany her to an activity she had stopped going to so that she could regain her confidence. She said she felt supported by me offering to do this. The fact that I had offered this seem to empower/ enable her to take the step to go on her own again which she managed to do once before the COVID-19 crisis started.

Over the course of the last four months I supported Ann with weekly visits and then phone calls during the COVID-19 Crisis and whilst she moved house. I offered a listening ear and we spoke together about how she could overcome certain difficulties. This involved us discussing the practicalities of how she could approach specific dilemmas. E.g. how to put up curtains in her new flat or be further supported with her caring role, how to communicate with the Housing Officer to ensure she got answers to her queries about the new flat, how to apply for grants to get white goods. She would tell me what she had done and I made suggestions I felt might be helpful and signposted or referred her to services she could access to support her and her son. For example, I referred her to SHINE for support with her bills, to the Carers Centre, to a subsidised handyperson service. I signposted her to mutual aid groups and referred her to voluntary services to bring her hot meals and food items during the COVID-19 Crisis.

During the COVID-19 Crisis she became very ill with suspected COVID-19, I ensured that I called her weekly to offer psychological support as she was so isolated. She later sent me a text saying, '…I'm so grateful for everything you helped me with. It made a huge difference to know someone cared…'

She has now moved and is settling in well. I continue to support her both psychologically and practically and we discuss weekly what she has achieved both for herself and her son. I often point out how resourceful she is. I believe that the one to one support and therapeutic way of working which offers a person centred, congruent and empathic presence means she feels cared for and validated as a person. The relationship we have built up and the support I have offered her has given her confidence and helped her to stay motivated. It has helped to stop her mood from becoming much lower. As a result of the referral to the WP the GP or nurse no longer needs to give her regular support on the phone.

Jenny

Jenny, is a 67-year-old woman, has dementia and a history of experiencing anxiety and depression. She has not been attending appointments recently and not taking some of her medication. Jenny has a number of supportive family members. Jenny finds it hard to do the daily tasks she used to and is not getting out much. Jenny talks a lot about wanting things to be how they used to be, and gets upset that she is just not herself these days. There are concerns about how her husband is coping.

I liaised with the community psychiatric nurse who said that she found communication with the family difficult as they seemed to be saying different things at different times and she was not sure how she could help at this stage. I had more time to speak with the family and try to understand what their views were around a number of issues. We all had a meeting together and discussed the issues around particular medications.

I have spent time with Jenny talking to her about her life, the things she enjoys, people who are significant to her. I have been out on walks with Jenny, and she has shown me around the neighbourhood as she grew up there.

I have referred Jenny to a befriending service and discussed other activities she may be supported to engage with. Jenny has said she enjoys spending time with me and her family have said she seems '*like a different person*' after I have visited.

A number of times the family have had medical related questions, and I have been able to find information out and communicate with them more quickly, and more frequently. Jenny's family have said this has 'gotten things sorted' that may otherwise have taken much longer and has made a huge difference to them.

COVID-19 specific: Jess

Jess was referred to me by a GP at the start of the COVID-19 crisis. She is a young single parent with a small child living in poverty in poor accommodation with no family support. I have never actually met Jess only spoken to her on the phone.

When I first started working with her, she was on the verge of a serious crisis. She suffers from depression and anxiety following a history of abuse and was very distressed a lot of the time meaning she was contacting the GP surgery every week. The GP referred her to me to see what support I could offer her.

Jess is extremely articulate and able to express her needs really well. I asked her what she needed and realised quickly that Jess needed a lot of practical support with getting food and hot meals. She felt paralysed by her environment and only had a microwave as the cooker was broken. She was in debt and couldn't afford to buy nappies or enough food for her and her small son. I immediately referred for food delivery to a Voluntary organisation called the Friendly Society that are helping people during the COVID-19 Crisis. This support is on a rolling basis and they contact Jess weekly. I also got hot meals delivered by a restaurant that is offering free meals to vulnerable people. This is usually only on a two weekly basis but I liaised with the owner of the restaurant and she agreed to do this on an ongoing basis during the COVID-19 crisis. This has been particularly beneficial as the hot meal is home cooked and both Jess and her son have really benefitted from this nourishment.

I have called Jess weekly and talked through what other support she feels she needs since she was referred to me. It was soon clear from speaking to her that she would benefit from long term support and so with her agreement I have completed a Wellbeing Plan and Network map with her so that we can try and work on some of her goals. I have referred her to services for support with her housing/debt management (CAB/ Engage Hackney) She was also happy for me to liaise with a Health Visitor from the surgery so she could get some advice regarding her parenting role and I discussed with Jess the idea of her having a family support worker to support her with parenting her son. She was keen on this idea so I then discussed this with the Health Visitor who contacted Jess. Jess and the health visitor also started to have weekly calls as a result and I have liaised with the health visitor when Jess needs something relating to her parenting. This has meant that between myself and the health visitor Jess is contacted at least twice a week for support. I have also liaised with the GP with regards to getting support letters for her benefits and to her lettings agent to take the pressure and stress off her. Jess and I discuss every week how she would like to be supported and everything I do is after we have spoken and she has agreed to my actions.

