UCLPartners

Peer Coaching

The UCLPartners-Primrose guide to Peer Coaching for someone with a Severe Mental Illness in the context of their physical health

Welcome to the UCLPartners-Primrose guide to Peer Coaching

This document is a guide to peer coaching within the UCLPartners-Primrose (UCLP-Primrose) framework. A Peer Coach is a role which can be undertaken by a peer support worker, but with a specific task of supporting and coaching patients to reach their wellbeing goals. Not all practices will have peer coaching available, but where they are (or someone in a similar role), then it's important to incorporate them into the UCLPartners-Primrose framework. This document will outline some guidance for peer coaches.

What is UCLPartners-Primrose?

The UCLP-Primrose framework has been developed to help people with Severe Mental Illness receive the best care for their physical health as well as their mental health. The framework is designed so that those patients with the greatest clinical risk from physical risk factors are prioritised. Working with the framework ensures that patients receive the treatment they need at the right time. Lowering blood pressure and cholesterol for example will lead to rapid reduction in risk of a heart attack or stroke.

All patients with a diagnosis of a Severe Mental Illness should receive an annual Physical Health Check. Following this, depending on their needs, the person may receive clinical support, intensive behaviour change support, or support from a mental health nurse to help them engage with their physical health.

At any point during this journey, if the patient desires it, it can be very helpful for them to have further support from a Peer Coach. Best evidence shows that peer support in this context helps with relapse prevention and improves physical health outcomes.

What role will you play?

Peer Coaches have lived experience of mental health challenges. As such, they play an invaluable role by supporting others, building on shared experiences and empathy, and thereby improving patient health outcomes. For more information about peer support work, please see the HEE competency framework.

Peer coach appointments are a key element in the UCLP-Primrose pathway as these appointments are less structured, giving space for the patient to really feel heard and to lead in their own health journey. Peer coaches can facilitate the patient in determining the help they need, whether that be for their physical health, mental health, or a broader social need.

If peer coaches are available, then they can be incorporated in various ways. Here are some suggestions:

For peer coaches to be trained to deliver the intensive behaviour change appointments.

For peer coaches to support patients who are receiving intensive behaviour support.

For peer coaches to support patients who are coming into the practice for a physical health check.

Supporting patients with broader recovery goals.

Helping to identify wider social needs, for example with housing or money.

It's important that, regardless of where in the pathway the Peer Coach works, all UCLP-Primrose colleagues work together, communicating to each other patient priorities and outcomes continuously throughout the process.

The following pages provide one example of how peer coaching can be used within UCLP-Primrose. This example is taken from Primrose-A, delivered in London. Here, peer coaches focused either on supporting the patient with their cardiovascular goal, or on a separate recovery-focused goal.

Peer Coaching Example

Peer Coaching during Primrose-A

In the original model, Primrose-A, Peer Coaches provided four one hour appointments over a six month period. Peer Coaches facilitated the patient in determining the help they needed to achieve their cardiovascular goal, and suggested how to get that help. They also provided help in achieving a separate recovery goal. The Peer Coaching Flow Chart (below) shows suggested goals.

Next is a suggested appointment schedule for peer coaching, as used in Primrose-A. In general, the length and number of appointments will depend on the patient. Some patients may want more/fewer appointments than the suggested schedule. You may want to join the second Intensive Behaviour Change appointment and arrange subsequent appointments from there.

Suggested Appointment Schedule for Peer Coaches

First appointment

When: after 1st Intensive Behaviour Change appt/during second appt

Appointments 2-3

Length: one hour

When: every six weeks

Final Appointment

Length: one hour

When: Week 24

Please make sure you arrange the next appointment with the patient each time you see them. Record this in the patient's **'My Health Plan'.**

Peer Coaching Flow Chart *(example)*

These are suggested goals to be covered in **Peer Coach appointments**.

Choose **one recovery goal** with each patient.

You may wish to prioritise, **starting with the outcome on the left and moving to the right** if the outcomes are not relevant to the patient and their health.

In some instances, the patient might choose a goal that is less of a priority according to this flow chart.

Meaningful activity

1. Review current activities
2. Explore potential interests and local opportunities
3. Identify any existing goals and set new goals/plans for the future
4. Review progress and offer support e.g. in attending a local group/ service

Being social

1. Map social network and discuss who the patient spends time with
2. Explore local groups and opportunities to meet people
3. Identify any existing goals and set new goals/plans for the future
4. Review progress and offer support e.g. in attending a local group/ service

Education and training

1. Review educational interests
2. Explore educational opportunities e.g. Recovery College, Higher Education (if appropriate)
3. Identify any existing goals and set new goals/plans for the future
4. Review progress and offer support

Mental health

1. Discuss the patient's views on symptoms they may have
2. Explore potential support e.g. offer review with GP/SMI Nurse/Psychiatrist
3. Identify any existing goals and set new goals – co-produce a staying well and support plan
4. Review progress and offer support

Accommodation

1. Discuss where the patient is living and whether it is a safe environment
2. Explore housing support e.g. Citizens Advice
3. Identify any existing goals and set new goals/plans for the future
4. Review progress and offer support

Education and training

1. Understand the support currently offered to the patient
2. Explore other opportunities for support
3. Identify any existing goals and set new goals/plans for the future
4. Review progress and offer support

Monitor attendance at support services (and offer to join the patient if appropriate)

Monitor progress using 'My Health Plan'

Involve supportive others

First Peer Coaching Appointment *(example)*

Peer Coaches provide less structured appointments, ensuring that priority needs (as determined by the patient) are attended to. Peer Coaches facilitate the patient in determining the help they need to achieve their cardiovascular goal, and suggest how to get that help. They may also provide help in achieving a separate "recovery goal". **There are seven suggested steps to work through in the first Peer Coach appointment, but this will vary depending on the help the patient has identified as needed.**

