PERSONALISED CARE IN PRACTICE
COMPREHENSIVE CARE COORDINATOR TRAINING PROGRAMME

A Personalised Care Institute (PCI) accredited training programme for Care Coordinators working in GP practices delivering Personalised Care. The training programme is also suitable for Social Prescribing Link Workers and Health and Wellbeing Coaches.

The Comprehensive Care Coordinator training programme connects the values, behaviours and capabilities required for Personalised Care with the requirements of PCNs (Primary Care Networks) - providing a thorough, connected, contextualised training programme and a solid foundation on which to build.

The Personalised Care in Practice – Comprehensive Care Coordinator training programme:

- ✓ is accredited by the Personalised Care Institute (PCI)
- ✓ is currently delivered online via Microsoft Teams with potential to be delivered face to face or via group sessions in-house depending upon demand
- ✓ is suitable for prospective or existing Care Coordinators, Social Prescribing Link Workers and Health and Wellbeing Coaches
- ✓ consists of seven modules delivered across three days plus a half day follow up action learning set/peer review session
- ✓ where, due to PCN/practice demands/commitments participants are unable to commit to 3 consecutive days of training, the programme can be undertaken flexibly across over an extended time period dependent upon module availability
- ✓ is tailored to the requirements of the Practices and Primary Care Network/s
- ✓ is inclusive of ongoing access to Pathways CIC Care Coordinator peer support network- a forum for ongoing support, learning and sharing of best practice
- ✓ has been developed with direct experience of recruiting, hosting and training people within ARRS (Additional Roles Reimbursement Scheme) posts
- ✓ has been developed in collaboration with subject matter experts, a peer review group of service users with respect to what matters to them and Pathways staff currently delivering personalised care
- ✓ is overseen by a GP Lead
- ✓ is continuously improved following participants' feedback
- ✓ results in 21 CPD hours and a completion certificate upon successful completion.

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CPD HOURS

The Personalised Care in Practice – Comprehensive Care Coordinator Training Programme comprises 7 modules plus a half-day follow-up action learning set/peer learning session tailored to participant/group needs held approximately a month after completion of the training programme.

Module 1	**INTRODUCTION TO PERSONALISED CARE**	This module provides an introduction to Personalised Care
Module 2	**ROLE OF THE CARE COORDINATOR/SOCIAL PRESCRIBER, HEALTH AND WELLBEING COACH AND CONTEXT**	This module provides an introduction to the roles of the Care Coordinator, Social Prescribing Link Worker and Health and Wellbeing Coach and how they work together within practice
Module 3	**PATIENT ENGAGEMENT**	This module provides an introduction to patient engagement and an overview of themes, models, approaches and guidance to engage, support and enable patients in a safe and effective way and environment. This module reflects upon the health needs of local communities and the diversity of patients within practice and how engagement and support can be adapted to meet those varying needs.
Module 4	**COMMUNICATION**	This module explores communication skills and styles and how to build trusted relationships whilst managing patient expectations and working within boundaries.
Module 5	**HEALTH AWARENESS**	This module provides an introduction to community health needs/ locality understanding. It reflects upon health inequalities, the social determinants of health and the benefits of promoting self-efficacy through the instigation of behaviour change via the delivery of brief interventions.
Module 6	**MANAGEMENT - referrals and caseload**	This module provides an introduction to referral generation and managing a caseload of patients including organisation skills/prioritisation.
Module 7	**PROGRAMME REVIEW**	This module reviews the competencies of the participants roles and their alignment with the core capabilities, models/approaches and components of Personalised Care. It explores participants expectations of their role within the practice and potential barriers to delivering personalised care. Opportunities for continued professional development and where to seek support when needed will be explored.
Follow up module	**ACTION LEARNING SET/PEER REVIEW SESSION**	This module is an Action Learning Set/peer review session to take place approximately a month following completion of the Comprehensive Care Coordinator Training programme The Action Learning Set is specifically tailored to Personalised Care Support plans and the application of Personalised Care knowledge and understanding within practice. The peer review session will provide an opportunity to explore and address personalised care challenges/barriers that participants have experienced in the workplace.

WHAT IS A CARE COORDINATOR?

The role of the Care Coordinator is an exciting new role that has been created, along with other roles, such as the Social Prescription Link Worker and Health and Wellbeing Coach, to provide additional or enhanced services within General Practice. These additional roles, or enhanced service, form part of a long-term package of general practice reform which was set out in the NHS long term plan. The role of a Care Coordinator is fully embedded within PCN (Primary Care Networks) core network practices and they play an important part at the MDT (multi-disciplinary team) meetings.

Care Coordinators provide extra time, capacity and expertise to support patients in preparing for or in following up clinical conversations they have with primary care professionals. They will work closely with the GPs and other primary care professionals within the PCN to identify and manage a caseload of identified patients, making sure that appropriate support is made available to them and their carers and ensuring that their changing needs are addressed. They focus on delivery of the Comprehensive Model for Personalised Care to reflect local priorities, health inequalities or population health management risk stratification (NHS HEALTH England – Care Coordinator).

Pathways CIC is a forward thinking, innovative Social Enterprise operating across the North West of England.

We deliver a range of pioneering health, work and wellbeing programmes designed to create sustainable change for individuals and for local communities, with a focus on enabling people to live happier and healthier lives. We have been listed as one of the top 100 Social Enterprises in the UK (NatWestSE100), hold GOLD accreditation from Investors in People (IIP) and are identified as one of the top 10% of IIP employers, gaining the IiP Small Businesses of the Year 2020 Award.

Pathways CIC has direct experience of recruiting, training and hosting staff under the NHS Additional Role Reimbursement scheme (ARRS). This experience has informed the development of the Personalised Care in Practice – Comprehensive Care Coordinator training programme.

As an ISO 9001 accredited organisation Pathways CIC seeks to continuously improve and feedback relating to each training module will be sought from participants to facilitate the continuous improvement of the training programme.

Regular reviews will be undertaken to review the impact and effectiveness of training provided.

Thank you for your interest in our training programme.
To reserve a place please click on the Eventbrite link.
If you'd like further information please contact:

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