I have provided ongoing emotional support and encouragement to Jess. I have signposted her to organisations that can offer counselling support and I always commend her on her resourcefulness and ability to keep going in such difficult circumstances. She has an incredible determination to improve her situation for her and her son and I feel that the support I offer has meant she does not feel so alone of uncared for in this endeavour.

I have noticed that over the last two weeks she has seemed less distressed and a bit more in control of her situation. She is currently liaising with the services I have referred her to and also others that she has contacted herself. We regularly check in to see if there is anything she needs or if there is other support I can offer. She no longer contacts the GP every week.

This has been a very good example of the positive outcomes that someone can achieve for themselves with the backup of a WP who has offered a regular, reliable and consistent approach. It

has also been very helpful being able to contact a GP quickly and directly on her behalf when needed.

6.1. Patient feedback

The WBPs have received very positive feedback from their patients. Some of these are below with further examples of patient experience in Appendix 2.

- Patient: '*Thank you so much for all your support, kindness and compassion….'*
- Relative/ carer: '*You actually help. A lot of people come and talk but they don't do nothing'*
- *'(Last year I had a lot of support through the Hackney and City Carers Centre (Mentor Terrace) and learnt to really value the difference having someone to reach out to could be. I believe it was their support that gave me the confidence to begin to share my concerns regarding my mum with her GP in the first place)'.*
- Patient going through cancer treatment: '*Thank you this is the first time I have laughed for over a week'*
- Patient: '*I've never been able to speak to anyone before like I can speak to you…'*
- Relative/ carer: '*What you done already has really helped cos of where you are. You have been able to sort things out like about her injection, and the OT, you sorted it out and it's only been a week… it's lifted a huge weight'*
- Email from relative/ carer of 93-year-old patient who is housebound: *'I think your new service is amazing and really hope the pilot will be mainstreamed. It must be helping a lot of people in our situation.*
- Patient who has no recourse to public funds – I arranged for a foodbank voucher, she texted to say '*Just to say a big thank you, I am just leaving the foodbank, they gave me the food'*
- *I know my mum has enjoyed meeting you and receiving your calls and looks forward to hopefully being able to see you again in the (near) future. :)'*
- Patient: '*There have been times during this COVID-19 crisis that I just would not have known where to turn'.*
- Carer during COVID-19: *'I was making my own searches in terms of options for emergency support but you were able to give me verified contact details. It helped so much to know that there would be some support available that I could easily make contact with if I had to self-isolate myself'.*
- Patient who needed support to sort out long term debt and liaise with Council *'I can now vacuum my carpet I was too scared to do it before, scared of everything. I couldn't have done it without you.'*

6.2. Feedback from professionals

The impact of WBPs on the experience of the GPs and other H&SC professionals involved in patient care has been hugely positive and shows the value they give to the experience of their colleagues and to patient centred care. Some examples of feedback collected by the WBPs across their networks are shown below.

- GP regarding a patient: *'Just had a blood test, his thyroid function is no longer off the scale…it's better than it has been in years….*
- GP re following up with Alzheimer's Hackney navigator to get support for a patient while his wife was in hospital: *'The work you do is amazing and so valuable'*
- GP re supporting patient who has lost her husband from the COVID-19 virus: '*I think you have said something which she found very supportive and told me she enjoyed the chat with you last time'*
- Social worker: '*It sounds as if you're doing a great job in supporting mother at this time…'*
- Lead Nurse: '*People need someone to help them… e.g. attend meetings, where they don't have the confidence… getting that person to access services. Sometimes people don't meet the criteria for services, they fall back into the sidelines…'*
- GP: '*I think your input led to this patient opening up to me about the abuse…'*
- Senior Occupational Therapy Practitioner: *'I feel that this role supports the Social Care OT and Social work role in supporting clients and developing strong working relationships. Where clients need prompts to attend appointments, maintain social and family relationships and engage more in society to form more meaning roles and occupations. We don't always have the time to see clients as often as we can and provide this structure, routine and meaning to their lives. It is early days, but I see the role as essential in supporting clients and to enable and support, rather than "do for" and is developing skills and resilience in managing what is important to the client.*
- GP Supervisor: '*All the GPs have been feeding back how grateful they are for your support'*
- GP: '*I've really appreciated learning from you about local services available for our patients – lots of things I didn't know about'*
- Psychotherapy service: '*It's so great that someone like you will be working with this person. We've really struggled in getting him to access our support so you being able to help bridge that gap is great'*
- Nurse: *'I really appreciate your support with this family as I don't know what I can do at this point'*
- Social worker: '*The support you have provided so far has really helped this carer with the pressure'*
- GP regarding support offered to person going through the appeal process for PIP, he just heard yesterday he has got the enhanced rate for daily living and mobility: *'Thanks for all your help to make it possible'*

- Social prescriber manager: *'It really helps to do this co-working around people facing the most complex problems, it's really important to be able to work together and provide more comprehensive support'*

- Supervising GP: '*We are lucky to have WBP in our practice. It has made huge difference to our patients during COVID crisis. WBP has been very Proactive in supporting people in need and is great asset to practice.'*

- Practice Nurse: *'At a very uncertain time, during this pandemic it has been a real relief to have someone who can check on the 'well-being' of the most vulnerable patients. All contact was telephone based but it was beneficial to have someone with the time to be able to advise, signpost, help and assist patients in various ways. Many patients benefited from having contact with a well-being practitioner.'*

7. Challenges

7.1. Structural barriers and gaps

For many of the people referred, the dominant problem is debt/difficulties with benefits, and lack of suitable housing. When this is combined with mental health issues, the anxiety caused can mean that any other support work, has to take second place, to enable that person to feel that their money issues are in a better place. However, if a person is in an appeal system for challenging a benefit decision, it can take between six months-one year. Coping with this uncertainty can have a really detrimental impact on their mental health.

