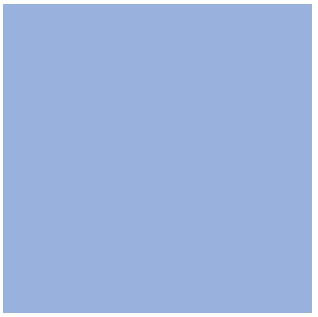
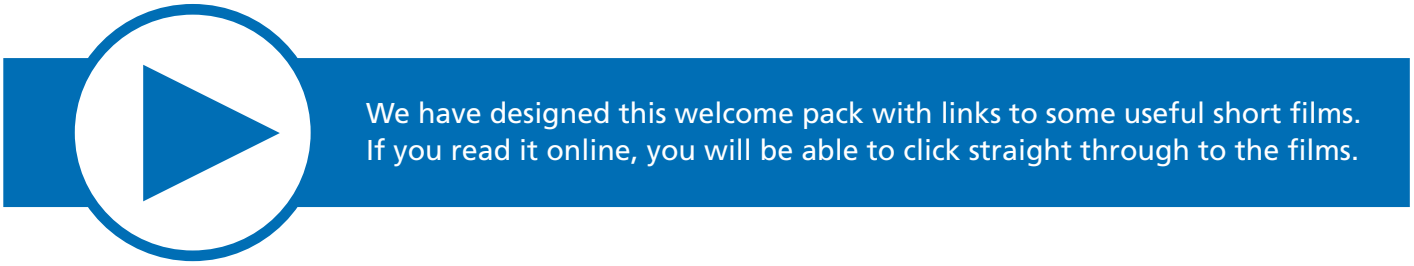
Personalised Care



Welcome!

An induction guide for care coordinator workers in primary care networks.



We have designed this welcome pack with links to some useful short films.
If you read it online, you will be able to click straight through to the films.

Welcome

Welcome to the NHS

I'm so delighted that you've chosen to be part of a fabulous team in general practice and in your community. Your role is part of an ever-growing team in primary care. You are one of the future guardians of the NHS. What you will do for your patients will change their world and will change the way we practise as GPs.

So, I'm delighted to welcome you. Enjoy this pack. Enjoy your job, and good luck.

Dr Nikki Kanani
GP and Medical Director for Primary Care

Introduction

Welcome to your new role as a care coordinator. You will be working with your primary care network (PCN) team to support people through personalised care, helping people to improve their health and wellbeing by treating them holistically and starting from what matters to them.

Care coordinators will play an important role within a PCN to proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services.

The care coordinator role will ensure patient health and care planning is timely, efficient, and patient-centred. The role will include responsibilities for the coordination of the patient's journey through primary care and secondary care. This is achieved by bringing together all the information about a person's identified care and support needs and exploring options to meet these within a single personalised care and support plan, based on what matters to the person.

The care coordination role is embedded within the Primary Care Network Direct Enhanced Service, which aligns to the NHS Long Term Plan's commitment to make personalised care business as usual across the health and care system[1].

You are joining primary care networks at a very exciting time. The Network Contract DES Specification 2020/21[2] provides reimbursement for three personalised care roles based in PCNs: social prescribing link workers, health and wellbeing coaches, and care coordinators.

Supporting information on these three roles can be found in the Network Contract DES Guidance 2020/21.[3] The introduction of health and wellbeing coaches and care coordinators from April 2020 is in addition to the existing social prescribing link worker role which has been in place since July 2019.

Working together through a single point of access, these three roles reduce and support the workload of GPs and other staff by supporting people to take more control of their health and wellbeing and addressing wider detriments of health, such as poor housing, debt, stress and loneliness. Your contribution enriches the skill mix of primary care teams. As a result, people have improved lives, benefit from timely access to health services, and are supported to develop the skills and confidence to manage their own health and wellbeing.

These roles are intended to become an integral part of the core general practice throughout England, embedding personalised care within PCNs and supporting all professionals to take a personalised care approach.

These are exciting times, and you are a part of it.

This welcome pack won't give you all the information you need, but we hope it will help you to find your feet in your new role. It will also point you in the direction of more detailed information that might be useful to you.

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1 https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/
2 https://www.england.nhs.uk/publication/des-contract-specification-2020-21-pcn-entitlements-and-requirements/
3 https://www.england.nhs.uk/publication/des-guidance-2020-21/

Setting the scene – personalised care

In January 2019, just after the NHS celebrated its 70th birthday, the NHS Long Term Plan was published. It was based on pride in all the good things the NHS has achieved in its first 70 years, but it acknowledged that there are challenges to be met if the service is to be fit for the future. The Plan wants to redesign patient care to future-proof the NHS for the decade ahead, so that we will be able to celebrate its 80th birthday in the best possible shape.

