Peer Support Session

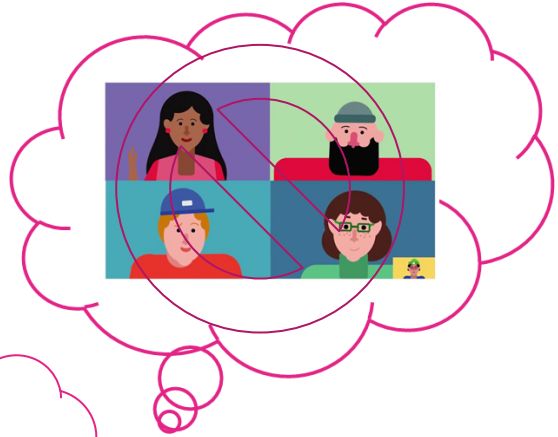
New Care Coordinators in London

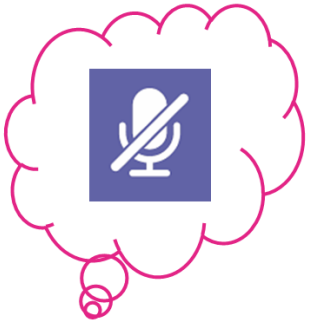
August 2022

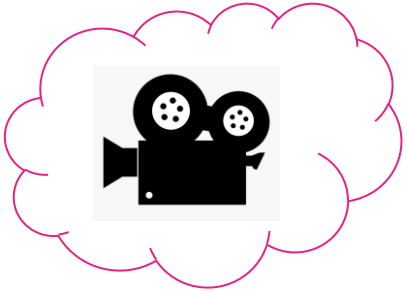
Healthy London Partnership

NHS England

Housekeeping







Q&A

Plan for today

JOIN THE CONVERSATION

It is an informal session – talk to each other & share resources in the chat

TIME	ITEM
1.00pm	**Introductions**
1.10pm	**Rafif Mansour – Care Coordinator Network Manager** Welcome to your role The context of Care Coordination in London, PCNs and ICSs
1.25pm	**Katie Smith & Imogen Lai, Care Coordinators in Lewisham** The why behind the Care Coordinator role – the importance in primary care Examples of things a care coordinator can work on Top tips from a care coordinators perspective
1.40pm	**Jenny Brooks – Health Inequalities Project manager** What support is available to you
1.50	**Rafif Mansour – Care Coordinator Network Manager** Important takeaways
2.00	**Q&A and Networking**
2.30pm	**Close**

Overview – what will you leave with…

By the end of this session, you will be able to:

- ✓ Understand support options available for London CCs
- ✓ Understand the CC role and the NHS structures around your role
- ✓ Sign up for mailing lists, forums and places allowing collaboration
- ✓ Find adequate resources to help you in your daily tasks
- ✓ Connect with other CCs

London Care Coordinator Network Manager

- I am the London Care Coordinator Network Manager. My role is primarily to help develop Care Coordinators across London, build peer support and networking opportunities for them locally and help PCNs understand and embed the role effectively

- We now have a group of Local CC Champions for each of the five ICS areas in London who are also helping to connect local CCs and share local knowledge and resources

- Together with the other London Personalised Care Team leads I support supervisors or employers on how the role can be better supported, developed and integrated, providing clarity on where they sit within the wider personalised care and health inequalities agenda

- I regularly share the feedback and challenges of London CCs to the national NHSE team and have been involved with the work on the new CC roadmap outlining the national expectation in terms of training, role, supervision and support

- I work alongside Jenny Brooks, project officer at Healthy London Partnership to support you. Please contact us if you have any queries (see contacts page)