There is a predominant practice of professionals completing the piece of work needed, and then closing the case. Most professionals have a limited remit and timeframe. As soon as the service has been provided the case is closed, rather than having some scope to keep the case open, and follow up to see if the support has met the needs. There does not seem to be a culture to share information across health and social care (of course with the essential element that the person has consented), in part due to professionals not having the time to do this 'linking up' work.

There are also many gaps because of limited criteria to access services. A few people have found that when they have asked services to support re Housing needs, they have been told by various services they cannot help with this. A number of people have not met criteria for more intensive mental health support, even though they have ongoing mental health problems that impact on their life daily. The WP has at times provided a 'holding' space for those people who are waiting for counselling services to start but who have no other support in place. The WP provides a space that they would otherwise not have. Additionally, Mental health services seem to discharge people quickly – we have at times been advocating on behalf an individual to keep their 'case open'.

7.2. COVID-19 challenges

During the time in lockdown, it has been very difficult to access help for people who are not able to follow advice over the phone, such as completing a form for those who do not have anyone living with them who can help. This has applied to patients already on the caseload as well as those directly affected by COVID-19.

In these circumstances, WBPs have advocated for people e.g. written to the DWP to ask for their discretion, regarding time limits for completing forms and have referred to CAB for telephone support too; also contacted the council on their behalf to ask that there are no changes made to their

housing benefit/council tax, until they are able to complete the Work capability form for ESA. The council has contacted me to say they are not going to make any changes until July. WBPs have posted forms and cycled (respecting physical distance rules) to post a claim form through a person's door, where the person had lost the form and did not have access to a printer.

The work to support to attend appointments has had to be put on hold, and in most cases a lot of the appointments have been postponed. The same is the case for people who WBPs were going to start supporting to attend some community activities. However, where this has been helpful to the person, we have continued to call to see how they are doing during this time.

For people who have a hearing impairment/and don't want to use a hearing aid, it has also been more challenging to continue the support needed, as it was much easier to understand the needs when you had some visual prompts too, and could get up close. WBPs have tried to be in contact with people in this person's support network who are key workers and able to visit still.

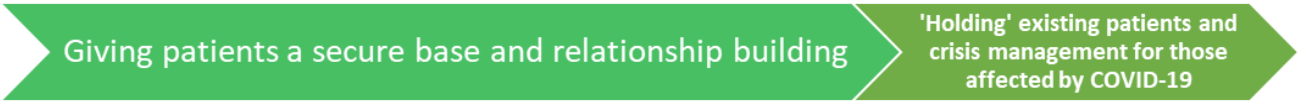
There have been some online supports which have been able to continue through this period, eg a referral made to the Alive and Kicking programme (before lockdown), to support with weight management, and the child and parent have started to access their 1:1 online programme, so it was really positive to see the work could still continue.; also online support from Core Sports/Arts.

Multi-disciplinary work has been able to continue via email, phone, and Zoom calls. One of us attended the Hackney Marshes Neighbourhood Conversation on 16th April, and one of us took part in Shoreditch Park and Hoxton PCN Neighbourhood networking meeting, facilitated by the Shoreditch Trust on 22nd April. WBPs have been in touch with a range of professionals via email and phone. One of us took part in a core CP meeting via telephone conferencing too. The nature of the COVID-19 work has also led the whole team to discovering and building relationships with a range of voluntary sector organisations, such as the Good Gym and CAB.

8. Conclusions and learning

8.1. Main conclusions

In a short space of time the WBPs have demonstrated their usefulness and have become integral to the day to day working of the practice team and the wider social prescribing team. Just 5 weeks after the launch of the service, the COVID-19 pandemic meant that the WBPs had to quickly adapt to the change in ways of working, approach and an increase in caseload. They moved from giving patients a secure base and relationship building to working alongside patients affected by COVID-19 (often in crisis) whilst continuing to support their existing caseload and adding to it from the COVID-19 cohort as appropriate.



During the COVID-19 pandemic, feedback shows that the service has become an invaluable resource, as the WBPs have been able to use their skills to support the practices in a time of great need. They have worked through lists of patients affected by COVID-19, many of them vulnerable, and, using local knowledge, have been able to assist them to gain access to the help available. They have been able to ensure vulnerable patients remain protected; working quickly and effectively within the restrictions that the pandemic has imposed on their usual operational model.

8.2. Improving joint working at practice level

Over the last few months the GPs have been able to see the WBP as a reliable and responsive source of support to be able to start to address some of the social, emotional and practice issues that their patients have flagged up with them in the surgery. The WBP provides a crucial link between the GPs and other services that the GPs do not have the time to research themselves but can refer to the WBP to do this. The WBP has the time to get to understand the complexity of the issues and how they are impacting on the person in a way the GP does not. This may enable a more holistic approach for people through joint working with the GP and WBP leading to better outcomes for people; and offer an improved understanding by the GP of some of the non-medical complex difficulties that people are going through as a result of the work carried out by the WBP with these individuals. The WBP role is supportive to the GPs who want the patient to get the support and services they need beyond their medical needs.