One of the big practical changes which the Long Term Plan[4] commits to is that "people will get more control over their own health and more personalised care when they need it." This is because evidence shows that people will have better experiences and improved health and wellbeing if they can actively shape their care and support.

You can read more about personalised care – what it means, and what we're going to do about it – in Universal Personalised Care.[5] Its main aim is that up to 2.5 million people will benefit from personalised care by 2023/24. This will give them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their lives.

An animation explains more about the meaning of personalised care.[6]

4 https://www.longtermplan.nhs.uk/
5 https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/
6 https://www.youtube.com/watch?v=RXOd-7rn6so

"I worked in general practice for nine years as a receptionist, then reception manager, before taking this role.

The care coordinators make a massive difference in the homes and practices; I have not had one negative comment. In one home I have contact with they were battling with the practice to get everyone their flu jabs, so I coordinated this service. Then I set up proxy ordering as they had constant issues with missing meds. It changed things massively, saving them so much time. I spoke to the manager the week after; she said how her life has changed since I started and is so much easier now, which was so nice to hear and so rewarding to see that we are making a difference.

I was really nervous about changing jobs after being at the practice for so long, but I absolutely love my job, to see that we are making a difference. It is definitely the best decision I have made. I do some mentoring as well, which gives me great satisfaction."

N.B.

We are working on a range of areas to help us embed personalised care – and in your role as a care coordinator, you are part of this.

These are the six main areas we are working in:

- Supported self-management, especially for people with long-term conditions
- Shared decision-making between professionals and the people they support
- Social prescribing and community-based support
- Personalised care and support plans
- Choice – over where and how people receive care
- Personal health budgets for people with complex physical needs

It's estimated that one in five of the people who go to see their GP are troubled by things that can't be cured by medical treatment. GPs tell us they spend significant amounts of time dealing with the effects of poor housing, debt, stress and loneliness. Many people are overwhelmed and can't reach out to make the connections that could make a difference to their situation.

This is especially true for people who have long-term conditions, who need support with their mental health, who are lonely or isolated, or who have complex social needs that affect their wellbeing.

And that's where you come in. As a care coordinator you will work as part of a multidisciplinary team (MDT) within your practice to identify the people most in need of proactive support.

Who do you work for – and what is a primary care network?

You have joined a primary care network (PCN)

You will become an important member of your PCN multidisciplinary team, working in partnership with the health and wellbeing coaches and the social prescribing link workers and taking referrals from all member practices.

PCNs are a key part of the NHS Long Term Plan. They are groups of GP practices and local partners, usually covering between 30,000 and 50,000 patients. GP practices in England have been part of PCNs since July 2019.

The practices and their partners work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas. By working together, they can provide more proactive and personalised care. They help to make health and social care more joined up. In parts of the country where emerging PCNs are already in place, there are clear benefits for patients and clinicians.

An animation explains more about primary care networks.[7]

7 https://www.youtube.com/watch?v=W19DtEsc8Ys&feature=youtu.be

What will you be doing as a care coordinator?

What is care coordination and what is SSM?

As a care coordinator you will be working as part of a multidisciplinary team within your practice to identify people in need of proactive support. This could mean, for example, people living with frailty or people with multiple long-term physical and mental health conditions.

You will work with people individually, building trusting relationships, listening closely to what matters to them, and working with them to develop a personalised care and support plan.

You will review people's needs and help to connect them to the services and support they require, whether within the practice or elsewhere – for example, community and hospital-based services.You may support people in preparing for or following up clinical conversations they have with healthcare professionals, to enable them to be actively involved in managing their care and supported to make choices that are right for them.