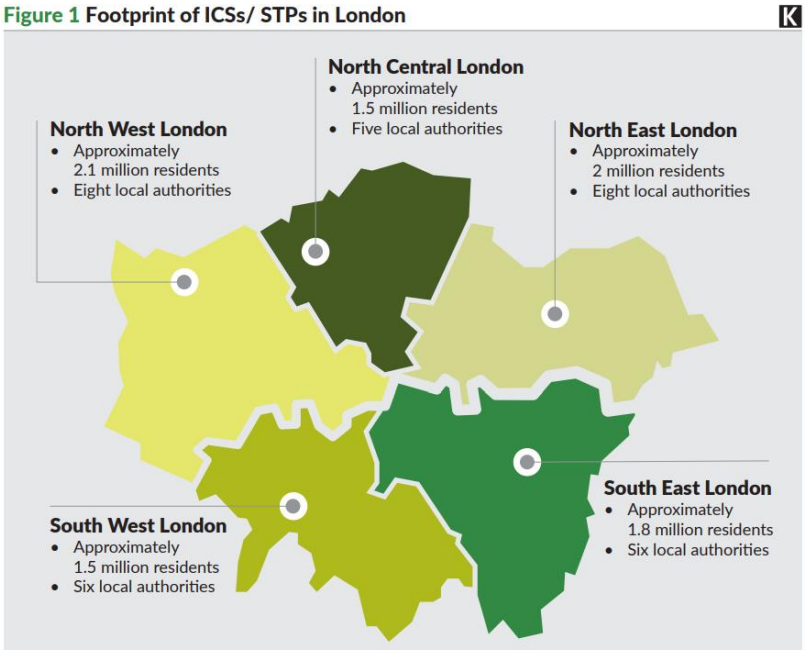
Rafif Mansour, Salaried GP in Barnet, SPIN fellow working in collaboration with Barnet training hub to support Care Coordinators

Care Coordinators in London

In London, there are…

- Five Integrated Care Systems
- 200 Primary Care Networks

Integrated Care System (ICS)	Number of CCs
NCL (Barnet, Camden, Haringey, Enfield, Islington)	64
NEL (Barking & Dagenham, Havering, Redbridge, Waltham Forest, Tower Hamlets, Newham, Hackney)	64
NWL (Brent, Central/Westminster, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, West/Kensington & Chelsea)	44
SEL (Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark)	89
SWL (Croydon, Kingston, Merton, Richmond, Sutton, Wandsworth)	81
Grand Total	342



NEW CARE COORDINATORS IN LONDON

NHS Long Term Plan

"As medicine advances, health needs change and society develops, the NHS has to continually move forward so that in 10 years time we have a service fit for the future."
- NHS Long Term Plan

- Personalised care is one of the five major, practical changes to the NHS that will take place over the next five years, as set out the published Long Term Plan

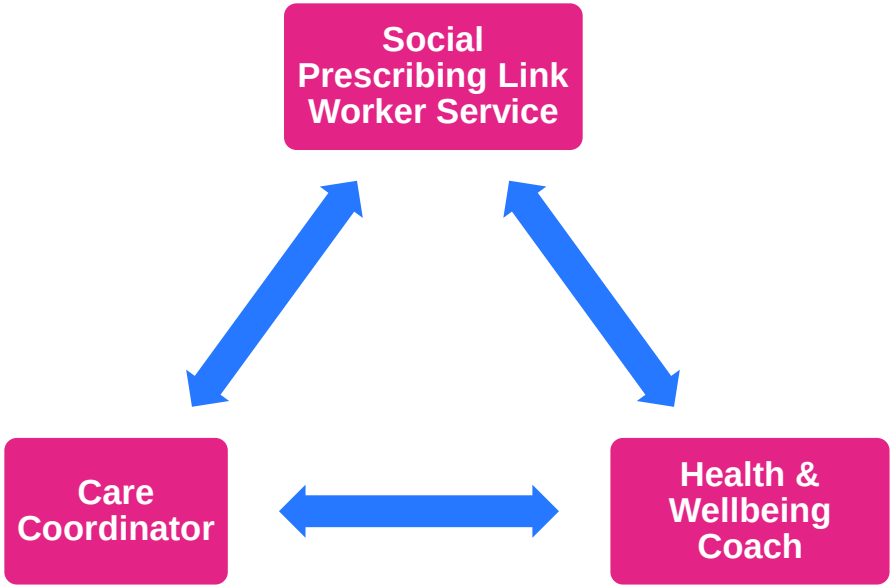
- Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs

