BIRMINGHAM CITY University

NHS

Care coordination in primary care

NHS England and NHS Improvement
in collaboration with Health Education
England and Birmingham City University

The key role of care coordination within the NHS Long Term Plan

In January 2019, just after celebrating its 70th birthday, the NHS published its new Long Term Plan (LTP). This builds on the policy platform laid out in the 2014 NHS Five Year Forward View, which spelled out the need to integrate care to meet the needs of a changing population.

The LTP aims to redesign patient care and future-proof the NHS so that it will be in the best possible shape when we celebrate its 80th birthday.

Improving health through personalised care

Evidence shows that people will have better experiences and improved health and wellbeing if they can actively shape their own care and support. One of the main commitments in the LTP is that: *"People will get more control over their own health and more personalised care when they need it".*

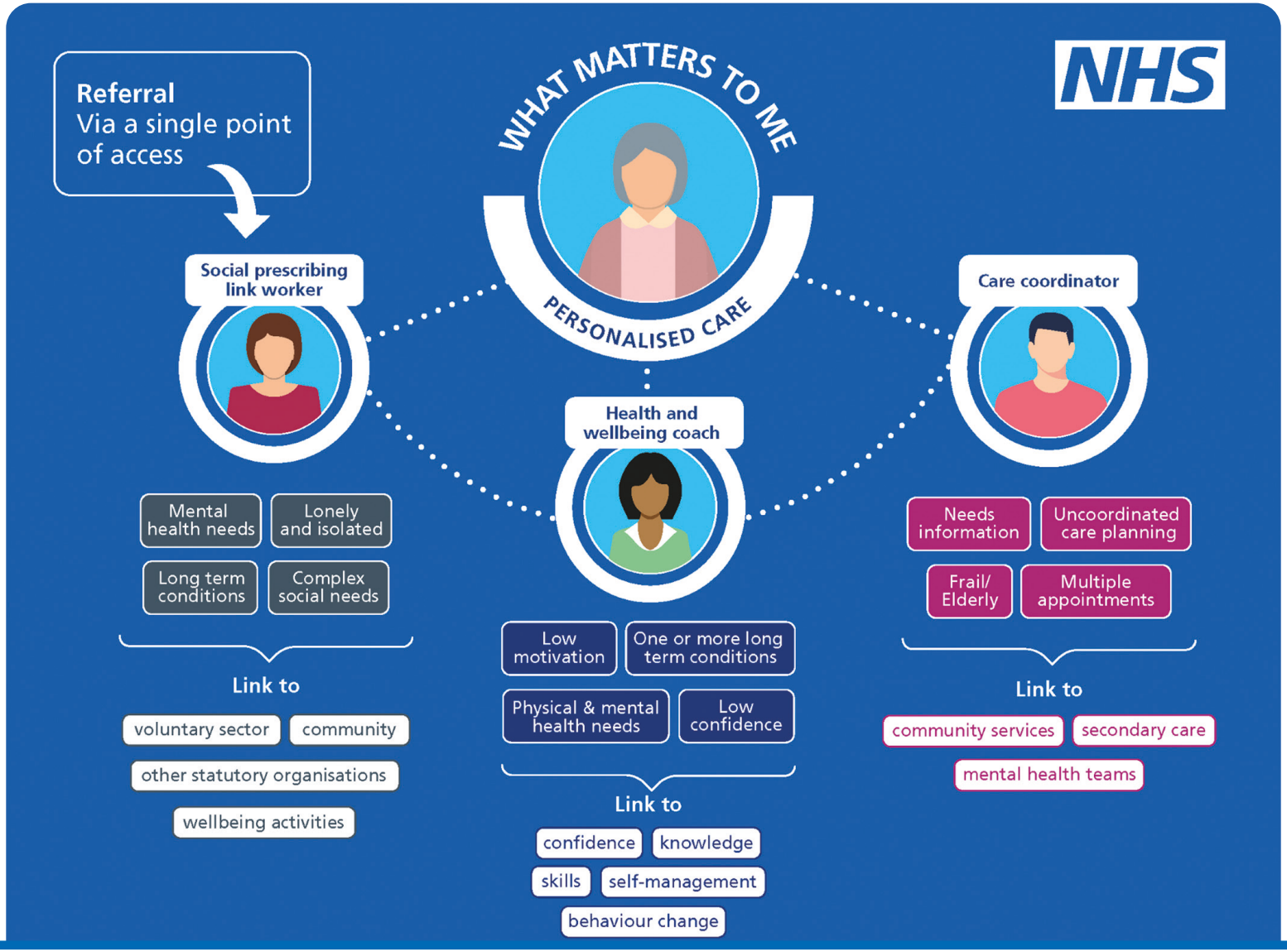
Care coordinators are one of several new roles that support this commitment. They do this by:

- providing a more joined-up and coordinated care journey for patients, instead of each encounter with services being seen as a single, unconnected 'episode' of care
- acting as a single point of contact for patients to navigate the health and care system
- breaking down traditional barriers between health and care organisations, teams and funding streams, to support the increasing number of people with long-term health conditions.
- reducing health inequalities within the patient population and providing solutions to ensure equity of health care is delivered.

Delivering care within local communities

The LTP also highlights a need to focus services around local communities, local GP practices and primary care networks (PCNs) to help rebuild and reconnect primary healthcare teams across the area they cover. A care coordinator can help to identify high-risk patient populations before their care needs become more complex and care outside the community is needed. This can include the elderly and people with highly complex needs, as they can struggle to coordinate their care with all the relevant services on their own.

Care coordination as part of personalised care in PCNs



Navigating the health and care system

The coordination of care has been identified nationally and internationally as a key strategy that can potentially improve the effectiveness, safety and efficiency of health and care systems.

Navigating the systems – finding the way to the right place and the right person at the right time – can be a challenge for patients. Current care systems can be disjointed, and communication processes vary between primary care and speciality sites. The diagram on the right shows some of the workforce in a primary care setting that a patient may come into contact with.

It is important for some patients to have help coordinating their care to ensure they are getting the right support from the right person at the right time. Confusion can arise along the lines of 'who, what and where' when developing coordinated care roles, and though no single model of coordinated care is universally applicable across patient populations, research has found economic and clinical benefits associated with various coordination interventions.

Well-designed, targeted coordinated care can improve outcomes for everyone, including patients, health and care services and staff.

Care coordination in primary care

Care coordinators can work as part of a multidisciplinary team (MDT) within a GP practice or PCN to identify people in need of proactive support. This could be, for example, people who are frail or have multiple long-term physical and mental health conditions.

They work with people individually, building trusting relationships and listening closely to what matters to them to develop a personalised care and support plan. This includes reviewing their needs and helping to connect them to the services and support they require within the practice or elsewhere, for example community and secondary services.

Another key part of the role is to provide support for people who are preparing for clinical conversations with healthcare professionals or following up on those conversations, to ensure they can be actively involved in managing their care and supported to make choices that are right for them.

Care coordinators work closely with GPs and practice teams to help manage caseloads. They act as a central point of contact so that appropriate support can be made available to individuals and their carers which helps them to manage their condition and addresses their needs.

Where a PCN employs or engages a care coordinator under the additional roles reimbursement scheme (ARRS), the PCN must ensure that the care coordinator:

- is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute[1]; and
- works closely and in partnership with the social prescribing link worker(s) or social prescribing service provider and health and wellbeing coach(es).

The ARRS guidance (2019/20) states that from April 2020 each PCN will be allocated an additional roles reimbursement sum, which will be based upon the PCN's weighted population share. PCNs will be able to recruit from within the reimbursable roles as required to support delivery of the Network Contract DES.