Because a WBP can work very closely with the person it is possible to develop a network of support around that person. The WBP can respond to that person much more closely, not just appointments for half a day a week like other visiting services. It is also possible to be flexible and arrange to meet that person at their home or another community setting. As a WBP you are able to do this intensive work, you are able to build a close and trusting relationship, the person will share with you quickly any issues they are experiencing. It is also possible to have the time to understand the network of services around that person, and to be able to hold the network (gently) accountable for the work promised, and to be able to very quickly feedback any issues or problems. As without this, it is very easy for months to go by, without anyone realising that something has gone wrong with a referral, and this often means having to start again, leading to more delays for the person to have their needs met.

The WBPs been attending practice MDT meetings, and have been able to update the MDT about support of patients discussed in the meeting who they have been providing support for, and pick up new referrals for patients who have not previously been offered support. WBPs have also been able to offer suggestions at practice MDTs around options for support, enabling a more holistic approach to patient centred care - 'The glue that makes it all come together'. The MDTs have given the WBPs the opportunity to learn about other organisations attending the MDT meetings. This also gives WBP the opportunity to liaise directly about people who need support with these organisations.

The significance of the service in the lives of the patients who are discussed at MDT has been acknowledged by the professionals attending these meetings. The WBP service is seen as a ‘service that they have been waiting for a long time in these meetings’ as it complements the neighbourhood model where there is a real need for a holistic, wellbeing focus and a non-medical approach. The WBPs provide and get very good feedback in the MDT meetings as patients relate differently to them as a non-task based service. The WBPs use the practice MDTs as an opportunity to feedback on identified gaps in current care packages and provision of services.

9. Recommendations and next steps

Current funding for the WBPs is time-limited via a grant from the CEPN, and will end in January 2021. In view of the adaptability and flexibility of the service, the impact achieved in such a short time, and the pressures on primary care arising from patients affected by COVID-19, we would recommend some thinking with partners around how we scale up and mainstream this service in order to create a sustainable ‘business as usual’ WBP service for Hackney. We have, in sections 9.1 and 9.2, outlined some options for consideration.

9.1. Strengthen and enhance the service

One option would be to follow successful models such as Mendip Health Connections and look at how the WBPs could be supported by trained volunteers in the GP practice or another already established voluntary service to manage a greater caseload more cost effectively. In this way the WBPs would carry out the initial assessment and complex support and when/if appropriate (and the patient agrees) introduce a volunteer who could pick up ongoing, simpler tasks, maintain contact with the patient and chase other agencies as necessary. This model is also used in some voluntary sector organisations. This allows the experts to do the expert work.

9.2. Working across a neighbourhood / PCN

The WBPs are one of many services in the City and Hackney community navigation 'landscape'. These are services that coordinate care/support and help residents to navigate the H&SC system. There has been a strategic group working to integrate these services in order to improve wellbeing by tacking the social determinants of health.

At the same time the City and Hackney neighbourhood programme was working to set up a Neighbourhood Team (NT) for each neighbourhood/PCN that would be multi-agency, multi-disciplinary and meet on a monthly basis (MDM) to review support for patients with complex needs who cannot be 'held' by one service.

The advent of COVID-19 has accelerated the launch of the NT MDM and these meetings are now live and will have rolled out all 8 City and Hackney neighbourhoods/PCNs by the end of June 2020. The NT MDM will continue beyond our immediate response to the pandemic.

The patients discussed at the NT MDMs might include any of the following:

- People who are falling between the gaps between services
- Where there is a presence of serious unmanaged conditions
- Where the case has touched a number of different professionals
- Where there are recurrent crises or frequent incident reports.

Critical to the success of these MDMs is a care coordination/care navigation function which is described as follows [1]

- Holistically bringing together all of a person's identified support and care needs
- Supporting people in preparing for shared decision making conversations
- Providing advocacy such that individuals develop trust with all organisations providing support to them

[1] nb. These functions are not a replacement for a commitment by individual teams within the Neighbourhood Team to continue care and support for individuals. Any care coordination function should be carried out alongside existing professionals rather than a replacement for.

- Working alongside the NT to ensure there is a single personalised care and support plan for individuals based on what is important to them
- Where possible helping people to manage their own needs and ensuring people have good information to help them make decisions about their care
- Work with specialist teams to ensure that issues are unblocked and care/support is available when needed
- Working alongside individual members of the Integrated Neighbourhood Teams to support the follow-up of actions following the meeting and ensure that actions are completed
- Work alongside social prescribing leads to help people access voluntary support where this is appropriate

There is a recognition that there are already existing roles within City and Hackney providing care coordination related functions and that further work is required to agree the exact care coordination functions that are needed and how this lines up with existing roles across City and Hackney.

We feel that this is an excellent opportunity now to share the learning from the WBP service and to lock this into the development of the care coordination / care navigation role within the MDM, especially as the NT MDM cohort is consistent with those the WBPs work alongside and the core functions and methodology of the role align with the WBP ethos and process.