Personalised care

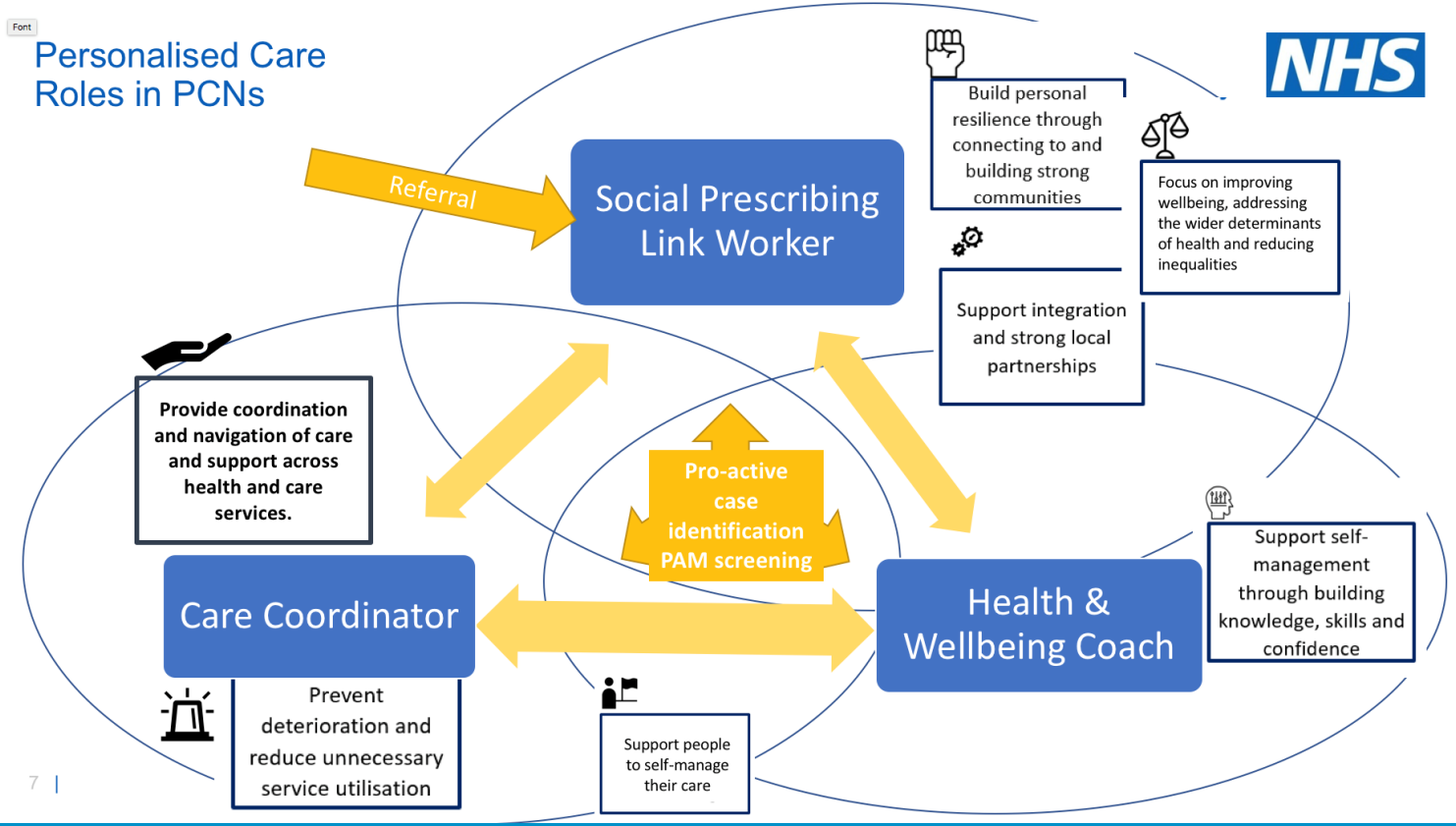
- improves people's health and wellbeing
- joins up care in local communities
- reduces pressure on stretched NHS services and helps the health and care system to be more efficient
- helps people with multiple physical and mental health conditions make decisions about managing their health, so they can live the life they want to live, based on what matters to them, as well as the evidence-based, good quality information from the health and care professionals who support them
- recognises that, for many people, their needs arise from circumstances beyond the purely medical, and will support them to connect to the care and support options available in their communities
- Personalised care also has a positive impact on health inequalities, taking account of different backgrounds and preferences, with people from lower socioeconomic groups able to benefit the most from personalised care

How does the care coordinator role fit in?

- A number of new ‘additional roles’ have been introduced as part of the strategies to try and achieve this long term plan
- Care co-coordinators, social prescribers and health and wellbeing coaches are a triad of additional roles whose main aim is to assist in achieving personalisation of care



Personalised care ARRS roles



NEW CARE COORDINATORS IN LONDON

Care coordinator role

Care coordinators 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.

They work closely with GPs and practice teams to manage a caseload of patients, acting as a central point of contact to ensure appropriate support is made available to them and their carers; supporting them to understand and manage their condition and ensuring their changing needs are addressed.