1. *www.personalisedcareinstitute.org.uk/our-personalised-care-curriculum/*

Care coordination role in primary care

- Proactively identify and work with a cohort of people to support their personalised care requirements.
- Bring together all of a person's identified care and support needs and what matters to them; explore the options to address these in a single personalised care and support plan.
- Help people to manage their needs, answering their queries and supporting them to make appointments.
- Support people to take up training or employment and access appropriate benefits where eligible.
- Raise awareness of shared decision-making and decision support tools and assist people to be more prepared to have a shared decision-making conversation.
- Ensure that people have high-quality health information to help them make choices about their care.
- Assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing; explore and assist people to access personal health budgets where appropriate.
- Provide coordination and navigation for individuals and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches and other primary care roles.
- Support the coordination and delivery of multidisciplinary teams within PCNs.

Adapted from the BMA's
The primary care network handbook 2020/21[2]

2. *www.bma.org.uk/media/4222/bma-pcn-handbook-2021.pdf*

Benefits for PCNs

PCNs are expected to think about the wider health of their population and develop a more comprehensive and coordinated set of services that anticipate rising demand and support for better personalised care.

Care coordinators play an important role within a PCN, working as part of a multidisciplinary team that includes health professionals, social prescribing link workers and health and wellbeing coaches, referring people to them and receiving referrals in return.

They proactively identify and work with people, including those who are frail, elderly or vulnerable and those with long-term conditions, to provide coordination of care and support.

For the most vulnerable people in the community, care coordinators can be the go-to person if their needs change or if something goes wrong with service delivery.

Care coordinators help to focus delivery of the comprehensive model for personalised care to reflect local priorities, health inequalities or population health management risk stratification.

Working across a PCN, a care coordinator can help to reduce unnecessary appointments and acute hospital admissions.

Care coordinators and other personalised care roles

The three specific personalised care roles in primary care – social prescribing link workers, health and wellbeing coaches and care coordinators – work together and in partnership with other professionals as part of the general practice team and part of a wider multiagency integrated team.

There are some similarities across the three roles in that they all enable people to develop the skills and confidence to manage their own health and wellbeing.

However, each role offers a unique contribution, as set out here.

Care coordinator

- Central point of contact
- Support a patient through their care journey
- Support people to understand and manage their condition
- Help people to prepare for or follow up from clinical conversations they have with primary care professionals