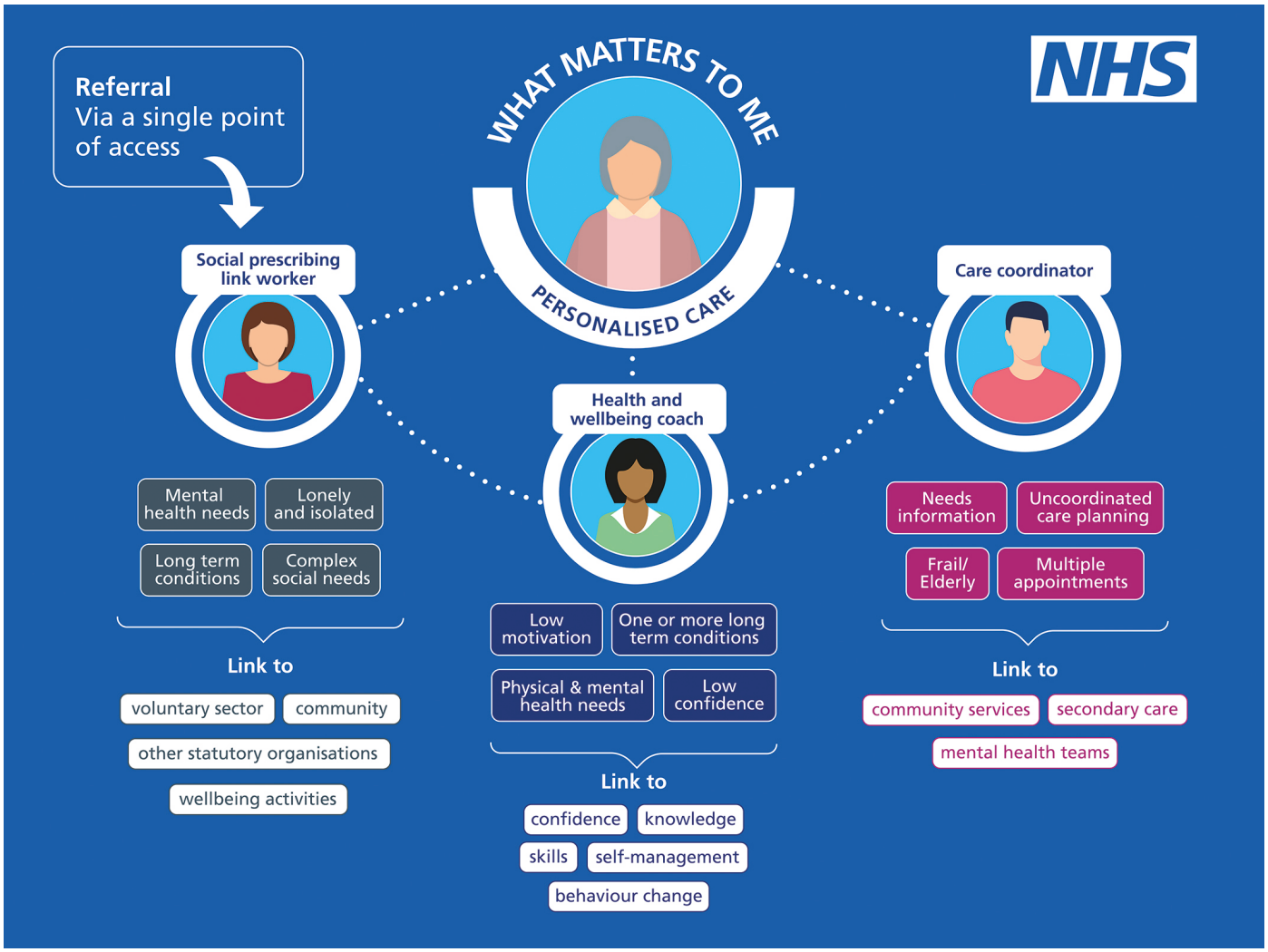
You will work closely with social prescribing link workers and health and wellbeing coaches, referring people to them and also receiving referrals in return.

You will work with a caseload of patients at any one time, acting as a central point of contact. A key part of your role will include developing personalised care and support plans with people and ensuring the support they need is available, particularly at times when their needs are changing.

As you will need to ensure that your caseload is manageable and that you have capacity to accept new referrals, it will be important that you work with people in a way that enables them to move on. This might involve referring them to a health and wellbeing coach for support to build up their knowledge, skills and confidence in managing their condition, or to a social prescribing link worker to provide them with further support and connections into the voluntary and community sector. It will be important to work with people in a way that, as far as possible, avoids them becoming dependent on primary care and encourages them to self-manage their own care and support as much as they can; this is supported self-management (SSM).

There will usually be a single point of access to ensure that people receive the right support at the right time. This single point of access will generally be via the social prescribing link worker(s), who will work in partnership with you and the health and wellbeing coach to triage referrals, as set out in the Network Contract Directed Enhanced Service (DES) Guidance 2020/21.

