Coordinating Care:
In primary, community and outpatient settings

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In June 2014, the Academy of Medical Royal Colleges (the Academy) published: *Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients*, which was designed to support the delivery of a number of recommendations outlined in the Francis Report. In particular it recommended the need for a named clinician who is accountable for a patient’s care while they are in hospital.

Following the publication of this guidance, the Secretary of State for Health in England asked the Academy to consider the accountability of clinicians to their patients in out of hospital and outpatient settings. This is the Academy’s response to that request.

Meeting patient needs for health and social care is becoming more complex. The vision of integrated care is sometimes put at risk from lack of coordination. Most patients know to go to their general practice to coordinate their care, and know who ‘their GP’ is.

Since April 2014, GP practices have been given incentives to ensure that the most vulnerable 2% of adult patients have care plans. By April 2016, all patients will have a named GP, although there are and will be some circumstances in which the lead coordinator of their care outside of hospital is not their GP.
Recommendations

Principal Recommendation: Leadership in clinical coordination

The Lead Clinical Coordinator, generally but not necessarily always the GP, role will involve overseeing all clinical decisions and interventions experienced by a patient. This will ensure that decisions overall are in the best interests of the patient’s health and well being, and that opportunities are taken to maximise the future health and well being of the patient. Importantly the Lead Clinical Coordinator role should be the most appropriate healthcare professional explicitly matched to a specific person with complex needs or multi-morbidity.

Development of the navigator role

A Navigator oversees a patient’s care pathway, ensuring that care is, as far as possible, efficiently integrated. This maximises convenience to the patient and the use of their and the health service’s resources. Navigators already exist in some general practices but in others they are called (or are subsumed under) Care Coordinators or Self Care Facilitators. We believe that the role of Navigator is a necessary part of effective coordination of care.

High quality care plans

Effective care plans must be based on patient expectation (the ‘I’ statement) with healthcare professional’s input, to design a plan that is consistent with the best evidence and local resources to meet that expectation. Plans should include the amount of contact a patient should have with their general practice.

Ideally, a person should have just one care plan to cover all their needs, and that plan should be available to, and followed by, all those delivering their health and social care, including shared care. Assisting in the design of care plans is a key role for the Navigator.

Shared electronic health records

Good coordination and integration of care requires NHS England to promote the evolution of ‘fit for purpose’ shared health records, that include a care plan, the lead coordinator of care (usually named GP) and the Navigator.

Other conditions need to be in place to progress

These include: improved clinical and social care communications, improved handovers and negotiation of resources and contracts leadership.

Develop on current practice

The vast majority of general practices know who their most complex and vulnerable patients are and review them regularly (and use the repeat prescribing system to ensure regular review).

General practices have care plans for these patients that they and the patient follow, and coordinate care with all those involved. This process needs to be standard practice in all community and outpatient settings.
Problems to be addressed

Many patients, including those with complex needs, already understand who the main coordinator of their clinical care is and who to turn to for help in navigating the NHS to achieve the care that they require. Coordination is usually undertaken by their general practitioner and their general practice. However, there are challenges to coordinated, integrated care such as:

1. Care, for many people, is becoming more complicated. Patients with multimorbidity and complex needs are becoming more common and their care will continue to become more challenging over time. Further, there are those in vulnerable groups where care coordination is especially difficult due to how they access services and the multiple agencies involved. These groups include those with drugs and alcohol issues, the homeless, sexually exploited children and sex workers. In addition, care for vulnerable children and adults can be poorly coordinated if all agencies do not work together.

2. Care is delivered by multiple agencies, teams and individuals. The more agencies, teams and individuals involved in the care of a patient, the greater the scope is for confusion about who is leading their clinical coordination and who to turn to when processes fail. The most vulnerable time is when patients are in transition between services.