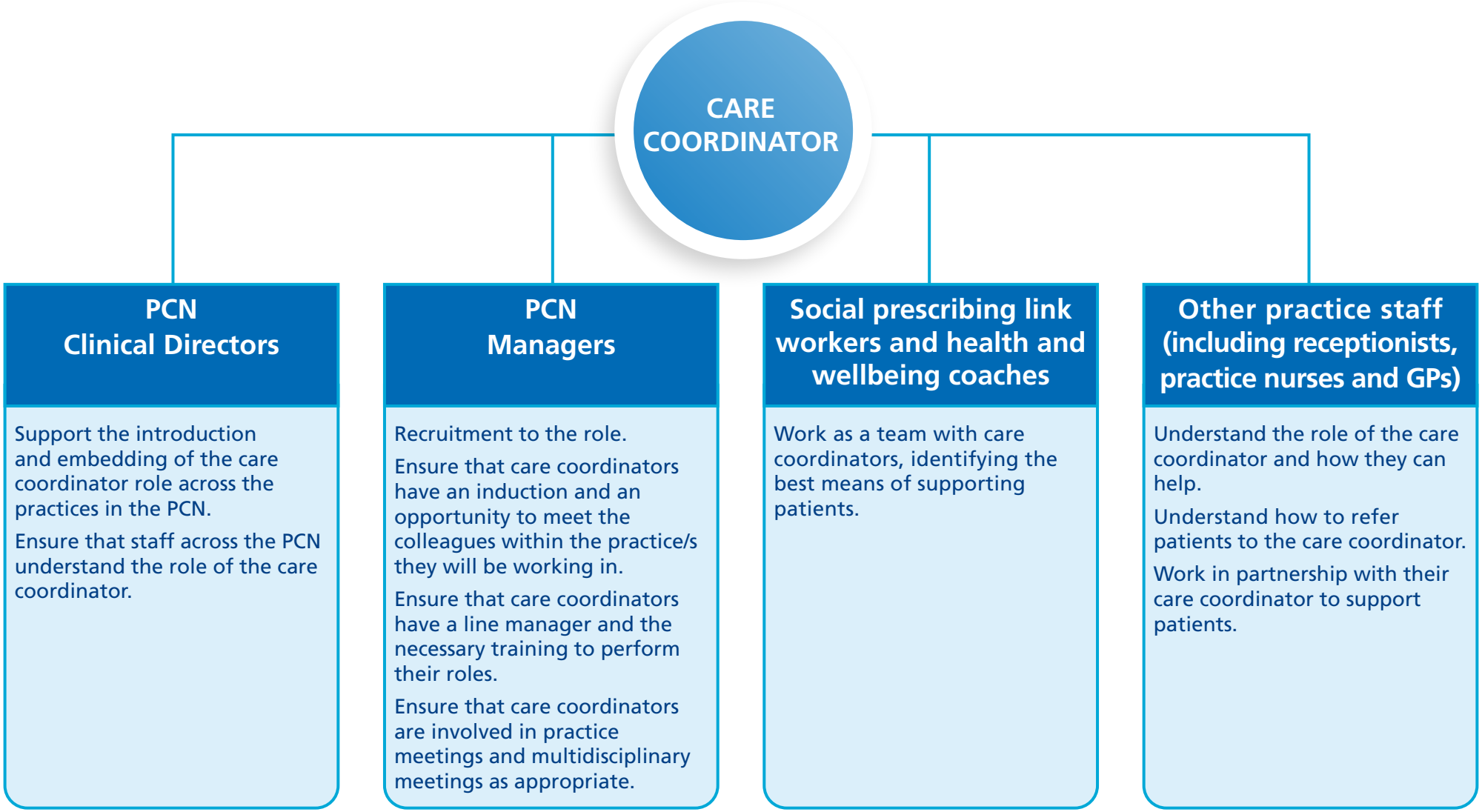
Health and wellbeing coach

- Highly skilled in coaching and behavioural change
- Support people to develop their knowledge, skills and confidence to become active participants in looking after their own health
- Support people to reflect on and change their health-related behaviours
- Help people reach their self-identified health and wellbeing goals

Social prescribing link worker

- Address the wider determinants of physical and mental health such as poor housing, debt, stress and loneliness
- Work collaboratively with a variety of local partners and connect people to local community groups and agencies for practical and emotional support and to activities that promote health and wellbeing (such as the arts, sports, or natural environment)

The care coordinator support network within primary care



Checklist for care coordinators – key elements of the role

Personalised care

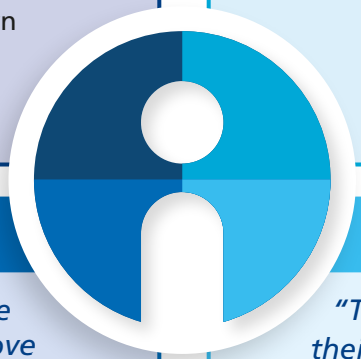
"Putting people and their families at the centre of decisions and considering them experts, working alongside professionals to achieve the best outcomes." Care coordinator

- ✔ Understanding that effective personalised care requires several discussions.
- ✔ Taking into account what matters to an individual and their expressed needs.
- ✔ Enabling a patient to have more control in managing their own health and wellbeing.

Relationships

"If effective coordination is to occur, participants must be connected by relationships of shared goals and mutual respect." Care coordinator

- ✔ Building relationships with MDTs to become a key part of the conversation.
- ✔ Working with health and wellbeing coaches and social prescribing link workers to make sure patients get the best care.
- ✔ Building relationships with patients so they trust in the coordination of their health journey
  - ✔ Developing a proactive plan of care jointly created and managed by the patient/family and healthcare team.
  - ✔ Establishing relationships with GPs, pharmacists and other clinical leads who will have an impact on patients' care.