This document has outlined the many advantages to having the WBPs based in a practice, however, at this stage, we feel it is worth exploring whether these roles could be scaled up to meet the care coordination requirement for NT MDMs and what this might look like.

Working across a larger geography would have implications in terms of data access and caseload but would bring together our aspirations as a system to build a cohesive care co-ordination offer around each MDM, supporting work at all levels, and linking to a strong volunteering service offer at practice level. This would bring the best of the range of skills we already have into an organised function in order to build on the ethos of the WBP worker and to use that senior skill and resource to shape that ethos throughout our care co-ordination wider Neighbourhood Team.

We would hope that these findings can start a conversation between City and Hackney system partners as to how the WBP service can be developed in future.

Authors: Julie Vazquez and the WBP team

If you should have any queries about the service, please direct them to
Julie Vázquez, Neighbourhood Development Manager, at j.vazquez@nhs.net

Appendix 1
Further patient stories

Jackie

Jackie was first referred because of the stress the unsuitability of her accommodation was causing. Jackie was receiving support from other agencies, but this support was time limited or infrequent, and when one service ended, I was able to confirm that I was still able to support. Due to building a relationship with Jackie she was able to trust me with information about her deteriorating relationship with her adult daughter (age 18) and agree to a referral to social services, which has now led to her daughter accessing help from a social worker and being allocated a Young Hackney worker. Because I have been able to support the whole family, it has been possible to look at both the needs of the mother, her son, who has special needs, and the older daughter.

Peter

I supported Peter, who was being told by the pension service that he needed to have a bank account, but he only had a post office account. Because of this he was being told he could not complete their questions. I called the service, and established it was okay for him to have a post office account, but in around a year, he would have to think about changing, as the contract with the Post Office was ending with the DWP. He was then able to complete the form with the pension service.

Maria

Maria, who is 53-year-old woman, has been experiencing a range of physical problems including persistent pain, but many medical investigations have not found the cause of this. Maria often calls 999 and frequently attends A&E at many different hospitals seeking medical attention for these problems. Maria has faced a number of traumatic experiences in her life. She has in the past been referred to mental health services which she has not found helpful.

In my work with Maria, I have acknowledged the problems she is experiencing and discussed the role of the medical system for her. Maria has agreed to and we have begun working with the High Intensity User Team at Homerton hospital to collaboratively write a care plan for how medical professionals respond to her.

Maria has shared with me that some of her family do not believe her when she has talked about her physical problems with them. We have agreed that a longer term plan is that, led by her, I will work to support her family to understand her experiences and invite their support.

Maria has asked for me to advocate as she wants a housing transfer, however, she does not meet criteria for priority. I have discussed this openly and with respect, acknowledging that it is understandable that she would want to live somewhere she feels most comfortable.

It is my understanding that Maria is often not believed, that she may be viewed as ‘fabricating’ her physical problems, that perhaps she is trying to get access to particular things which is perceived as ‘manipulative’, and that she may be seen as a ‘time waster’. In my interactions with Maria, I seek to acknowledge and value her experiences and beliefs.

Sharon

Sharon was referred because of social isolation. She has battled multiple physical and mental health issues including a haemorrhage a few years ago which resulted in her losing her verbal and motor functions although she has largely regained these through persistence and physiotherapy. Sharon has also overcome a dependency on crack cocaine and heroin and had now been off these completely for 3 years.

At our initial appointment we explored what would be helpful to Sharon, what changes she wanted to make and it was evident that she was motivated and thoughtful about her next steps. We also reflected on some of the huge changes that Sharon has made and the vast obstacles she has overcome. Sharon wanted to visit a community garden project to see if she would feel comfortable here as she is green fingered and keen to meet new people as she had stopped seeing her former friends when she came off drugs. Sharon was also keen to join a creative writing group as she has written journals on and off over the years and was keen to explore this again now as she felt in a very different space.

We attended the community garden together in Hoxton, Sharon was enthusiastic and found the fellow gardeners inclusive and welcoming. We were planning our second visit, so that Sharon felt more established and comfortable to go alone, when the lockdown was introduced.

Since lockdown we have been speaking at least once a week on the phone. Some of this has been in relation to practical barriers that Sharon is confronted with as she is not able to go out as she has been advised to shield. I have made referrals to the local church who have been bringing food parcels at intervals. We have also talked about the impact on wellbeing that this crisis is having on Sharon and society more widely. Sharon has had a few issues with credit on her phone so I have also arranged for the surgery to contact her when she needed to speak to her GP.

We have started to revisit the goals that we had originally set out, and have been exploring alternative ways for Sharon to access to a laptop and then get involved with a community or online writing group.

Tommy

Tommy was referred for support to attend important medical appointments. He was staying in a hostel in a neighbouring borough. I went to visit him in his hostel and met with his key worker. We agreed with his consent that we would work together to support him to attend the appointments. On one occasion I arranged to meet him at the appointment, on another I went to the hostel to meet him and then go with him to the appointment at the GP surgery. Initially he did not feel able to go, but with encouragement from his key worker, he did decide to go with me, and we arrived back to the surgery just in time for him to have his leg dressed. Working together with his support worker before lockdown, I was able to ask for changes to the timing and location of his appointments, to lead to better attendance.