Care coordination as part of personalised care in PCNs



You're not on your own

You will be part of a team with a variety of different skills – a multidisciplinary team. This could include pharmacists, physiotherapists, and other professionals and practitioners within general practice. Your PCN's core network practices will identify a first point of contact for general advice and support and provide supervision for you. This could be one or more people.

Ways of working

Your role is to help people gain more choice and control over their own health and care. To do this you will need to take a 'what matters to me' approach, so that together you can create a personalised care and support plan.

'What matters to me' approach

As a care coordinator, you will help people to focus on what matters to them, giving them time to tell their stories. By building rapport with people and providing non-judgmental support, you will help them to identify what is important to them, and what the obstacles are to achieving this. This will vary from one individual to another.

To be effective in this approach, you will need to:

- Listen actively and show you understand what matters most to the person
- Provide non-judgmental support
- Reflect to people what you understand they have said, checking understanding
- Put what matters most to the person at the heart of every conversation
- Be warm and friendly
- Treat each person with dignity and respect
- Where a person is not happy with their support, enable them to make a complaint

By taking this approach, you want each person to be able to say:

- I am listened to and understood, and 'what matters to me' is central to all our work together
- I am respected and treated with dignity as an individual
- My human rights are protected, and I do not experience discrimination
- I experience warm, compassionate, personalised care and support
- If I raise a concern or make a complaint, it is acted on quickly

"I interact with various primary care professionals and health care providers like GP leads for a care home, a clinical director, a CCG care home pharmacist, PCN pharmacists, an OT and an SPLW to manage a caseload of identified patients, making sure appropriate support is made available to them and ensuring that their changing needs are addressed."

S.P.

Personalised care and support plans

You should help the people who need your support to create a simple personalised care and support plan. It is essential that this is developed jointly by you and the person you are supporting, and that they own its content. They should have a copy of the plan to keep and refer to. When developing a support plan, the following checklist[8] can be used as a guide.

The plan is a summary of:

- What matters to them
- How best to support them – what people need to know about them
- Any health conditions that groups and agencies need to know about
- Their goals
- What support they are being connected to, such as community groups and services
- What they can do to support themselves to meet their goals
- Review – how it's going and what changes have taken place
- Permissions – to share stories, be involved in evaluation and take part in satisfaction surveys

We have put an example template for a personalised care and support plan in Annex 1, which you can use or adapt.

8 https://www.aomrc.org.uk/wp-content/uploads/2020/12/Personalised_Care_Support_Planning_Checklist.pdf

How will you know if you're making a difference?

We know you will make a difference to people's lives, but we need to be able to measure the impact that you have. This is important so that we can build strong evidence for the coordination of care, and so that we plan properly for the future.

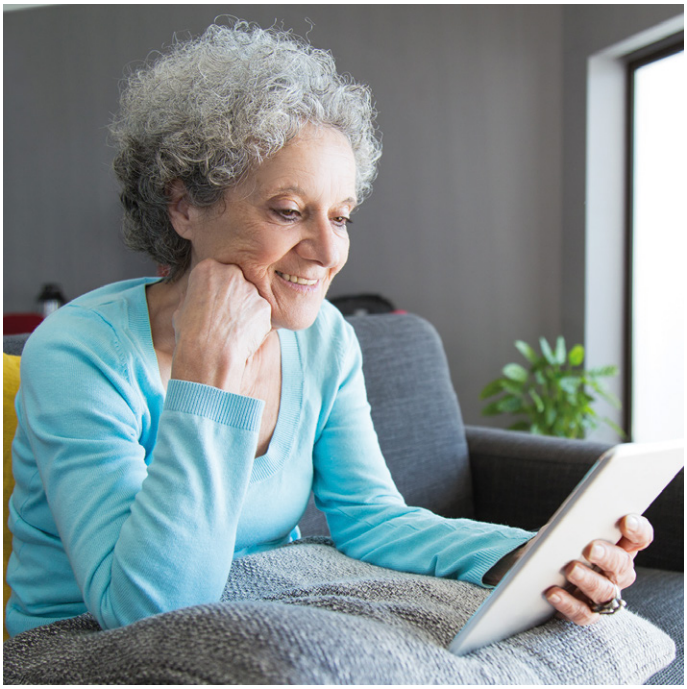
Measuring health and wellbeing

You will need to measure the effect that your work has on people's health and wellbeing. If you are part of an existing scheme, you may already have a system for doing this, and you can continue to use that. If not, speak to your PCN and find out what they use. You will need to work with your colleagues to develop ways of recording this information securely, and in a way that can be shared further down the line.

