Care Coordinator (CC)
Workforce Development Framework Summary

1. Introduction

- This summary is adapted by Transformation Partners in Health and Care (TPHC) from the CC framework developed by NHS England, in collaboration with range of stakeholders including Health Education England (HEE).
- The WDF focuses on the core functions, skills and competencies of the CC role alongside the professional support, training and development CCs require to enable them to practice safely, work effectively, and support improved outcomes for people and communities.
- We have summarised the key points and resources from the full 22-page WFD. Each heading in this summary is linked back to the corresponding section if the full detail is required.

2. Context

- The NHS Long Term Plan states that personalised care should become business as usual across the health and care system, Care Coordinators support this commitment.
- Funding is provided to expand the primary care workforce and employ personalised care roles, through the Additional Role Reimbursement Scheme (ARRs), as part of the Network Contract Directed Enhanced Service (DES).

3. What is a Care Coordinator?

- Care Coordination supports people with complex health and care needs, and long-term conditions to navigate the healthcare system and make decisions based on what matters to them.
- People can be easily referred to CCs from NHS agencies, including the other personalised care roles and wider settings e.g. care homes and community teams or they may be proactively targeted through identification at multidisciplinary team meetings (MDTs) or analysing practice data.
- For more information about the CC role see TPHC's one pager about CCs.
- Find out more about the benefits of the role. The boundaries of the role are also explained here.

4. Employing a care coordinator

- The CC recruitment pack developed by NHSE England, contains a job description and person spec which can be tailored to the employer.
- Making sense of coordinated care, produced by HEE and Birmingham City University, is helpful for setting up a care co-ordinator service.
- Requirements for employing CCs are outlined on pg. 99 onwards of the Network Contract DES specification.

5. Training requirements prior to taking referrals

- Personalised care and care co-ordination training.
  - This includes a Two-day accredited care co-ordinator training and e-learning on PCSP and shared decision making.

- Ensure Induction and training is specific to the setting the role is working in.
- They may also benefit from completing the Care Certificate and ongoing training detailed here (section 8).

6. Supervision requirements

- PCNs have a contractual responsibility to provide supervision as set out in the Network Contract DES contract specification. If care-coordinators are commissioned through a third party, these supervision requirements should be fulfilled within the arrangement. This includes:

1. Regular line management and appraisals as per the employer's usual arrangements.
2. A designated supervisor or supervisors whom they can meet with on at least a monthly basis (FTE staff).
   i. Supervisors should be experienced members of staff with a good understanding of the role of a care co-ordinator and ideally an understanding of advanced communication skills.
3. Supervision meetings should allow discussion for patient related concerns and support the CC to follow safeguarding procedures.
4. A named first point of contact for general advice and support (the supervisor or someone else).

Read more about the role of supervisors in CC's ongoing development.

7. Ways of working – professional framework

- Caseload
  - CCs should work closely within a MDT and manage a caseload of patients, working with them face-to-face and virtually.
  - Caseload to be determined locally depending on needs of complex patients – e.g. hospital discharges, people living with cancer, mental health patients.
- Referral
  - Can come from anywhere in the health and social care system, in communities and the voluntary sector or via self-referral.
  - CCs may also proactively identify people who could benefit from support, using tools including population health data, or using GP records to identify frequent attendance, lack of engagement or long term conditions.
- MDT work
  - Role in arranging the MDT, proactive patient finding.
  - CCs are a central point of contact for staff/patients, sharing information between all parties.
  - Advocate for 'what matters most' to the patient in the MDT.
  - CCs must have access to other healthcare professionals, electronic 'live' and paper-based record systems for each practice, and support and training to use these.

- Working with the three personalised ARRs roles
  - Can refer between the three roles to achieve empowerment of patient to self-manage.
  - Share information on different aspects of patient care e.g. by holding regular meetings to discuss shared patient caseloads.

8. Competency framework

- The Competency Framework sets out the competencies that all CCs require to be effective and assists those who employ or direct the activities of CCs to understand how these competencies can be achieved.
- There are four key areas:
  - Personalised care
  - Relationships
  - Communication
  - Continuous learning
- It is aligned to the NHS England sample Job Description for CCs and the Core Curriculum for Personalised Care published by the PCI.
- The framework can be used with the Portfolio of Evidence to enable supervisors and CCs to explore their skills and development needs.

9. Ongoing training and CPD

Care coordinators should have:

- Dedicated time and funding for training and attending peer support. Funding streams for PCNs to develop and support ARRs.
- Supervision, appraisals, and personal and professional development planning using the competency framework.
- Portfolio of evidence to structure conversation around CPD.
- Training could be informal, such as attending webinars, or formal offers via the PCI, Training Hubs, Leadership for Personalised Care, a PCN, trust, or integrated care system (ICS).

More information on training and CPD for care coordinators 6-12 months into post.

Additional training is required for Care Coordinators to develop into specialist roles, who may work in specific settings.

10. Entry to the role

- There is no set career route into becoming a care co-ordinator.
- People need transferrable skills to meet the core competencies required.
- A community health and wellbeing worker apprenticeship is one route.

11. Career development

- There are various options for career development, but no set route.
- Excellent entry level career in the health and care sector.
- Portfolio of evidence may help identify transferable skills and consider next steps.

Management and leadership roles:

- Line management of personalised care roles or teams may be a natural progression for experienced care co-ordinators, find out more.

Useful resources can be found here.