1 **Introduction**	Introduce yourself and explain the role of a Peer Coach Get to know the patient and understand the difficulties they're facing
2 **Review physical health goal**	Ask the patient which area of their cardiovascular health they have chosen to focus on with the Intensive Behaviour Change practitioner. Review the goal set with the Intensive Behaviour Change practitioner and ensure they are feasible and desirable
3 **Set recovery goal (if needed)**	Facilitate a conversation around the different aspects of recovery and explore the patients interests and priorities Ask if the patient would like to set a separate recovery goal – see The Peer Coaching Flow Chart, page 4 for suggested goals Ensure that the goal is SMART Record the goal in the 'My goal' section of 'My Health Plan'
4 **Develop/ review action plan**	If the patient would like assistance in achieving their cardiovascular health goal, review their action plan and make any changes to ensure that it's feasible If the patient would like to set a recovery goal, make a separate action plan Record the action plan in the My Action Plan section of the 'My Health Plan'
5 **Encourage recording**	Together with the patient decide how progress towards the goal will be recorded Encourage the patient to complete the My Progress section of 'My Health Plan'
6 **Offer support**	Ask the patient how best you can support them in achieving their goal(s) Offer to join the patient in attending a local service/group
7 **Arrange the next appt.**	Ask the patient if they are happy with the decisions made and if they have further questions Arrange the next appointment. Record the time and date on 'My Health Plan' Provide two copies of the 'My Health Plan' – one for the patient and one for you

SMART:
Specific: Clearly defined
Measurable: Such as measuring the number of minutes walked per day.
Attainable: Set a realistic, attainable goal then work up to more ambitious goals.
Relevant: Set a goal that is relevant to the patient so they can see the link between their behaviour and the health benefit.
Timely: Set the goal within a time frame that works for the patient.

Subsequent Peer Coaching Appointment *(example)*

There are seven steps to work through with each patient at subsequent Peer Coach appointments (including the final appointment)

1 **Introduction**	If this is the final appointment, explain that it is the final Peer Coach appointment, but patients should feel encouraged to continue to progress towards their goal
2 **Review progress**	Use 'My Health Plan' to review progress towards their cardiovascular health and recovery goals Give positive feedback on progress If the goal is achieved either set another or maintain the same goal If the goal is partly or not achieved, revise the action plan to reduce or set a new goal
3 **Coping with Setbacks**	Be positive about setbacks Tell the patient that change is rarely a smooth process and there are often setbacks along the way
4 **Develop/ maintain an action plan**	Together with the patient, make an action plan as to when, where and with whom the target behaviour will be performed (and will continue to be performed once Primrose appointments are over) Record the action plan in the My Action Plan section of the 'My Health Plan' Encourage habit formation
5 **Encourage recording**	Together with the patient decide how progress towards the goal will be recorded Encourage the patient to complete the My Progress section of 'My Health Plan'
6 **Arrange the next appt. (if needed)**	If this is not the final appointment, arrange the next appointment. Record the time and date on My Health Plan' If this is the final appointment, thank the patient for attending Primrose A appointments Ask the patient if they are happy with the decisions made and if they have further questions Provide two copies of the 'My Health Plan' – one for the patient and one for you
7 **Arrange the Next Appt**	If this is the final appointment, discuss the patient's plans for the future and how they're going to sustain their plans Consider community resources they could utilise, such as MIND Crisis planning – ensure that the patient knows who to contact if things become difficult and has a clear idea of where to go for help

Priority 1
CVD risk factors poorly controlled
Obesity on antipsychotic medication

Priority 2
No BP in 18 months (proxy for health check and possible indicator of non-engagement)

Priority 3
All others with CVD risk factors

Priority 4
All others

Invited for SMI Annual Health Check

Patient engages

Patient does not engage

The Physical Health Check: HCA* (default pathway)

- Physical health check e.g. BP, weight, bloods, screening
- Identify physical health red flags
- Structured support for education and self management
- Identify social concerns & mental health red flags
- Explore patient's priorities
- Assess carer/friend/formal support needed to address physical health
- Brief interventions and signposting (e.g. smoking)

*This may be a HCA or another member of the wider workforce eg wellbeing coach, social prescriber.

Clinical Review: Nurse/pharmacist/GP

- Review clinical conditions
- Optimise medication
- Manage clinical risk factors & co-morbidities
- Agree health priority and behaviour change goals

Intensive Support for Behaviour Change: Trained staff member

- Working intensively on patient-led cardiovascular goals e.g. smoking cessation, weight management, adherence
- If available, Peer Coaches to provide less structured appointments to support the CVD goal or separate recovery focused goal

Mental Health Review: MH nurse

- Undertake desktop review of patient to assess their mental health/complexity, to determine reasons they may not be engaging, and to assess their need for support
- Contact patient/ family/MH services to assess current mental health
- Review and respond to mental health needs
- Oversee and support patient journey where required
- Allocate staff member to accompany to appointments where needed
- Joint consultations with clinician or HCA type role as needed for physical health interventions
- Support behaviour change with brief and intensive interventions
- Refer for peer support if available and desired.

Outreach

- Home visits
- Accompany to appointments

Specialist Support

- Core Community Mental Health Service or Specialist Mental Health Team

Wider Social Support: Social provider

- Maximise use of existing structures (social prescribing, MIND, care navigators) to address wider wellbeing concerns e.g. isolation/ accommodation/financial concerns. All clinicians to support patients to engage with wider social support at each stage in the Pathway, if needed.

UCLPartners –Primrose: The Pathway

Notes

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