3. Poor communication. The absence of a single integrated patient record can, for example, result in duplication, delay, poor access to and availability of information, poor coordination of care and lack of communication between health and social care professionals. In the absence of a shared patient record, communication is degraded between the more formal and informal carers involved with a patient’s care, and the more complex their needs, the poorer that communication can become. In addition, a single patient might have multiple care plans, each developed independently of the other.

4. There is a constant stream of patients with Mortality and complex needs, rather than a constant pool. Mortality rates are particularly high within this group and so patients exit and enter the system more quickly. Those professionals delivering and coordinating their care, must recognise and respond to an ever changing group of patients.

While most patients expect their general practice to coordinate their care, there are circumstances in which the responsibility for coordinating a person’s care is devolved to other healthcare professionals, for example:

- During palliative and terminal care in a hospice
- People with cancers requiring consultant-led therapy managed as outpatients
- Patients on dialysis
- Those who are HIV positive
- Fit, pregnant women registered with a midwife for antenatal care
- Patients with significant mental health issues under intensive mental health team oversight.

There will be other examples, but any such variation from the standard GP-led model needs to be explicit, recorded, with patient approval and within a care plan in which involvement of the GP, as clinical generalist, is clear. This report sets out a vision for better coordination, with improved communication and a clear understanding of who is responsible for coordinating a patient’s care based on a single shared care plan.

We have recognised the following key issues:

- The principles of good care coordination
- Leadership in clinical coordination
- Implementation
- Next steps.
Principle 1:
Clinical coordination must be based on and reinforce underpinning values of good care

Values include continuity, choice, personal care, access to expert generalism, compassion and commitment. In particular, clinical coordination must be patient centred. Although clinical guidelines and care pathways appear to offer a standardised vision of ideal care, there are three complexities.

First, by the age of 65 half of all people have more than one chronic condition and therefore more than one guideline or pathway may apply. Second, one person’s needs and priorities may dictate a course of action that would not be chosen for another apparently similar person. Third, the person’s views may change over time.
Principle 2:
People with complex needs should have a care plan which includes the expected frequency of their reviews

Care plans are an essential tool for planning, coordinating and auditing a person’s care over time. A care plan should distil clinical and social care objectives, the agreed ways to achieve those objectives and advise on lifestyle and self care.

Care plans should include any shared care agreements. Planned review frequency should be agreed (including the maximum time between reviews), but will need to be flexible to changing circumstances.
Principle 3: 
Every person should know who to approach to coordinated, and how to resolve problems with, their care

For many patients, especially younger ones who do not have a long-term condition, healthcare needs are irregular and straightforward. They are satisfied with, episodic care when required and value access and speed of delivery over continuity. Although almost all are registered with a general practice, they may use A&E and urgent GP appointments for their care. This creates a risk that their long term needs for health promotion and disease prevention are not met. As a result public education campaigns, call and recall, combined with opportunistic interventions, will continue to be required.

At the other end of the spectrum are people with complex needs, multimorbidity or serious mental health problems. They need integrated, coordinated care which is personal and with a high level of continuity. This group of people is the focus of this report.

Of course, most people are at varying points on the spectrum and will move across it as their circumstances change. The issues addressed in this report will apply to them variably both in intensity and over time. So the key should be risk-based assessment linked to proportionality i.e. the use of coordinators, or navigators, must be justified by the patient’s best interests and must be an appropriate use of limited NHS resources. The assessment must not disempower those patients, their carers and their family members who are effectively coordinating many aspects of their care. For the navigation roles to be effective, each patient, and their carer/s, must know who their navigators are, how and when to access them, and what to expect from their support.
Principle 4: Accountability for coordination is primarily to the patient

All health and social care professionals are accountable to their professional and licensing bodies for any serious shortfall in their care for patients. In addition, Lead Clinical Coordinators will be accountable to the NHS for resource usage, to their colleagues for fair and equitable prioritisation and good communication and to their Responsible Officer for their personal development. General practice staff members are accountable to their employer, who is often the practice partnership.

