Primary Care Network Health and Wellbeing Coach

Primary Care Network: Northfield, Harborne and Quinton PCN (NHQ PCN)

Reports to: Nominated Clinical Lead within PCN/ Practice

Managed by: PCN Management Lead / Clinical Director

Salary: £25,000-£29,000 depending on experience

Hours: Full time (37.5 hours)

Job Summary

The post holder will have responsibility for proactively reaching out to and providing lifestyle input into a defined cohort of patients.

They will be a key member of the Primary Care Network (PCN) team, playing a critical role in engaging patients and use health coaching techniques to support them to take an active role in their health and wellbeing.

A Health and Wellbeing Coach works with a range of individuals, this role will be initially focusing on those with Type 2 diabetes and obesity.

The post holder will work closely with the other members of the primary care team and complex care teams in the management and decision making about care and service provision for individual patients. This will include:

- Care planning, health coaching and delivery of systematic self-management support based on a knowledge of individual's activation levels.
- Support effective team working in primary care networks through taking on appropriate practice-based tasks and attending regular multidisciplinary team (MDT) meetings when required.
- Support for individuals to access appropriate community resources and services.

Job purpose

- Identification of people who would benefit from health and well-being coaching interventions.
- Responsibility for providing support (clinical or non-clinical) to a cohort of patients who will benefit from proactive health management.
- To accept referrals from members of the general practice and PCN teams.
- Teaching and supporting patients and carers to understand and manage their own conditions and maintain an independent lifestyle through health coaching techniques to encourage patient activation.
- Supporting the development of personalised patient care and support plans, liaising with the GP practice team, patient and or carer and specialist teams as appropriate.

- Playing an active role in MDT meetings if required (regular practice meetings to discuss high risk and or complex patients) by gathering information and being prepared to update the team on patient progress towards goals etc. (as per their care plan)
- Map and connect community activities and resources at a locality level including working closely with the Social Prescribing Link Worker to support the PCN population.
- Support the delivery of community based public health initiatives such as physical activity, healthy eating, and social connectedness.
- Adopting a multi-disciplinary and multi-agency approach to care, ensuring that all aspects of the patients' needs are met.
- Participating in relevant clinical and service audits
- Maintaining professional and personal development aligned to role.

Key role requirements

- To possess the knowledge and skills to motivate and deliver education to patients to engage in dietary and lifestyle changes to benefit health, for example education regarding low carb diets for diabetes.
- To be involved in group activities, consultations, and support groups to facilitate improvements in health and well-being.
- Focus on obesity (BMI >30), Type 2 diabetes and pre-diabetes.
- Coach and motivate patients through multiple sessions to identify their needs, set goals, and support them to implement their personalised health and care plan.
- Provide personalised support to individuals, their families, and carers to ensure that they are active participants in their own healthcare; empowering them to take more control in managing their own health and wellbeing, to live independently, and improve their health outcomes through:
  A) Providing interventions such as self-management education and peer support.
  B) Supporting people to establish and attain goals set by the person based on what is important to them, building on goals that are important to the individual.
  C) Working with the social prescribing service to connect them to community-based activities which support their health and wellbeing.
- Provide support to local community groups and work with other health, social care, and voluntary sector providers to support the patients' health and well-being holistically.
- Ensure that fellow PCN staff are made aware of health coaching and social prescribing services and support colleagues to improve their skills and understanding of personalised care, behavioral approaches, and ensuring consistency in the follow up of people's goals where an MDT is involved.
- Raise awareness within the PCN of shared decision making and decision support tools and supporting people in shared decision-making conversations.
- Work with people with lower activation to understand their level of knowledge, skills, and confidence (their "Activation" level) when engaging with their health and wellbeing.
- Facilitate groups of patients- in group consultations to assist patients to work with others for their own goals, including case finding groups of like-minded people.
- Utilise existing IT and MDT channels to screen patients, with an aim to identify those that would benefit from health coaching.

