Care Coordinator- Minimum Requirements

1. **Where a PCN employs or engages a Care Coordinator under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Care Coordinator:**

    a) is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute. [84] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

    b) works closely and in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider and Health and Wellbeing Coach(es),

    c) in order to deliver the key responsibilities outlined in section 2

2. **Where a PCN employs or engages one or more Care Coordinators under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Care Coordinator has the following key responsibilities, in delivering health services:**

    a) utilise population health intelligence to proactively identify and work with a cohort of patients to deliver personalised care;

    b) support patients to utilise decision aids in preparation for a shared decision-making conversation;

    c) holistically bring together all of a person's identified care and support needs, and explore options to meet these within a single personalised care and support plan (PCSP), in line with PCSP best practice, based on what matters to the person;

    d) help people to manage their needs through answering queries, making and managing appointments, and ensuring that people have good quality written or verbal information to help them make choices about their care;

    e) support people to take up training and employment, and to access appropriate benefits where eligible;

    f) support people to understand their level of knowledge, skills and confidence (their "**Activation**" level) when engaging with their health and wellbeing, including through the use of the Patient Activation Measure;

    g) assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing and increase their activation level; page 77

    h) explore and assist people to access personal health budgets where appropriate;

    i) provide coordination and navigation for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals; and support the coordination and delivery of MDTs within the PCN.

3. **The following sets out the key wider responsibilities of Care Coordinators:**

    a) work with the GPs and other primary care professionals within the PCN to identify and manage a caseload of patients, and where required and as appropriate, refer people back to other health professionals within the PCN;

    b) raise awareness within the PCN of shared-decision making and decision support tools; and

    c) raise awareness of how to identify patients who may benefit from shared decision making and support PCN staff and patients to be more prepared to have shared decision-making conversations.

4. **A PCN must be satisfied that organisations and groups to whom its Care Coordinator directs patients:**

    a. have basic safeguarding processes in place for vulnerable individuals; and

    b. provide opportunities for the patient to develop friendships and a sense

    c. of belonging, as well as to build knowledge, skills and confidence.

5. **A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the PCN's Care Coordinator(s). This could be provided by one or more named individuals within the PCN.**

6. **A PCN will ensure the PCN's Care Coordinator(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.**

7. **A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Care Coordinator(s). page 78**