However, any healthcare professional’s main accountability is to the patient and their carers. In allocating coordinators to a patient, that person and their carer must be involved in the choice (although choice within realistic available options) and should understand the nature of each role.
1. Leadership in clinical coordination

The vast majority of UK residents are registered with a general practice. In recent years the role of the general practitioner as the main clinical coordinator has been reinforced through:

- In recent years the role of the general practitioner as the main clinical coordinator has been reinforced through the development of Enhanced Services which ensure that the most vulnerable patients for unplanned hospital admission (2% of patients over the age of 18) have care coordination and care plans. The Enhanced Service contract payments are supplemented by local payments from some Clinical Commissioning Groups (and such extra payments are necessary to ensure the scheme’s viability).

- The requirement for all patients aged 75 and over to know the name of the GP taking responsibility for coordinating their care.

- All patients, by April 2016, will know the identity of their coordinating GP (Named Accountable GP).
Recommendations explained

These requirements provide the framework for clinical coordination. However, there are areas that may need building on over time.

First, the number of people who need explicit care coordination and care plans may be less than or not exceed 2%. It may be better to concentrate care coordination on fewer patients, with better outcomes, but any change needs to be based on evidence.

Second, it is not enough to ensure that the patient and their carers know who their named GP is. All those involved in caring for that patient, in community teams, social care, outreach and at outpatients must know who to look to to help them navigate the system.

Third, the available technology must support care planning, communication and information sharing.

It must be recognised that there are times when it is appropriate for another healthcare professional, other than the GP, to lead the clinical coordination of care (see examples above), including nurses and other allied healthcare professionals who are sufficiently skilled and supported. For example, for patients in the community with complex mental health conditions, the most appropriate Lead Clinical Coordinator may be a consultant psychiatrist, or for the frail elderly, a consultant community geriatrician could be most appropriate.

In addition to healthcare professionals and carers, local communities can play a key role in coordinating patients’ care. There are a number of localities with a wide range of community assets, which could be harnessed to support and deliver clinical coordinators. For example Dudley and Isle of Wight’s NHS Clinical Commissioning Group, both of which are part of NHS England’s Vanguard programme, 6 hundreds of voluntary organisations work in collaboration with the NHS to support people with long term conditions.

The Lead Clinical Coordinator role will involve overseeing all clinical decisions and interventions experienced by a patient. This will ensure that decisions overall are in the best interests of the patient’s health and well being, and that opportunities are taken to maximise the future health and well being of the patient.

The Lead Clinical Coordinator will ensure that:

- All those involved in delivering a patient’s care fully understand their role
- The patient’s needs and priorities are central, both at the time and proactively for the future
- Through information, education (health promotion and opportunity for health gain) and support, patients and their carers are empowered to take more responsibility for healthcare decisions that affect them, and to practise self care
- Higher risk patients with complex needs or multimorbidity are identified as requiring a Lead Clinical Coordinator
- Care planning is used so that there is shared clarity around decision making
- The patient is protected from ineffectual or potentially harmful interventions (e.g. poly-pharmacy), unnecessary duplication (e.g. investigations) and unneeded consultations
- Regular communication, including the rationale for decisions made, between all health and social care professionals, the patient, their carers and their key family members takes place
- Opportunities are offered to review the person’s progress against their evolving needs and priorities.
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Recommendations explained

Importantly the Lead Clinical Coordinator role should be the most appropriate healthcare professional explicitly matched to a specific person with complex needs or multimorbidity. This could, for example, be a nurse, a social worker or an alcohol worker. Patient choice may also influence this decision, temporarily or permanently, so any handovers are essential for all concerned.

While the Lead Clinical Coordinator is an accepted part of a general practitioner’s role, the implementation of the fourth year of vocational training for general practice will provide an opportunity to ensure that these skills are maximised. Along with the Navigator role this is consistent with the direction of travel of NHS England’s models of care, Multispecialty Community Provider or Integrated Hospital and Primary Care Provider, and the ambitions of many of the Vanguard pilots. The role is also consistent with the RCGP’s Inquiry into Patient Centred Care and the Willis Shape of Caring Review.