Sophia

There have been long standing issues around Sophia accessing the support she needed, such a Carer and Wheelchair. Sorting these issues out had been taking the GP a lot of time.

My aim in getting involved was to create a multi-disciplinary team around Sophia. As my observation was that agencies did not communicate, and this led to gaps and misunderstanding. There had been a referral for a wheelchair, and Sophia had been waiting many months for an assessment, but then this was stopped by another agency who wanted to see if she was able to be mobile. By coordinating the views of the multi-disciplinary network, it was possible to change this, and she was allocated a wheelchair just before the COVID-19 lockdown. I have supported Sophia by making sure hospital transport was booked and liaising with her 'MDT', I have also carried out joint home visits with professionals in the network, and by being up to date with the situation, I have avoided professionals referring back to services who have already closed or said they cannot help.

By being in close contact with Sophia's carer and care agency during lockdown, I have still been able to help. I have alerted the GP that her medication was running low or needing a change. Just before lockdown, following from my suggestion that a multi-disciplinary meeting was needed, a date had been set, which was a very promising development. Unfortunately, this date was then cancelled, however, because I now have contact details for the professionals in Sophia's 'MDT network', I have found that everyone can be cc'd in emails (if relevant) and they have responded quickly to issues raised.

I had also begun to build up some trust with Sophia so that she had agreed to a referral to have an assessment for hearing aids. Many of the difficulties and frustrations she experiences, is because she is unable to hear people.

COVID-19 Case Studies

James

James was over £1000 in debt with is utility bill, during lockdown, I have managed by phone to get the information needed to submit a grant application to help to reduce this debt with Scottish Power. (Later heard that Scottish Power have agreed to write off £969.24 of his debt and arrange a payment plan, where he pays of £1 a month towards his arrears)

It was also very difficult to be able to find any financial help for a person who has to shield, and as a result is not able to do his cleaning job. He has no recourse to public funds, as he in on a six-month visit visa. He is getting his food delivered but he has no money to pay his rent, and is facing eviction in a few months. I contacted the Council discretionary fund but they were unable to help with money, but could help in kind with food vouchers. I also called Shelter, but they said there was not financial help available to pay the rent in these circumstances. With permission from the person, I spoke to his friend, to find out if he could draw on any informal networks to help pay his rent, but unfortunately no one he knew was in a position to help out. I remain in contact with James and continue to try and help him resolve his debt issues.

Mo

Mo was referred to me by one of the GP's to call and offer support following the onset of lockdown. Mo lives alone in supported accommodation although he has a partner who lives in Colombia whom he has some video contact with so has some virtual social interaction. Mo described that he did have a friend who was helping him out here and there with food shopping so he was fine for the time being. He said he was doing ok and not in need of weekly calls but was happy to take my number in case something came up.

A week later Mo called me and asked if it would be possible to be referred to a food parcel scheme as he was worried about relying on his friend who lived outside of London and he was running low on food. I contacted the council scheme for support for vulnerable people in the borough and although the staff were very helpful and proactive there was a three day wait before the food would arrive.

I called the local church who have been very active in the community and by lunch time they had brought him food to last until the council's parcel arrived.

Since then Mo has requested a weekly call, partly to ensure the food has arrived but Mo is starting to talk more about the impact this is having on him emotionally. We have built a good rapport and the support has evolved around the challenges being presented by this crisis.

Appendix 2
Further feedback from patients and carers

- Patient who has to shield, receives Government parcel, since 23rd March, I have been in weekly contact, Joy described me as her '*connection to the outside world'*
- Carer: *'I have found that being able to discuss aspects of her behaviour or situation with you brings a different perspective and proportionality that has really helped me to see different options and ways forward. It can be so easy to fall into a certain kind of coping mechanism because you are either to tired or stressed to see outside the box. Our conversations have enabled me to see different aspects of her care and to try to experiment with other solutions'.*
- Patient who experiences anxiety and is also having cope with a recent bereavement, I am in regular contact, supporting with understanding paperwork for Probate, listening, helping it to feel less overwhelming, text message received '*Thx ever so much for listening'* – she recently had a consultation with her GP described my support as '*brilliant'* in the notes.
- Patient who has needed support during COVID-19 with referral for food and to help access laptops for her children '*The family are very grateful…thank you.'*
- Jane decided she did not want a referral for a volunteer after our conversation, but still texted to say '*I am very grateful for your shopping advice help. It's also good to know that there's help if needed'*
- Patient who was very tearful as she had no food left or money to pay for food, I was able to put in a referral to the Good Gym immediately and the next day she had some essential food. When we spoke, her whole tone of voice had changed, as she said that due to the help, she was feeling '*much happier*'
- Patient: '*These visits are helping. Knowing someone is there I can reach out to. I find that really supportive'*
- Patient who experiences a lot of anxiety: '*I felt very relaxed after the visit last week*'
- Relative/ carer: *'It really helped spending that time, cos the district nurses don't have that time to talk. You made an old lady very happy… she had a good couple days after that visit, it was fantastic'*
- Patient: '*It was helpful to talk to you, it was good to have someone to listen to my view*'
- Patient: *'I've always been on my own at these appointments in the past…'*
- Relative/ carer: '*The position you're in… really helps… you get back to us. Really well needed at each GP, it touches all bases at once, an essential part of the team'*
- Patient: *'I can't believe you've been able to help me with that, I've been worrying about that for months and no one has been able to help me*' (after contacting the council to get some locks changed due to a DV risk within a day)
- Patient: *'Your support makes me feel like someone cares, thankyou'*