Continuous learning

"The ability to demonstrate reflective practice, based on the best available evidence, and to assess and continually improve the services delivered as an individual provider and as a member of a multidisciplinary team." Care coordinator

- ✔ Participating in practice-based learning and improvement activities that involve investigation and evaluation of patient experiences, evidence and resources.
- ✔ Putting new techniques and information/knowledge into practical use.
- ✔ Regularly engaging in interdisciplinary staff training provided by the PCN.

Communication

"The ability to quickly establish rapport with patients and their family members in an empathetic and sensitive manner." Care coordinator

- ✔ Being able to communicate your patient's story clearly and concisely to multiple stakeholders.
- ✔ Using accurate and clear communication to reduce the repetition of the same information to different people.
- ✔ Identifying a patient's concern or issue and taking steps to correct it.
- ✔ Integrating care from the separate providers participating in a particular person's care into a cohesive and functioning whole, capable of addressing the person's needs.

Checklist for managers developing the role across a PCN

Making the case for the role

- ✔ Is there a robust case for employing a care coordinator? Take stock of what is already in place; identify gaps and develop an idea of how you think the care coordinator role would work in your area.
- ✔ Do key people within the PCN understand the role?
- ✔ What specific issues will the role address within your PCN and patient caseload? It might be best to map out your idea of the role and share it with key stakeholders.
- ✔ How are the challenges currently being addressed and how will a care coordinator do this better?

Recruiting and developing care coordinators

- ✔ Consider the appropriate and reliable resourcing of new recruits. The role of the care coordinator will vary between PCNs, which is why they offer truly local and personalised support. It's critical to ensure that the appropriate amount of resource is available to sustain a successful care coordinator role.
- ✔ Does your recruitment strategy for the care coordinator reflect the demographic population they will serve?
- ✔ Have you ensured that care coordinators you employ have the opportunity to undertake appropriate training as set out by the Personalised Care Institute?
- ✔ Does your PCN have appropriate resources to monitor and develop new care coordinators?

Preparing people to see care coordinators

- ✔ Is the PCN clear about the care coordination service it is offering?
- ✔ Are the PCN's patients aware of the new role and what it can offer to people?
- ✔ Is there a plan to ensure each person seeing the care coordinator for the first time has been able to prepare anything they wish to bring to the conversation and feels ready to participate?

Introducing care coordinators to the MDT and PCN as part of an integrated care system

- ✔ Are existing practice staff, social prescribing link workers, health and wellbeing coaches and the wider PCN prepared to support and integrate with the service delivered by the care coordinator?
- ✔ How will you fully integrate the care coordinator in the MDT within the practice and across the wider PCN and integrated care system to realise the benefits of the new role for the local population?
- ✔ Does the care coordinator have access to appropriate electronic records? Are they included in team meetings at a practice and PCN level?

Further support and reading

- Supported self-management workspace – FutureNHS Collaboration Platform
  www.england.nhs.uk/personalisedcare/supported-self-management/
- Birmingham City University
  www.bcu.ac.uk/health
- Coordinating Care Online Resource
  www.coordinatingcare.health
- Health Education England, Care Navigation Framework
  www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf
- Health Education England, Integrated Care Toolkit
  https://learning.wm.hee.nhs.uk/node/898
- Health Education England, Strategic framework
  www.hee.nhs.uk/our-work/strategic-framework
- NHS England Five Year Forward View
  www.england.nhs.uk/five-year-forward-view/
- NHS England
  www.england.nhs.uk/gp/gpfv
- Relational Coordination
  https://heller.brandeis.edu/relational-coordination/
- University of Westminster, Making sense of social prescribing
  https://westminsterresearch.westminster.ac.uk/download/f3cf4b949511304f762bdec13784425103107269 7ae511a462eac9150d6ba8e0/1340196/Making-sense-of-social-prescribing%202017.pdf
- World Health Organization: Strengthening a competent health workforce for the provision of coordinated/ integrated health services:
  www.euro.who.int/__data/assets/pdf_file/0010/288253/HWF-Competencies-Paper-160915-final.pdf

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