Other responsibilities

- To act at all times in an anti-discriminatory manner
- To be able to plan and respond to workload according to operational priorities
- To support the delivery of these functions across wider locality areas where necessary
- To undertake any training required in order to maintain competency including mandatory training
- To contribute to, and work within a safe working environment.
- The Health and Wellbeing Coach must at all times carry out duties and responsibilities with due regard to the GP Practice's equal opportunity policies and procedures
- The Health and Wellbeing Coach is expected to take responsibility for self-development on a continuous basis, undertaking on-the-job training as required
- The Health and Wellbeing Coach must be aware of individual responsibilities under the Health and Safety at Work Act, and identify and report as necessary any untoward accident, incident or potentially hazardous environment.

Patient Care

- Communicate effectively and sensitively and use language appropriate to a patient and carer/relative's condition and level of understanding
- Effectively use all methods of communication and be aware of and manage barriers to communication
- Effectively recognise and manage challenging behaviours, carers and or relatives
- Provide information to patients, their carers and/or relatives on behalf of the team

Supporting Care Delivery

- Be the point of liaison for service users and interface with all health and social care professionals, including keeping everyone informed and updated
- Follow through actions identified by the MDT including arranging tests, referrals, signposting, etc.
- Follow through with service users and others involved to ensure all services and care arrangements are in place

Autonomy/Scope within Role

- The post holder will be required to work within clearly defined organisational protocols, policies and procedures

Key Relationships

Key Working Relationships Internal:

- Clinical Lead for the MDT
- GPs and General practice teams within the PCN
- PCN Clinical Director
- MDT members including but not exhaustive: Clinical Pharmacists, technicians, Physician Associates, Physios, Paramedics, Social Prescribing Link Workers, Care Coordinators

Key Working Relationships External:

- GPs from neighbouring PCNs
- Service providers
- Social care
- Voluntary services
- Patients/service users
- Carers/relatives

Health and Safety/Risk Management

- The post-holder must comply at all times with the organisation and Practice's Health and Safety policies, in particular by following agreed safe working procedures and reporting incidents using the organisation's Incident Reporting System.

- The post-holder will comply with the Data Protection Act (1984), The General Data Protection Regulations (2018) and the Access to Health Records Act (1990).

- The post-holder will comply with all necessary training requirements relevant to the role as identified by the organisation.

Equality and Diversity

- The post-holder must co-operate with all policies and procedures designed to ensure equality of employment. Co-workers, patients and visitors must be treated equally irrespective of gender, ethnic origin, age, disability, sexual orientation, religion etc.

Respect for Patient Confidentiality

- The post-holder should always respect patient confidentiality and not divulge patient information unless sanctioned by the requirements of the role.

Special Working Conditions

- The post-holder is required to travel independently between practice sites (where applicable), and to attend meetings etc. hosted by other agencies.

Job Description Agreement

This job description is intended as a basic guide to the scope and responsibilities of the post and is not exhaustive. It will be subject to regular review and amendment as necessary in consultation with the post holder.

Primary Care Network Health and Wellbeing Coach Person Specification

	Essential	Desirable
Qualifications	• English and Maths GCSE or equivalent	• NVQ Level III (Health and Social Care) or equivalent as a minimum • Formal training in working with long term conditions
Experience	• Evidence of ability to both work autonomously and to seek support and guidance when appropriate. • Evidence of working within a team setting • Evidence of achieving targets and proactive approach	• Experience of working with individuals with long term conditions • Evidence of working within a multidisciplinary team • Evidence of target based work experience • Experience working with GP surgeries in this role would be advantageous • Be prepared to undertake all training as required The Personalised Care Institute (live from April 2020) will set out what training is available and expected for Health coaching link workers. • Smoking cessation training (or willingness to train) • Experience with alcohol or drugs brief intervention training (or willingness to train) • Experience of working with groups (or willingness to train) • Experience in health and nutrition work with patients (or willingness to train)
Personal qualities	• IT skills • Good Communication skills and interpersonal skills, including an ability to build rapport and establish good one to one relationships quickly • Ability to deal with challenging behaviour	• Experience of using databases • Experience of working without direct supervision • Experience of using community based activities and resources to support individuals

	• Ability to effectively manage a variable workload • Good team work • Ability to multi-task • Ability to work independently	
Special requirements	• Ability to demonstrate sensitivity, empathy and compassion to the needs of the service users and carers • Ability to motivate others • Ability to work flexibly in an innovative and developing role • Some evening work may be required • Ability to be flexible with hours if required. • Ability to drive/ have own transport	• An understanding of the importance of carer involvement