2 Appointed navigators need to be in place

A Navigator oversees a patient’s care pathway, ensuring that it is, as far as possible, efficiently integrated. This maximises convenience to the patient and the use of their and the health service’s resources.

Navigators already exist in some general practices but in others they are called (or are subsumed under) Care Coordinators or Self Care Facilitators. We believe that the role of Navigator is a necessary part of effective coordination of care.

The Navigator will recognise that:

- Advocacy for the person and their carers, based on clear communication and fair priority, is necessary to ensure efficient and effective care
- The person’s needs and priorities are central, but can only be met in the context of the availability and provision of health services and the mandated access targets

- The process of care needs to be coordinated in the best interests of the person, within the context of the availability and provision of health services
- Information, education and support can empower people and their carers to take more responsibility for the processes of healthcare delivery.

The key elements of the Navigator Role are:

- Ensuring that a care plan begins with the person’s needs and priorities and reflects the healthcare professionals commitments to meet those needs
- Overseeing the multiplicity of interventions offered to a person, to ensure that duplication and repetition is minimised, through regular contact (face-to-face, on the telephone or by email as appropriate) with the most vulnerable, and that appropriate services, including the third sector, are accessed
- Offering support in self care and concordance, helping disengaged people to recognise the benefits of engagement
- Giving lifestyle advice and support to help people lead healthier lives, including in groups when appropriate
- Advocating for people with complex needs within the health and social care system
- Liaising, on the person’s behalf, with healthcare professionals in many settings, social care workers, community nurses and matrons, and all others involved in an individual’s care
- Involving healthcare professionals, such as the GP or practice nurse, when care needs are not being met or have changed.

If the case for such a role were accepted, then the basic qualifications, training, person specification, terms and conditions and ideal numbers per 10,000 population will need to be agreed.
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Recommendations explained

3 High quality Care Plans

Effective care plans must be based on patient expectation (the ‘I’ statement) with healthcare professional’s input, to design a plan that is consistent with the best evidence and local resources to meet that expectation.

Plans should include the amount of contact a patient should have with their general practice. Ideally, a person should have just one care plan to cover all their needs, and that plan should be available to, and followed by, all those delivering their health and social care, including shared care. Assisting in the design of care plans is a key role for the Navigator.

4 Shared Electronic Health Records

Good coordination and integration of care requires NHS England to promote the evolution of ‘fit for purpose’ shared health records with the ability to:

- Record the Lead Clinical Coordinator, the Navigator and other professionals involved, at the front of the GP computer record, which will be shared across healthcare organisations
- Record an electronic care plan which is shared with all relevant healthcare professionals and which can be updated to reflect changes in circumstances
- Transmit the above information in any referral process
- Correspond in a way that reflects roles and identities. In particular, letters from hospitals should be explicitly addressed to the patient’s Lead Clinical Coordinator as well as the referrer (if different). 12

In time, effective clinical coordination requires:

- A single shared common clinical record that identifies, as a minimum, all clinical and or social carers involved in that person’s care. In particular the Lead Clinical Coordinator and those supporting clinical care – including the Navigator. It should also identify the care plan being followed and current and recent interventions.

5 Developing current practice

The vast majority of general practices know who their most complex and vulnerable patients are and review them regularly (and use the repeat prescribing system to ensure regular review). General practices have care plans for these patients that they and the patient follow, and coordinate care with all those involved. When necessary, for example during end of life care, review may occur daily. For others with multiple but stable illnesses, review may be annually or twice yearly, all intervals will involve clinical judgement and patient agreement. Agreeing a regular review plan with a patient, which is appropriate to their needs should be standard practice.

