Partnership for Change

CONNECTED CARE

Transforming Care Coordination

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CONTENTS

FOREWORD

The NHS is perceived by the public as one of our greatest national resources.[1] Yet, satisfaction with this great institution has never been lower.[2] As charities representing patients from across the health sector, we hear the frustration of patients who don't get the quality of care that they deserve. Often, these frustrations are borne out of poorly coordinated care, with patients frequently needing to retell their stories, chase up referrals, and advocate for themselves in a convoluted care system.[3 4 5 6]

Partnership for Change

10 Patient Groups since 2023

The Partnership for Change began in July 2023. It is a collaboration between ten patient groups brought together by Pfizer. Pfizer works closely with health charities across a wide range of health conditions and sought to convene these organisations to understand some of the common challenges facing patients across the UK health systems. Pfizer has funded the group to foster a shared voice to address these challenges.

Our partnership gives us a broad overview of the collective challenges faced by different patient communities, and the change in government presents an opportunity to reflect collectively on what those challenges are and how we, as a society, can meet those challenges.

It is vital that, during this period of change, we put patient experience at the heart of reform. Across all of our patient populations, we are all too familiar with the frustration that patients feel in their interactions with the health system.

But, while there are unquestionably deep, entrenched challenges that the NHS faces,[7] there is also so much good work that goes on across the health system. Taking practical steps towards lasting improvement must involve identifying what is already out there that works, identifying the common themes that drive their success, and scaling these initiatives in a way that is sensitive to changing local needs and contexts.

Reform is needed to prioritise patient experience through care coordination.

We need a serious programme of reform that prioritises patient experience through care coordination; we need an NHS that encourages collaboration to develop, thrive, and grow, delivering the best experience for patients. The Prime Minister rightly acknowledged that new money for the NHS will not have the desired impact without reform.[8] Patient experience and care coordination must be central to any prescription for better care.

This first report from our partnership presents our **call to action** on one of the fundamental challenges underlying all of our patients' experience of healthcare:

POOR CARE COORDINATION

The organisations involved in the **Partnership for Change** are:

Blood cancer UK

age UK

Kidney Care UK

Meningitis now

alopecia uk

fight bladder CANCER

GENETIC ALLIANCE UK

Pfizer

the patients association

the migraine trust

SICKLE CELL SOCIETY

EXECUTIVE SUMMARY

Why care coordination?

The new NHS 10 Year Health Plan offers an essential chance to improve healthcare by addressing persistent issues affecting patient experiences. With satisfaction with the NHS at an all-time low,[2] it is time to address the root causes of these poor experiences. We argue that a focus on care coordination is vital for realising the three 'big shifts' envisaged in the NHS 10 Year Health Plan, and must be embedded into reforms, so that the plan delivers a health service that offers seamless, holistic patient care.

As a group of charities representing various health conditions, our beneficiaries regularly experience poor care coordination, undermining their trust and confidence in the health system. Patients often struggle to navigate a fragmented system, leading to worse outcomes and additional strain on the system. Despite initiatives to improve care integration,[9] patient experiences show that more work is needed. Identifying and scaling best practices system-wide is essential to achieve seamless patient care.

What is care coordination?

Care coordination involves healthcare efforts to enhance patient care through collaboration within and across services, ensuring a cohesive, efficient experience.

In this report, care coordination means that patients receive straightforward, seamless care from all healthcare services and professionals they encounter. To a patient, the health service should feel as though it functions, as far as possible, as a single entity.

Importance of care coordination

Improved care coordination is vital for patient experience and system efficiency. The NHS's current fragmentation affects patient access and pathways, leading to negative outcomes[10,11] and increased readmission.

Effective care coordination enhances patient experiences and reduces unnecessary hospital visits, saving time and resources. Good care coordination would also benefit carers and families, easing health inequalities.

Current state

Care coordination has been a political priority, with initiatives like the 2014 Five Year Forward View[12] and development of Integrated Care Systems (ICSs).[13] However, financial constraints, staff reductions, and accountability systems that predate ICSs have prevented integration from reaching its full potential.[13] A lack of patient experience data examining how well services are working together also hampers improvement efforts.[14]

Local examples of successful care coordination exist,[15] but scaling these initiatives while tailoring them to local needs is crucial.

Key elements of effective care coordination

1. **Good communication:** Timely, accurate communication between healthcare professionals and patients, with clear roles and responsibilities.
2. **Valuing patient experience:** Prioritising patient experience alongside clinical effectiveness and safety, engaging with qualitative data, and involving patients in care planning.
3. **Measurement:** Systematic collection, organisation, and use of patient experience data, with accountability and commissioning based on these outcomes.
4. **Culture of collaboration:** Shifting from siloed working to a culture of collaboration, fostering trust, safety, and a shared purpose.
5. **Digital facilitation:** Using digital tools like the NHS app to enhance coordination while maintaining strong interpersonal relationships.
6. **Focus on transitions:** Using care coordinators to ensure smooth transitions between all transition points, such as between primary and secondary care and between child, adolescent and adult care, particularly for complex conditions.
7. **Involving the voluntary and community sector (VCS):** Ensuring VCS involvement in decision-making and signposting, given their crucial role in filling service gaps.