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

Care coordinators could potentially provide time, capacity and expertise to support people in preparing for or following-up clinical conversations they have with primary care professionals

How will a care coordinator achieve this?

- **Proactively identify patients** who need support to:
  - be actively involved in managing their care and to make choices that are right for them
  - understand and manage their condition, ensuring changing needs are addressed
  - prepare for follow-up clinical conversations with primary care professionals
  - develop personalised care & support plans
- **Provide coordination and access** to other appropriate services and support.
  - Referrals to other ARRs/allied roles
  - Signposting to supportive organisations
  - Ensure appointments are appropriate for patient needs – eg virtual/f2f
- **Tend to work with** people with multiple appointments, frail/elderly and people with long term conditions (LTCs).
  - Follow up after hospital discharge
  - Ensure no obstacles to medication compliance, eg arrange fossette boxes
  - Ensure POC in place – link between primary and social care

Advocate

Enable

Co-ordinate

“Node”

Empower

Motivate

Support

Navigate

Guide

Working structures

PCN Care Coordinator	Practice Care Coordinator
Part of a team of CCs	Individual CC for each Practice
Managed by PCN manager	Managed by Practice Manager
Share work on cohorts of patients e.g. Pre-Diabetic, Learning Disability, Weight Management	Usually manages individual case load of patients, referred by colleagues within the practice to eg, help chase appointments, arrange transport, liaise with MDT
Less involvement with individual Practices	Referrals from/to other ARRS roles – SPLW, HWBCs
Clinical Supervision and line management	Clinical Supervision and line management

The why behind the Care Coordinator role

Katie Smith & Imogen Lai, PCN Care Coordinators in Lewisham

- We act as bridges between GP practices and patients. Lewisham is a very diverse borough, with residences from different socioeconomic, culture and languages backgrounds; which leads to high health inequalities.
- Three main aspects of our job: Health check, Digital hubs and Care Navigations.
- Taking Care into community: outreach program

The why behind the Care Coordinator role

Care Navigation:

- Referrals: GP, FoH, Social Prescriber, Mental Health and Well being Team (MHWT), Self-referral and Care Coordinator referral.
- Case study 1: Referral between different teams
- Case study 2: Referral back to GP
- Case study 3: The need of MDT meeting

Quotes about the Care Coordinator service

There's a lot of naiveté about diabetes & cholesterol – some believed only those who were (very) obese got these diseases.

Call & recall is crucial in our PCN because of the many who are illiterate, have learning disabilities or simply don't understand or speak English – letters, texts or voicemail from their GP surgery inviting them for healthchecks or appointments don't work.

At least 5 different patients have expressed shock with the recommendation to have at least 5 portions of fruit and vegetables

We use translators for around 21% of our patients during our health check clinics and given them printed resources in their spoken language – these patients are the ones most grateful and happiest for our service.

We've had many patients so thankful and overwhelmed by our service that they've asked for paid or volunteer roles within our team. Many ask if they can bring their family or friends for a health check

It's amazing how many people believe they are healthy, and say they feel absolutely fine and get shocked with their results. Even I have been shocked by their blood test results given the healthy, even muscular appearance of some patients.

We can really see the value in our work when we identify patients with total cholesterol levels well over 7.5 mmol/L, or HbA1c levels at pre-diabetic levels or well over 80 mmol/mol, or blood pressure above 180/120, especially if the patients had no symptoms

What support you can expect

Monthly Peer Support Sessions – These happen on Mondays usually at the end of the month, if you sign up to the mailing list, you will receive the calendar invites.

The plan for these sessions is below. Please find the recordings and resources from the sessions here.

- May:
  - **Day in the life of a Care Coordinator** (2 care coordinators presenting for ~10 minutes about their work, what it looks like day-to-day, split of activities, groups they are a part of)
- July- Dec:
  - **Spotlight on different work areas/cohorts**
  - Including background to clinical area/service, presenting of case studies, tools/tips to work with this patient group, external speaker, working through a patient case example
  - Example areas: SMI, Care homes, Carers, Frail, Health inclusion groups, excluded groups/lack of access

1:1 Support Sessions

These sessions are designed to offer additional support to work through challenges or help you develop your role further. They run every other Monday. You can sign up as an individual or small group. Please sign up for a 30 minute slot here

Connect to peers

Please contact the care coordinator champions in your ICS to be included in ICS level peer support groups, conversations and meetings.