There are, however, issues that have been identified:

- Not all practices and GPs can work to this standard, due to workload pressures and recruitment problems
- Care plans are sometimes implicit rather than explicit but should reflect informal care
- The wider the team involved in an individual person’s care, the less likely there is to be effective care coordination due to poor inter-agency communication. The Lead Clinical Coordinator should help address this
- The current record structures do not facilitate good practice because information is not shared sufficiently.

Provided electronic health records and care plans are available 24 hours, seven days a week, they can be effective in ensuring integrated care in all clinical and care encounters. Decisions taken urgently, in acute care settings and out of hours, can be communicated back to the person’s General Practitioner or other Lead Clinical Coordinator.
6 Other conditions to be in place in order to progress

Although there are many examples of good clinical coordination and care coordination in outpatient, community and primary care settings, there are some clear constraints that need to be addressed before coordination can be effectively implemented throughout the NHS, which is recognised by the Five Year Forward View.

Those include:

1. Communication. In addition to a shared record, all key health or social care professionals have a responsibility to communicate regularly and effectively with each other, and especially with the Lead Clinical Coordinator.

2. Improved handovers. People should not need to be concerned when they cross healthcare boundaries or interfaces. However, this ambition requires that handovers are seamless and effective so that care doesn’t fall down at these points of vulnerability.\(^{13}\)

3. Resources and contract. The implications of increased coordination need to be taken into account in resource allocation and contracting. Current efforts to support and rebuild the primary care workforce should help with this.

4. Cultural alignment. The necessity and potential benefits need to be presented coherently to all health and social care professionals and their teams. Only if there is strong political and managerial leadership will the influencing and advocacy roles of the coordinators be realised.
Effective implementation of care coordination requires:

1. Leadership in Clinical Coordination
2. Appointed navigators need to be in place
3. High quality Care Plans
4. Shared electronic health records
5. Developing current practice
6. Other conditions to be in place to ensure progress.
Any roll out of our recommendations should only occur when the above conditions are met. Interventions must be proportionate and focused on those patients with the greatest need. Roll out must avoid being another ‘tick box’ exercise by concentrating coordination on those who will genuinely benefit, with the resources to deliver.

Success will only occur through evidence that it is a facet of good practice which increases patient safety, improves quality of care, empowers patients and their carers, reduces inefficiencies and facilitates professional and patient satisfaction.

When the time is right for roll out it should be undertaken through pilot schemes that are properly evaluated. The evaluation should continue beyond the early adopters so that the benefits and costs can be assessed when ordinary health communities sign up. The roll out should be undertaken with the Coalition for Collaborative Care.

The resource implication for general practitioners and their practices need to be carefully evaluated and in particular it will be essential to:

- Avoid sudden and fast implementation that becomes a bureaucratic exercise
- Concentrate on building on current implicit arrangements to make them explicit which will help patients use their NHS more effectively and avoid workload stress among healthcare practitioners.

Once roll out is agreed, there are a number of ways in which it could be monitored. This will require professional discussion, but might include:

- Numbers/percent of patients identified by each GP and each practice as having multimorbidities and/or complex needs, with feedback by the Clinical Commissioning Group identifying practices by, say, quintiles; but being used formatively to develop appropriate care in each practice community
- Number/percent of those identified as having multimorbidities and/or complex needs who have a recorded GP or other clinical coordinator, and a recorded care plan
- Awareness among those with multimorbidities and/or complex needs, measured through the GP Patient Survey, of how and from who to access clinical and care coordination.
References

2. There are exceptions such as those in prison, in care or in residential nursing homes, the homeless and migrants. They look to other sources of coordination.
7. This role description builds on the role in the DES and needs professional agreement
12. This is consistent with the Professional Records Standards Body’s (PRSB) minimum handover data
13. For example the PRSB’s electronic handover guidance: Guidance for Clinical Safety Officers on Implementing safer handovers for health IT systems; DH, 2012