Recommendations

Care coordination is a vital enabler that lies at that heart of all three of the 10 Year Health Plan's 'big shifts' in care. As the government plans for a new NHS 10 Year Health Plan, following Lord Darzi's review, the government should:

- **Elevate patient experience to equal importance with clinical excellence**
- **Improve communication between healthcare professionals and patients**
- **Develop a framework for acting on existing patient experience data**
- **Promote a culture of collaboration and coordination through existing networks, using a proactive behaviour/culture change approach**
- **Identify and scale successful local care coordination initiatives**
- **Use the NHS app for care coordination, respecting non-digital preferences**
- **Include the VCS in relevant policy discussions**

We contend that prioritising care coordination can enhance patient experiences, improve system efficiency, and ensure better health outcomes for all. In this report we have outlined why improved care coordination is the prescription for better care that the NHS, and the patients it serves, needs.

WHY CARE COORDINATION?

Poor care coordination is an endemic issue; it affects all of the patient communities represented by the authors of this report. The new NHS 10 Year Health Plan and reorganisation of NHS policymaking following the abolition of NHS England (NHSE) presents an opportunity to take stock of how we deliver healthcare. This is a chance for ambitious thinking; a chance to unpick the persistent issues that compromise patients' experience of their healthcare, and to put that patient experience at the heart of how we run our healthcare services.

We are encouraged that the government has recognised this opportunity and taken on Lord Darzi's independent investigation into the performance of the NHS to inform a new NHS 10 Year Health Plan.[16] This drive for reform comes at a time when satisfaction with the NHS is at a record low;[2] serious change is needed to improve patient care and win back the public's trust.

As a group of charities covering a range of health conditions, we are in a strong position to see the common challenges that affect all of our patient communities. Across all our engagement with those communities, the range of challenges that our patients face commonly stem from one underlying issue – poor coordination of care.

This lack of care coordination means that our patients have to be their own advocates, and attempt to navigate a complex, disjointed care system for themselves.[3] [4] [5] [6] The harder it is to navigate this system, the more likely it is that patients won't get the right outcomes, deepening health inequalities.[17]

Poorly coordinated care also creates failure demand – additional stresses on the system that arise from not getting it right first time. If we are to run an efficient, effective national health service that makes the best use of our stretched resources, we need to ensure that care is coordinated.

The issue of poorly coordinated care is not new. There have been multiple initiatives[18] to break down silos, improve collaboration across the system, to integrate care, and ultimately to improve care coordination. Yet, the patient experience we hear tells us that there is more work to do. Now is the time to take a critical look at these initiatives, to understand what is working and what isn't, and to ensure the best practice that does exist becomes the basis for common practice, across the whole system. We want everyone to be able to access care easily, across their entire patient journey, minimising the need for patients to self-advocate to achieve this goal.

What do we mean by care coordination?

Care coordination is a healthcare institution-led initiative for improved and efficient coordination of patient care between different domains of care, aimed at improved patient experience and system efficiencies. From the patient perspective, well-coordinated care should feel like moving through a single institution, rather than being moved between silos.

Care coordination involves numerous participants across a care pathway, requires them to have an understanding of each other's roles and resources, and aims to facilitate seamless delivery for the patient across this pathway.[19] Coordination of care between different healthcare institutions is perhaps the most obvious domain of coordination, but care must also be coordinated across each individual organisation, for example through accurate handovers, follow-ups, and information sharing between coworkers.[20]

In this report, care coordination means that patients receive straightforward, seamless care from all healthcare services and professionals they encounter. To a patient, the health service functions as a single entity.

WHY IS CARE COORDINATION IMPORTANT?

Delivering a seamless patient experience

The urgent need for improved care coordination is evident across three themes: patient experience, system outcomes and efficiencies, and wider societal impacts.

Looking first to patient experience; the NHS has become increasingly fragmented, specialised, and complex through a series of restructuring projects, resulting in a system that requires careful navigation.[21] The fragmentation between service commissioning, guidelines and delivery has a significant impact on patients' access across their pathway. A quote from the Royal College of Physicians Patient and Carer Network exemplifies this effect "it feels as though commissioners look at people as if they are made up of a number of parts that can be isolated, repaired, put back and the case is complete".[21]

Patient experience data shows the impact of fragmented care: patients routinely cite the importance of "coordination (within, across and with wider community resources), continuity, information sharing and engagement"[22] as essential in their experience of care. The English Cancer Patient Experience Survey shows that coordination and administration of care is the strongest predictor of patient satisfaction with cancer care, for example.[23] Foregrounding the patient voice within healthcare is essential, as it provides an essential holistic perspective of care, spanning different services, departments, and Trusts, to illustrate the complexities and urgency of care coordination.