- Patient who is 80 and has been housebound for several years phones the WP during COVID-19 lockdown to check the wellbeing of the WP whom she has met at home several times before: *'People will think differently after this [COVID-19 crisis]. As I said you're a lovely visitor. I've been thinking about you, if you've been ok, if your family is ok'*

- Carer: '*From a personal point of view I have found it incredibly useful to have someone I can share concerns regarding not only some elements of my mums health but also her safety and general wellbeing'*

- Carer: *'Up until your new service I had spoken to or seen her GPs on several occasions over the previous 16 or so months. (Far more than in the previous 16-year period combined). I was always conscious that some of the issues or concerns I discussed with them were not directly linked to her actual health in terms of medication but still had implications for her safety in particular and that in some way I was 'wasting their time' with these - not that I was ever given the impression that I was wasting their time'*

- Carer: *'My mum is very certain and convincing about her version or reality. My version and experience of the support she requires on a day to day, week by week basis can be quite different. At that point in time I felt I had nowhere else to have these concerns noted as my mum has not had a recent Needs Assessment, even though I had requested one around Jan 2019. (She has been assessed by an OT within the last year but she refused their recommendations & consent for alterations because she does not want to undergo a Financial Assessment, nor pay for any changes herself). I felt that as she was becoming more vulnerable I was too - in terms of the responsibility I felt I had should anything go terribly wrong, especially if I hadn't been able to have my concerns formally noted in the first instance'.*

- Carer: *'Because my mum did not have a formal diagnosis in terms of getting extra support this had also left me in a grey area myself'.*

- Carer: *'Your role has meant that I now have someone I can contact easily and run through maybe a current crisis or concern'.*

- Carer: *'Having someone who is available to listen and offer advice when they actually know the person involved is just such a relief'.*

- Carer: *'I have found your home visits to be very helpful'. This is both in terms of having someone as an observer to her home situation and as another voice of reason who my mum may be more willing to listen too. I believe it has also helped for her to get to know someone new - to be used as an example of how she could go on to build a relationship with a career in the future. I was also pleased that you were able to attend her recent assessment at the memory clinic, because of your home visits and getting to know her better, you were able to reinforce some of what the doctor was telling her regarding her situation'.*

- Carer: '*Your role has also been very timely because any progress towards further assessments my mum may require have come to a halt but your role has remained as a source of help, support and guidance'.*

Training Hub Workforce Enabler Board
Wellbeing Practitioners – request to extend the project

City & Hackney GP Confederation
A community interest company

1. Summary of the Wellbeing Practitioner Service

We know that the biggest determinants of health aren't what happens in the Doctor's surgery but what happens outside. As little as 10% of a population's health and wellbeing is linked to healthcare access, the other 90% is influenced by wider factors. This project is based on similar schemes in Frome and Manchester which demonstrated substantial health gains and substantial decreases in mainstream health costs following the embedding of these roles.

