Healthy London Partnership

Care Coordinators (CC)

What is a CC?

- Supports a caseload of patients with navigating the health care system, and **supports continuity of care** by being the **single point of communication** between the patient, their carers, professionals and services involved in their care
- Takes a personalised approach, focusing on what matters to patients most, using **personalised care support planning** tools (PCSPs)
- Acts as an **advocate** for specific patient groups who are vulnerable or have complex or long term conditions, e.g. frailty, severe mental illness
- Links in with social prescribing link workers and health and wellbeing coaches to refer people to more specialised support
- Receives referrals from professionals in primary care e.g. GPs, nurses, receptionists, social prescribing link workers
- **Proactively identifies vulnerable or complex patients** in MDTs and by searching electronic health systems data to add to caseload or refer to other services
- Champions health inequalities by supporting patients to overcome **barriers in access and uptake of health services** thereby reducing health inequalities
- Can be **practice or PCN based**, which means they may work on wider priorities across several practices or at just one practice

Unique contribution of a CC

- Acts as the **node of the GP surgery**, being a single point of access for vulnerable patients with complex conditions
- **Strengthens links** between the PCN/practice and services involved in care e.g. care homes, ambulance services, prevention programmes
- Saves GPs and other professionals time by **ensuring information about a patient is streamlined and easily accessible**
- Supports tackling health inequalities by **proactively identifying areas of unmet need** for practices and specific patients to work with or refer onwards
- Helps practices and PCNs in multidisciplinary team working by connecting individuals and supporting MDT meetings

What support do CCs need?

- Two types of **supervision**: clinical, line management
- **Peer support networks, webinars and shared learning:** opportunities to join Care Coordinator networks, capacity and time to attend webinars and support sessions every 2-4 weeks
- Meetings with the **other personalised care roles** to collaborate on caseloads (social prescribing link workers, health and wellbeing coaches) in their local area
- Included in MDT (**Multi-Disciplinary Team**) meetings
- Opportunities for **reflective practice**
- Resources and support for new CCs

Find out more about Care Coordinators here.

Who is the right person for the role?

Skills and attributes

- Highly organised and efficient
- Excellent listening and communication skills
- Good at maintaining relationships with a range of services and people
- Willingness to help and work as part of a team
- Proactive in identifying opportunities to support patients
- Good IT and record keeping skills
- Willingness to undertake training and develop
- Enthusiastic & self-motivated
- Good at problem solving and collaborating

Useful Experience

- Communication roles e.g. receptionist, call center, career advisor
- Used IT systems, data and analysis
- Worked with vulnerable people e.g. elderly or frail
- Worked in health care or caring environments
- Risk assessment and safeguarding

Employing CCs

- Band 4 AfC : Network Contract DES 2022/23
- Pay should reflect seniority and specialism, which may involve topping up ARRs reimbursement
- Draft CC Workforce Development framework

What training do CCs need?

- Personalised Care 2-day accredited training by Personalised Care Institute (PCI) plus e-learning
- Personalised Care Support Planning and Shared Decision Making
- How to communicate and support patients e.g. difficult conversations
- Local induction to the PCN system and health care landscape
- Electronic health systems and patient data
- Induction to MDT working & range of roles
- Health inequalities, identifying inequalities
- Cohort specific training e.g. diabetes, learning disabilities