

#### Tackling unplanned care with personalised health coaching in North East London

North East London (NEL) ICB, Health Navigator (HN) and UCLPartners are collaborating together to identify people likely to experience extended hospital stays in the next 6 months and offers them clinical coaching to reduce their risk of admission and increase their quality of life. We use a clinically validated Artificial Intelligence algorithm to identify patients at rising risk of experiencing an extended hospital stay. These individuals are then offered personalised clinical coaching delivered by qualified Health Navigator coaches. This initiative helps reduce the burden of unplanned care on the healthcare system, without increasing NHS workload. Qualified clinical coaches work directly with patients to educate them, improve care plan adherence, empower them to self-manage their conditions and coordinate with services, leading to fewer hospital admissions and less reliance on emergency services. This ensures that primary care teams can focus on proactive, efficient care, improving patient outcomes while alleviating pressure on busy practices.

This initiative aims to improve care for individuals at risk of unplanned hospital visits, supporting both patients and the healthcare system in North East London to achieve better outcomes.

You can find out more about this initiative here.

#### How patients are identified for the programme

The system uses risk stratification to generate risk scores for patients based on their likelihood of unplanned care. Patients are flagged as high-risk if they are predicted to **consume 3 or more bed days in the next 6 months**. Once flagged, they enter a clinical workflow where our coaches assess their eligibility. If deemed suitable and the patient provides consent, they are enrolled into the coaching programme to receive proactive support.

### How will we keep you up to date?

We will send you reports on the status of patients being onboarded, as well as those who were unreachable, declined to participate, or were excluded from the intervention. We will be updating the Shared Care Record platform with most up-to-date information so that the status of your patients will be as transparent as possible. We will also send you a summary of coaching interventions.

Patients who **decline** the service will also be flagged for your awareness. As they have been identified as being at high risk of consuming unplanned care, and they may require clinical follow-up. If you do speak to them, please encourage them to get in touch with us at HN.

## How to view patient status on the Shared Care Record

These details have also been entered into each patient's record within EMIS under the "Consultations" section. The administrative note will indicate one of the following outcomes: *No Contact, Declined, Excluded from Service*, or *Onboarded*. This ensures that any GP accessing the record can immediately view the patient's engagement status with the programme.

### What is included in the monthly email to practices

Each month, we send your practice a summary of patient activity related to the Clinical Coaching service. These updates focus on patients identified by the HN algorithm.

The email includes:



- A summary of patient engagement outcomes
- Notification that these updates are also reflected in the Shared Care Record for continuity across services.

## What this means for your practice

This information helps you quickly understand a patient's engagement with the personalised clinical coaching programme. By checking the "Consultations" section in EMIS, you can:

- <u>For onboarded patients:</u> Be reassured that structured support is in place, helping patient manage their health risks and reducing the likelihood of unplanned care.
- <u>For patients marked as Declined or No Contact:</u> Should you have contact with these patients, you may wish to encourage them to reach out to our team as they may benefit from clinical coaching due to their risk profile and current needs.

The programme has shown not to increase overall workload in primary care. We'd appreciate your support in raising awareness of the programme with reception and frontline staff, so they can guide patients who ask whether to engage with the clinical coaching programme.

Our team has delivered leaflets and posters to each practice. These materials are intended to be displayed to support patient awareness and understanding. If you haven't received any, or if you'd like additional copies, please contact us and we'll be happy to send more.

If you have any questions or would like further details on individual patients, please don't hesitate to get in touch.

# **Key contacts**

Health Navigator: Sophie Webster, Head of Delivery, sophie.webster@hn-company.co.uk

UCLPartners: Valentina Karas, Director of Implementation, UCLPartners, Valentina.karas@uclpartners.com