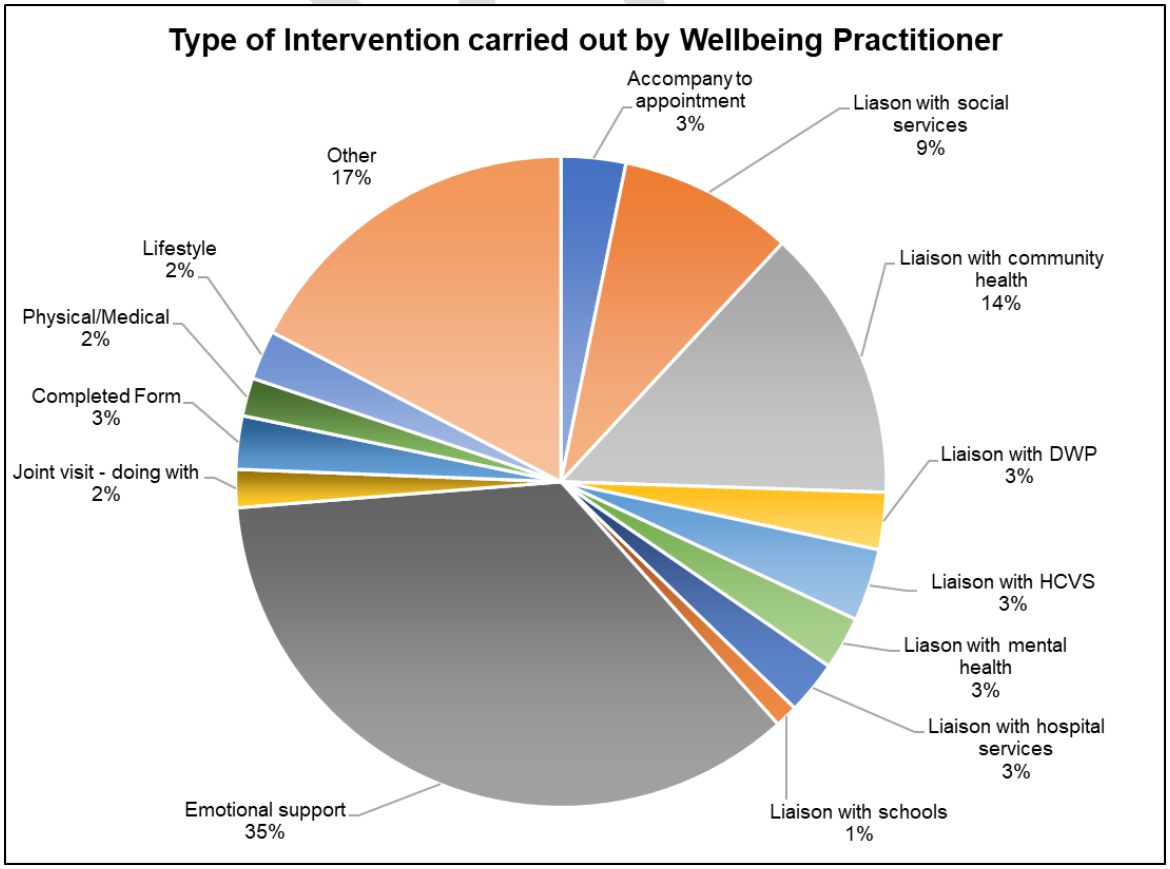
The role of the Wellbeing Practitioner is to work with the most disadvantaged in society, people who are unable to access the many voluntary and borough services available to people with social and mental health needs. The Wellbeing Practitioners (WBPs) have a 'never give up' philosophy and can visit individuals and their families in their home in order to support individuals to access the services they need to improve them health. Our WBPs support people with the social, emotional and practical problems they are facing, with flexibility and no limiting referral criteria, remit, or timeframes. 7 WBPs were employed, each based in 1 GP practice. Just 5 weeks after the launch of the service, the COVID-19 pandemic meant that the WBPs had to quickly adapt to the change in ways of working, approach and an increase in caseload. They moved from giving patients a secure base and relationship building to working alongside patients affected by COVID-19 (often in crisis) whilst continuing to support their existing caseload and adding to it from the COVID-19 cohort as appropriate.

An interim evaluation report was published in May 2020 which is attached.

Wellbeing Practitioners - First (

The following tables provide an overview about the type of work the WBPs do and their activity over the past few months:

Types of Intervention, February 2020 – April 2020



City & Hackney - Wellbeing Practitioners Monthly Report

Practices	PCN	Under care of advanced community care service	Patients entered onto advanced community care service	Patients given support and advice (COVID-19) since 1st March 2020	Risk to vulnerable persons assessed
Lower Clapton Group Practice	SE1 -Hackney Marshes	83	17	72	70
Latimer Health Centre	SE1 -Hackney Marshes	123	38	107	96
The Well Street Surgery	SE2 - Well St Common	201	27	186	181
Elsdale Street Surgery	SE2 - Well St Common	60	15	44	47
The Wick Health Centre	SE2 - Well St Common	70	11	58	56
The Lawson Practice	SW2 - Shoreditch Park	90	30	64	64
The Hoxton Surgery	SW2 - Shoreditch Park	33	2	33	33
Total		660	140	564	547

Feedback from practices and other staff has been 100% positive *'The work you do is amazing and so valuable'* Patients have been similarly appreciative *'Your support makes me feel like someone cares, thank you'*

2. Impact of COVID-19 on evaluation of the service

During the pandemic the WBPs were unable to see through much of their work with existing patients due to a pause or closure of existing support services. This has meant that expected outcomes have been delayed by approximately 6 months as face to face contact (with PPE) was not resumed until September. Many services are still not operational in the voluntary sector, for example befriending services, drop in centres and social activities and this has meant an extended period of isolation for this patient cohort.

3. Proposal for extension and costs

In view of this, we are asking that the Training Hub consider an extension to the pilot of 6 months from January 2021 (current employment contracts run until the 19th Jan 2021) to 16th July 2021 in order to enable us to deliver the full programme of work and be able to demonstrate via the final evaluation the impact of this service. Based on the last 6 months of expenditure the cost of extending the service (non recurrently) would be £139,973.89 (see attached finance schedule).

4. Sustainability and scaling up

The City and Hackney Neighbourhoods Programme has been working on the development of a model of community navigation and are developing a business case for non-recurrent funding to present to the CCG. We see the WBPs forming an integral part of this model, scaling up to work across neighbourhoods to support the work of the neighbourhood MDT. The CCG is looking at longer term financial modelling to assess how this might be recurrently funded, but this is not possible in the short term. The GP Confederation would like to lock the WBPs into into the development of the care coordination / care navigation role within the neighbourhoods, and enable them to become a core part of the Neighbourhood Multi-Disciplinary Team.

5. Summary

In summary the Wellbeing Practitioner pilot has, COVID-19 notwithstanding, shown itself to be a worthwhile service which is having a positive impact on the lives of its patients and the working lives of the health and wellbeing teams involved. It is recommended that the workforce enabler board consider supporting non recurrent support to extend this service for a further 6 months so that we can fully evaluate and so that the early strong indications of success will not be lost whilst a business case is developed for further sustainability.