If you do not know what ICS or PCN you work in, you can enter your practice name here to find out.

Care Coordinator Champion Contacts			
Name	**Email**	**ICS**	**Borough**
Ellie Hatch-Mccarthy	ellie.hatch-mccarthy@nhs.net	NCL	Barnet
Rupert York	rupert.york1@nhs.net	NCL	Camden
Nasima Begum	nasima.begum12@nhs.net	NEL	Hackney
Navjot Rai	navjot.rai@nhs.net	NEL	Redbridge
Francesca Caruana	francesca.caruana1@nhs.net	NEL	Tower Hamlets
Lucy Walsh	lucy.walsh9@nhs.net	NEL	Barking and Dagenham
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Kunal Trivedi	kunal.trivedi@nhs.net	SWL	Croydon

Have a read

NHS England has a range of materials to help you in your job. A section has been added to the FutureNHS Collaboration Platform* for new CCs which provides all the guidance, training, templates and info you need to carry out your role, including:

- Welcome pack for new Care Coordinators
- National Care Coordinator Future NHS area: National resources located here
- London Care Coordinator Future NHS area: here you can ask peers questions and access resources
- Care Coordinator roadmap (TBC March) – outlining development, training and the value of Care Coordinators
- Network Contract Directed Enhanced Service – page 89 details the contract guidelines around Care Coordinators and reimbursement of their pay through ARRS

* If you are not registered with the FutureNHS Collaboration Platform you can join here

Top tips for new Care Coordinators

1. Sign up to receive the fortnightly London Care Coordinator emails and hear about events, access peer support and general updates relating to Care Coordination
2. Attend the national Care Coordinator share and learn sessions. Sign up here
3. Watch and share this three-minute video on Care Coordinators in primary care with colleagues.
4. Undertake e-learning related to personalized care, care coordination or clinical conditions you may work with
5. Email the Care Coordinator champions in your ICS, to connect to CCs in your patch
6. Read Information for New Care Coordinators
7. Watch the webinar on the value of Care Coordinators in tackling health inequalities and showcase of examples across London.
8. Look through NHSE's Care Coordinator case studies here
9. Make sure you are looking after yourself, you can book a free coaching session for primary care staff

Key take aways

- The care coordinator role should be exciting and innovative, tailored to local areas
- This is a patient facing role with the aim for you to have a case load
- Be proactive – identify opportunities to support patients
- Be patient – the role is flexible and may take time to shape

Contacts

Please feel free to contact our team if you have any questions related to Care Coordination in London:

Rafif Mansour
Care Coordinator Network Manager
Email: r.mansour@nhs.net

Jenny Brooks
Health Inequalities Project Manager
Healthy London Partnership
Email: jennifer.brooks14@nhs.net

Resources for understanding primary care and the NHS

About the strategic direction of primary care

- Next steps for integrating primary care: Fuller Stocktake report
- Letter from Integrated Care System leaders
- Integrated care systems in London: Challenges and opportunities ahead (kingsfund.org.uk)
- What are provider collaboratives?

DES contract

- Network Contract Directed Enhanced Service – Contract specification 2022/23 – PCN Requirements and Entitlements
- Network Contract Directed Enhanced Service – Guidance for 2022/23 in England
- Network Contract Directed Enhanced Service – Frequently asked questions 2022/23
- PCN adjusted populations spreadsheet
- Network Contract Directed Enhanced Service – Investment and Impact Fund 2022/23: Updated Guidance
- Network Contract Directed Enhanced Service – Personalised Care: Social prescribing; shared decision making; digitising personalised care and support planning

Quality and Outcomes framework (QOF)

- Results for practices and guidance

Population health and health inequalities

- What is population health in the NHS – King's fund

Resources

- HLP Care Coordination Website
- London Mailing List and peer support sign up form
- Information for New Care Coordinators (National level)
- Welcome and induction pack for new Care Coordinators
- PCI Care Coordinator role description, access PCI accredited training here
- E-learning for healthcare platform
- Care Coordinator roadmap (including competency framework)
- Supported self management shared resources
- FutureNHS Collaboration Platform (National workspace including Webinars)
- FutureNHS Collaboration Platform (London Region page)
- Care Coordinator case studies
- Guidance on MDTs and working in MDTs
- MDT case studies
- Sign up to the personalised care bulletin
- Sign up for the integrated care bulletin

Q&A