Activity linked to care coordination should be recorded using the following **SNOMED code: 148481000000101 Seen by care coordinator (finding)**.

Measuring impact on the health and care system

As part of the PCN, you will have access to their IT system. Processes should be in place to use this system so that you can record your activity with people on their medical records. If this is not the case, speak to your line manager or supervisor about how you will work to record referrals and outcomes for those referred.



How we'll support you

Your care coordination supervisor

Your PCN will ensure you have access to care coordination training, including access to a care coordinator supervisor to provide direct supervision for your work. Care coordination supervision and ongoing peer support are required for all care coordinators and are separate and different from clinical and caseload supervision and one-to-one line management.

You will work with and be supported by a supervisor who will work with you on a one-to-one or group basis to work through your caseload activity to gain insight, support and direction on work you identify to enhance your skills and practice in a safe and non-judgmental environment.

Access to 'clinical' or non-managerial supervision

As well as the ongoing support you will receive from the care coordinator supervisor, you should have regular access to clinical or non-managerial supervision with both your GP and other relevant health professionals within the PCN. This 'clinical' or non-managerial supervision will help you to manage the emotional impact of your work and be guided by clinicians on dealing effectively with patient risk factors.

Learning, developmental and peer support

NHS England has developed learning and support for care coordinators – including regular webinars, an online learning programme, regional training workshops and informal peer support – as part of a regional supported self-management offer.

To access this learning and become part of the online learning community, or for further information, please email SSM england.supportedselfmanagement@nhs.net and tell us that you're a care coordinator, which PCN you're part of and your contact details.

Supported self-management mentors

The supported self-management mentors will support care coordinators and take part in regular online learning sessions with care coordinators and the national SSM team. The mentors will lead sessions on SSM and work with the national team to support the development of a community of practice through the care coordinator online collaborative, to continue to develop a high-quality support offer.

The mentors are experienced in SSM, including time as health and wellbeing coaches/care coordinators, with an added wealth of experience to draw upon from their work across the health and care system in a variety of roles within the health, care and Voluntary, Community and Social Enterprise (VCSE) community.

Online care coordinator learning

The online Personalised Care Institute (PCI) learning programme will offer a standardised training package for PCN care coordinators. It will include the core elements and skills required to do the job and to deliver care coordination as part of a PCN's multidisciplinary team. Funding for PCNs to commission this training and supervision has been made available.

Online collaboration

NHS England and NHS Improvement have set up an online community of people involved in SSM and care coordination. We call this our 'collaborative platform'. You will be encouraged to join it so that you can participate in forums with other care coordinators and people who work in SSM, to share best practice and access resources provided by the national team.

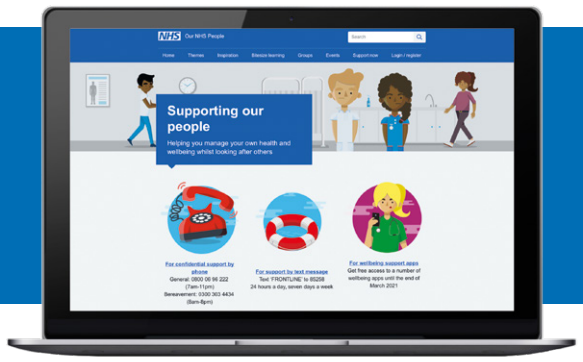
To join the online collaborative platform, please email england.supportedselfmanagement@nhs.net

National care coordinator 'share and learn' sessions

NHSE/I hold monthly share and learn sessions for care coordinators, focusing on relevant topics, which are co-chaired by the national team and the care coordinator mentors. These sessions add to what you already know about SSM and care coordination, illustrating how you can embed personalised care within your PCN through building a community of people who are as passionate as you are about improving people's knowledge, confidence and skills to take more control of their health and wellbeing.

For session details, join the online collaboration platform by emailing england.supportedselfmanagement@nhs.net

National health and wellbeing support to help care coordinators manage their own health while looking after others



A range of resources to help support your own health and wellbeing is available on the NHS People website at https://people.nhs.uk

A number of short guides provide help with skills and new ways to improve your experience of work.

There is specific coaching support for people working in primary care www.england.nhs.uk/supporting-our-nhs-people/wellbeing-support-options/looking-after-you-too/

Confidential support is also available by phone on **0800 06 96 222** (7am-11pm) for any general support, or **0300 303 4434** (8am-8pm) for bereavement-specific support.

For support by text message, **text 'FRONTLINE'** to **85258** (available 24 hours a day, seven days a week).

