Care co-ordinator

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Overview of the Role

Care co-ordinators provide extra time, capacity, and expertise to support patients in preparing for or in following-up clinical conversations they have with primary care professionals. They will work closely with the GPs and other primary care professionals within the Primary Care Network (PCN) to identify and manage a caseload of identified patients, making sure that appropriate support is made available to them and their carers and ensuring that their changing needs are addressed. They focus delivery of the Comprehensive Model for Personalised Care to reflect local priorities, health inequalities or population health management risk stratification.

Care coordinators are one of several new roles that support the NHS?s commitment to improve health through personalised care. 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.

Career Framework

The starting salary for Care Co-ordinators is AfC band 4.

Job Description

NHSE/I have developed a detailed job description and recruitment pack which is available on the Future

NHS website. Access to the site requires user registration [7]. Once registered, navigate to the role selection [8] page to find a range of supporting resources.

For a brief outline of responsibilities, skills and competencies please see below*

- 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 primary care network handbook 2020/212 [9]

Support available for introducing the role

The Advanced Roles Reimbursement Scheme (ARRS) guidance 2019/20 stated 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 Direct Enhanced Service (DES).

Education and training required

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

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Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute [10].

- Works closely and in partnership with the social prescribing link worker(s) or social prescribing service provider and health and wellbeing coach(es).

Care Coordinators should be familiar with the six components of the universal model for personalised care with a specific focus on:

- Support for self-management.
- Personalised care and support planning.
- Shared decision making.
- Social prescribing.
- Personal Health Budgets.

Care coordinators should also access statuary and mandatory training, including but not limited to:

- Principles of information governance, accountability and clinical governance.
- Maintenance of accurate and relevant records of agreed care and support needs.
- Identify when it is appropriate to share information with carers and do so.
- The professional and legal aspects of consent, capacity, and safeguarding.

Further information

Implementation guide: Universal Personal Care: Implementing the Comprehensive model [11]

Update to GP contract 2020/21 [12]

DES contract specification 2021/22 ? PCN requirements and entitlements [13]

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Links
[1] https://www.hee.nhs.uk/our-work
[2] https://www.e-lfh.org.uk/
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