**Q&A**

Recruiting and contracting

1. What skills, qualities and qualifications do a care coordinator need?
	1. The NHSE care coordinator competency framework (as part of the care coordinator roadmap) will cover this in detail (publication – March)
	2. In the meantime[, this HEE guide to the CC role](https://www.e-lfh.org.uk/wp-content/uploads/2020/10/Care-coordinator.pdf) highlights skills and areas for development.
	3. [Recruitment pack with sample JD, person spec and advert](https://future.nhs.uk/CareCoordinators/view?objectID=115491077)
	4. There is no set career route into becoming a care coordinator, however, as part of the care coordinator roadmap there is a plan to develop an apprenticeship route
2. What banding should a care coordinator be and when do they progress beyond a band 4?
3. When the role was first developed it was suggested as band 4 Afc minimum due to the amount available for reimbursement, however the role can be higher according to the teams need and wider personalised care strategy.
4. This guidance should not limit PCNs in the amount they pay care coordinators and the amount of responsibility they take on, and skillset they possess or develop. Where a care coordinator comes into a role with an advanced skillset, pay should be reflective of this.
5. The aspiration is that Care Coordination is a role that can be developed to take on emerging pieces of work to tackle health inequalities and in our view should attract the same pay at the other personalised care ARRS roles. In some areas they are topping up the reimbursement amount so that pay is equivalent to the other personalised care ARRS roles.
6. How is indemnity dealt with for CCs carrying out home visits? How can the risk of something clinical being missed be mitigated?
	1. This is something that has been asked before. We have put the question to national and they have indicated that it is up to individual PCNs. However, this is something that is likely to be covered in more detail in the CC roadmap, when published by NHSE.

Role clarity and boundaries

1. How do we prevent Care Coordinators being used solely as admin?
	1. Care Coordinators are not a purely administrative role, this should be outlined in the job description.
	2. Where a CC is being only used for admin, this should be raised with their supervisor as part of their regular supervision meetings, so they can be supported in developing a case load and patient facing work.
	3. Where a PCN or a practice is unclear about the work a care coordinator can take. Support can be accessed through the PCN advisor, please contact hlp.socialprescribing@nhs.net or book in a 1:1 meeting [here](https://calendly.com/pcn-advisors-london/30min?month=2022-03&date=2022-03-09).
2. Are there any specific complex needs you would recommend we focus on as care coordinators?
	1. You can consider the needs of your local populations, those with complex needs who require additional support or those impacted by health inequality. See the [CORE20PLUS5 guidance](https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/) for suggested approaches or use the [tool to identify inclusion health groups.](https://www.inclusion-health.org/pcn/)
	2. QOF conditions could also be a focus, such as those with a  learning disability. There are different tools to look at these in addition to local tools. For example: [Shape Atlas](https://shapeatlas.net/place/#7/52.603/-1.846/rh-0,rdr-t) allows you to compare QOF progress to neighbouring practices and PCNs.
	3. National programmes can be source of patient groups too. For example the national diabetes prevention programme or early cancer diagnosis, CCs can work to understand which patients might benefit from these programmes and engage them in enrolling.
	4. A suggested approach to this is supporting care coordinators initially with one type of patient group, to develop their expertise. Then, gradually this can be diversified with different groups of patients.
3. How can a care coordinator support population health management?
4. The [population health management workspace here](https://future.nhs.uk/populationhealth/grouphome) includes guidance, e-learning, case studies and guides on how to take a population health approach
5. On [slide](https://www.healthylondon.org/wp-content/uploads/2022/02/Feb-22-PCN-advisor-session-v2.pptx) 15 there are national data sources which can be used to identify health inequalities at a PCN or practice level. You could use dashboards to highlight areas of inequalities in your area.
6. You can look at the [CORE20PLUS5 guidance](https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/) for suggested groups to focus on or use the [tool to identify inclusion health groups,](https://www.inclusion-health.org/pcn/) to identify groups of people who may benefit from care coordination.
7. Once a target population has been identified, these can be targeted through searches on EMIS. [Case studies on what interventions have been used may be useful.](https://future.nhs.uk/populationhealth/view?objectID=32301904)
8. When is a patient too complex for a care coordinator to work with?
	1. Care coordinators are not clinicians and should not hold clinical risk.
	2. They should work alongside a GP, to support patients with complex needs. They should have regular scheduled supervision with a clinician as well as ad hoc access to a clinician to ask questions, to discuss any emerging issues with a patient.
	3. Through these discussions, the GP can assess the care coordinator’s competency around managing complexity of such patients.
	4. It is then up to the patient’s GP to decide what the care coordinator is able to continue supporting the patient with, depending on clinical risk.
9. How do you manage the 'overlap' of work with that undertaken by SPLW?
	1. The job descriptions of the roles should be reviewed when recruiting,  overlap understood and job content of both roles revised if needed.
	2. Slide 6 outlines the unique contributions of each role. [Here.](https://www.healthylondon.org/wp-content/uploads/2022/02/Feb-22-PCN-advisor-session-v2.pptx)
	3. Where only a CC or SPLW is employed, the individual role may look quite different. A blended role of social prescriber and care coordinator duties is common.
	4. Ensure both roles are meeting regularly to collaborate on caseloads, understand working boundaries and undertaking shared learning and training.
	5. A way of working should be set up to agree how the roles can communicate with each other on a day to day basis and process for referring to each other.