Patient experience data also highlight the heightened impact for those with multiple chronic conditions and complex care needs,[22] reflecting their increased exposure to healthcare systems and movement between services. Challenging transitions between services can cause stress and disruption of care for patients with long-term conditions and disabilities.[24] Many patients with long-term conditions also have mental health conditions, yet many patients report that management of mental health is not routinely offered as part of their care.

The 2021 APPG on Sickle Cell and Thalassaemia report 'No One's Listening' found that patients were being "let down by a lack of coordinated NHS care".[25] The report found that sickle cell patients had such negative experiences with healthcare systems that they would choose to miss appointments and avoid care, [25] a case of failure demand. A second report on sickle cell patients' experiences also cites the "persistent lack of communication and collaboration across healthcare professionals in hospitals and across different settings" reflecting care coordination breakdown, and how the situation transfers the burden of navigating the complex "yo-yo" system to the patient.[26]

Consequences of lack of care coordination

These issues with care coordination lead to negative outcomes for patients, healthcare systems, and wider society.

The healthcare system's care coordination issues of "poor professional and organisational alignment, lack of funding incentives for collaboration, and a continued top-down approach to management"[22] produce efficiency issues and measurable negative outcomes.[27] When coordinated care works well, there are not only improved patient experience and satisfaction outcomes, but also concrete system improvements. Matthew Taylor of the NHS Confederation has outlined, "care coordination avoids unnecessary visits to A&E and stays in hospital while ultimately saving time, addressing demand and improving flow".[28]

The concept of failure demand – additional stresses on the system that arise from not getting it right first time – is one of the many potential consequences of ineffective and uncoordinated care, and highlights the importance of getting it right first time.[29]

Poor coordination of care entrenches health inequalities, with a specific burden on carers,[30] as well as families and other healthcare professionals,[31] for example.

Looking at patients with rare diseases, specifically, one study highlighted the varied impacts of poorly coordinated care on families' and patients' physical health (including fatigue), financial loss (including loss of earnings and travel costs), and psychosocial impact (including disruption to school, work and emotional burden).[27] This demonstrates the knock-on consequences of badly coordinated care, and the spread from the initial negative patient experience to families and carers, and wider society.

There is a unique impact on carers, with the consequences of badly coordinated care pushing the burden of arranging care onto unpaid caregivers. The system's "paucity of care coordination models"[30] means that carers volunteer at a personal cost to themselves to provide coordination as a proxy to effective and reliable system care coordination.

CASE STUDY: Meningitis Now

In 2023, Meningitis Now surveyed people who'd had meningitis over the last five years.[3] They found that poor continuity of care was a consistent theme that emerged from the survey. Like many conditions, people with meningitis have multiple needs following their illness, requiring them to be seen by a variety of different services. The condition does not end at discharge from hospital after the acute period of illness has finished, and patients have ongoing needs that have to be met. Responses to the survey revealed issues with missing referrals, poor communication between departments, and an overall poor continuity of care following discharge from hospital.

One respondent to the survey said "I was referred for a hearing test and they didn't even know why."

Reflecting on their experience of a lack of continuity of care, another recommended to, "make it mandatory for meningitis patients to be discharged with a care plan (without the onus on the patient to self-serve/have to entirely educate themselves about what care they need, or have to try and book appointments and chase waiting lists themselves)."

People with meningitis need to have their holistic health needs met, both while they are in hospital and following discharge.

CASE STUDY: Alopecia UK

Testimonial from Sue Schilling, CEO of Alopecia UK:[4] "Every day we hear stories of people not getting a referral, or access to treatment, or those who are signed off from the secondary care without any care at all.

Alopecia can have a devastating psychosocial impact, where shame at looking so different can affect every social interaction, resulting in high levels of absenteeism from work, education and avoidance of socialising. For some people with alopecia, this can lead to isolation, reinforce mental health challenges, diminish life outcomes, and even lead to suicidal ideation.

Proper coordination between healthcare providers, mental health professionals, dermatologists, and wig suppliers would offer a more compassionate and supportive healthcare journey. It takes enormous internal resources to keep on fighting for support when you are most in need, and many people give up, they tell us it is too hard to navigate the "system".

That is why coordinated care matters, imagine if measures were aligned to patient voice. Perhaps this would lead to everyone having a better chance of accessing the care they need in a format that worked for them. I think that raising the importance of patient-led measures would help and ICB better plan and address some health inequalities in their local communities."