Annex 1
- personalised care support plan

MDT/IPC hub name	
Location	

Indicator	What works well?	Development actions
1. Execution of task • Are clear on their purpose • Understand the processes in place • State outcomes required • Identify actions to take forward		
2. IPC hub/MDT structure • Core membership is agreed on the basis of population need • Associate membership is agreed to support care planning as appropriate		
3. Meeting management • Frequency of meetings is agreed • Venue is agreed • Time and length of meeting is agreed		
4. Roles and functions The group has established key roles to support effective working, such as: • Lead practitioner (see role profile) • Meeting coordinator • Meeting chair • Integrated care coordinator • Collective leadership of the MDT		

Indicator	What works well?	Development actions
5. Integrated care processes • Valid consent is obtained and recorded from all referred adults, including consent for information sharing • Processes are in place to accommodate patients who may lack capacity, in line with the Mental Capacity Act 2005 • Members understand the principles of confidentiality • Processes are in place to enable recording of discussions • Processes are in place to document the single care and support plan • Process is in place to identify a single, named coordinator • Process is in place for timely review • Appropriate information governance approaches are in place		
6. Healthy debate and discussion • Discuss different professional approaches • Deal with disagreements immediately • Challenge the evidence behind ideas • Be interesting and persuasive in discussions • Ask deeper, probing questions • Discuss results of new approaches to care and support		
7. Trust within the team • Are open around gaps in knowledge and need for advice or assistance • Are comfortable sharing new ideas and challenging old ideas • Have shared purpose and unified goals • Are welcoming to new members / observers • Value all members of the MDT as equal partners (health, social care, VCSE sector)		

Indicator	What works well?	Development actions
8. Individual/collective commitment • Attend meetings regularly and on time • Pay attention to conversation • Commit to agreed actions and carry them out • Contribute to the process • Feel contributions are valued • Make decisions • Leave the meeting with a plan		
9. Acceptance of accountability • Identify who is responsible for action • Understand the potential impact of success on the wider health and social care system • Challenge lack of action or avoidance • Deal with poor performance • Don't allow shifting of blame • Admit to/take responsibility for errors		
10. Attention to results • Identify desired outcomes • Understand aims and objectives • Use clear processes to achieve results • Discuss and provide evidence for results • Take credit for positive results • Use creative approaches to obtain outcomes		

Annex 2
- additional resources

Better Conversation

'Better Conversation' resources for clinicians and health and care leaders, including video, infographics and a resource guide which contains case studies, evidence and tips on how to introduce a health coaching approach to improve the quality of conversation and help patients change behaviour.

www.betterconversation.co.uk

- Better Conversation: tools for action
  www.betterconversation.co.uk/images/Action_Booklet.pdf
- Better Conversation: a guide to health coaching
  www.betterconversation.co.uk/images/A_Better_Conversation_Resource_Guide.pdf

NHS England resources

- NHS Long Term Plan (2019)
  www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
- Personalised Care, including the comprehensive model of personalised care and Universal Personalised Care
  www.england.nhs.uk/personalisedcare
- Information on PCSPs and supporting systems to aid understanding of the national definition and criteria for personalised care and support planning, why it is important to focus on the whole of a person's life, and the five quality criteria which must be met for a clearly defined PCSP.
  www.aomrc.org.uk/wp-content/uploads/2020/12/Personalised_Care_Support_Planning_Checklist.pdf
- Social prescribing and community-based support: summary guide
  www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/
- Shared decision making: summary guide
  www.england.nhs.uk/publication/shared-decision-making-summary-guide
- Supported self-management: summary guide
  www.england.nhs.uk/publicati:on/supported-self-management-summary-guide

Personalised Care Institute

A virtual organisation accountable for setting the standards for evidence-based training in personalised care in England, the PCI provides a hub for all health and care staff to access personalised care training and development.

www.personalisedcareinstitute.org.uk

(All enquiries can be made through info@personalisedcareinstitute.org.uk)

Useful e-learning

- Interactive learning package to support the person-centred approaches framework
  www.e-lfh.org.uk/programmes/person-centred-approaches
- Information standard - making information accessible
  www.e-lfh.org.uk/programmes/the-information-standard
- Introduction to increasing physical activity
  www.e-lfh.org.uk/programmes/physical-activity-and-health
- Range of resources on shared decision making
  www.e-lfh.org.uk/programmes/shared-decision-making
- Introduction to personal health budgets
  www.e-lfh.org.uk/programmes/personal-health-budgets