Embedding the role

1. How can we make sure the CC role is more uniform across practices within one PCN?
	1. The role of a care coordinator, specifically the type of patients they work with should be aligned with local needs.
	2. However, for a single care coordinator working across multiple practices, considerable variation between practices can make embedding into the structure and managing capacity more difficult.
	3. A suggestion is to identify a common theme or health inequality across all practices for the CC to focus on initially, then gradually introduce more practice specific groups or workloads.
	4. Some PCNs have employed multiple CCs and specialised the role e.g. mental health care coordinator or digital exclusion care coordinator. This makes cross-practice working more streamlined and allows specialist knowledge to be developed more in depth.
2. What does a model of a CC working PCN wide look like? How does this compare to one working with a single GP practice?
	1. This depends on how aligned or collaborative a PCN is on their health inequalities agenda.
	2. Ideally a care coordinator should work across similar themes across practices in one PCN, with one area to start with. This can then evolve to multiple PCN wide areas or practice specific areas.
3. How can a CC work best with the other roles (SPLW and HWBC)?
	1. The [slides and case study examples](https://www.healthylondon.org/wp-content/uploads/2022/02/Feb-22-PCN-advisor-session-v2.pptx) outline this.
4. What are top tips for embedding care coordinators?
	1. **Comprehensive induction and training** (personalised care, IT systems, clinical conditions, referral pathways, GP systems)
	2. **Supervision** – at a practice and PCN level. Clinical supervision from someone who understands the importance of the role in reducing health inequalities.
	3. **Being strategic** with the role: Understanding what populations the care coordinator will work with and why, what are the intended outcomes.
	4. **Use the systems** – EMIS templates can support the management, reporting and evaluation on CC’s case load work.
	5. **Connecting**: ensure they are involved in practice MDTs, PCN wide meetings and have regular meetings with other Care Coordinators, Social Prescribing Link Workers, Health and Wellbeing Coaches. Encourage your CCs to sign up to regional peer support [here](https://forms.office.com/Pages/ResponsePage.aspx?id=W-CUeMNT90OW4O5-3wAfTAmCcv5o005Phr3bJRNnZ8RUQVgyTTUwVVhOQjMwMk9UMkYxOTNOREtVMyQlQCN0PWcu&wdLOR=cF95AA347-10B4-4CB9-B990-77F7892D1204).
5. How can CCs support MDTs?
	1. On slide 27 in the [PowerPoint,](https://www.healthylondon.org/wp-content/uploads/2022/02/Feb-22-PCN-advisor-session-v2.pptx) you will find a link to a guide to CCs supporting MDTs.

Supporting the role

1. Who is qualified to supervise CCs? What does good supervision look like?
	1. The NHSE competency framework will cover this in detail (publication – March)
	2. However there are few things that good supervision is comprised of:
		1. Minimum monthly basis
		2. Should be able to discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic, violence and support with mental health)
		3. Should be with a senior member of staff and in primary care this should be a GP
		4. Supervisors are also responsible for assessing the ongoing development and performance of a care co-ordinator by looking at their portfolio of evidence on a regular basis
		5. If the Care Coordinator is working in a PCN, the DES should outline the supervision requirements.
2. What training do care coordinators need? Are there any funded opportunities?
	1. The NHSE competency framework will cover this in detail (publication – March)
	2. However, there are a few core components of initial training:
		1. Personalised care and care co-ordination (PCI accredited training)
		2. Training specific to the setting they are working in
		3. About the service, team, partner organisations and locality
		4. Information on specific pathways or patients groups they will support
	3. And for ongoing training and development (suggested and not limited to)
		1. Coaching skills development
		2. Welfare rights training
		3. Advocacy training
		4. Developing peer and professional networks
		5. Relationship building within the practices, MDTs and priority setting
		6. Management training, CPD, specialist role development
3. Is there an annual appraisal process for CCs? Do the modules of training have to be repeated?
	1. It is good HR practice to have an annual appraisal for all staff groups.
	2. Should include multi source feedback, including the clinicians they interact with and agreement on areas for further development.
	3. The supervisor has a responsibility to assess the ongoing development and performance of a care co-ordinator by looking at their portfolio of evidence on a regular basis.
	4. Care Coordinator work can be evidenced in the following ways:
		1. Patient feedback via testimonials or surveys
		2. Patient reported outcome measures
		3. Feedback from MDT colleagues
		4. Competency measures link to their time in their role
		5. Completion of training
		6. Personalised care and support planning information