WHERE ARE WE NOW?

Care coordination is certainly not a new topic. The pressing need to help patients – especially those with long-term, complex conditions – to navigate the health system has led to care coordination being, at times, a political priority.[18]

The drive to coordinate care was accelerated in the 2014 Five Year Forward View, which aimed to dissolve the “traditional boundaries” between primary care, community services, and hospitals by shaping integrated systems of care around the patient.[12]

These concepts coalesced into the formation of Integrated Care Systems, which began to arrive in 2017 and were made statutory in the 2022 Health and Care Act.[32] However, as The King’s Fund has noted, these new care systems were “born into a storm”,[33] and have struggled to deliver on their central aim of integrating and coordinating care. As a result of the challenging financial environment that ICSs were born into, shortly after their creation, ICSs were required to reduce their running costs by 30%, leading to significant staff redundancies.[13] This level of uncertainty is clearly not conducive to a culture of excellence that prioritises patient experience.

The lack of dedicated resource means that ICSs have had to pursue better patient experience based on goodwill and their own initiative.[34] Taken in conjunction with the different starting points of each ICS, it is easy to see how rates of integration, focus on patient experience, and culture change are varied across the country, with a consequent impact on health inequalities.

These external challenges mean that ICSs are at risk of not delivering on their core purpose. While ICSs have precipitated some progress, and there are promising signs of a shift towards better system-focused behaviours and a clearer sense of shared purpose,[13] the patient experience of care is still not one of seamless coordination.

One problem is a lack of service user data on the success of coordination. Measurement and accountability of the system has not kept up with the way care is structured - too often, patient experience data focuses on individual services, not the way that they work together, or on a patient's experience across a whole care pathway.[35]

Despite the system-wide remit of ICSs, many can still find that the current incentive structure still prioritises NHS goals over the wider system goals.[13] Partly, this is due to representation of powerful actors such as acute trusts within ICSs, and partly to the fact that NHS bodies are accountable to the Department of Health and Social Care (DHSC) and the Care Quality Commission (CQC) only on the performance of the NHS. This reinforces old habits of behaviour and incentivises siloed thinking. Accountability needs to catch up with the integrated approach for the delivery of care, with more incentives to prioritise good, collaborative system working.

While it is true that ICSs have not yet reached their potential for facilitating care coordination, it is important to acknowledge that they are relatively new project, and their potential has been depressed by the economic circumstances they were born into. The new government has an opportunity to reinvigorate the care coordination discussion at ICS level, and deliver a truly seamless experience for patients, in partnership with local systems.

WHAT DOES GOOD LOOK LIKE?

While the overall picture is one of poorly coordinated care, there are examples of places where good work is happening. We need to grow and scale these initiatives where possible, but it is also important to understand that healthcare is local; these initiatives are designed to meet a unique local need. Coordination and collaboration have often grown from immediate necessity,[36] creating a patchwork of localised best practice that has arisen from local imperatives. We must therefore identify the common themes that have allowed examples of local best practice to succeed, so that we can apply these models in other local areas without inappropriately transposing individual programmes.

Good communication

Good communication is central to effective care coordination; it is the thread that ties together care coordination.[37] Accurate, easy-to-understand, timely communication is critical at every point in a patient's journey, both between healthcare professionals and between them and their patients. Communication can involve setting up appointments, sharing test results, onward referrals, seeking advice, and the whole range of healthcare activities.

Between healthcare professionals and patients, communication needs to be timely and easy to understand. It is important to avoid (or explain) complicated medical terms, and to be aware of patient's language preferences and level of understanding, with translations available where possible.

Between healthcare professionals, good communication is facilitated by an understanding of others' roles and responsibilities, where overall responsibility lies, as well as accurate and timely information sharing.

Valuing patient experience

Patient experience should be at the heart of care delivery. Good care is patient-centred and responsive to their needs. Much emphasis is currently placed on patient safety and clinical effectiveness as the primary dimensions of good care, but patient experience should be considered equally important.[34] Too often, patient experience is seen as the preserve of the nursing function, with not enough thought given to patients' experience of the system as a whole, and without enough buy-in from doctors and system leaders.[34]

A service that prioritises and learns from patient experience would prioritise better care coordination by design. Coordination is one of the key drivers of patient experience for all patients, but especially for those with complex or long-term conditions.

Cocreation is therefore an essential part of coordinating care. Understanding patients' needs, as expressed by the patients themselves, will lead to the greatest improvement.

Measurement

The maxim "what gets measured gets done" perhaps explains why coordination and patient experience are generally neglected, despite a widespread recognition that both are important.

Both patient safety and clinical effectiveness benefit from being indicators of quality care by virtue of being measured, and then by being backed by featuring in accountability for services.[34,38] By contrast, while patient experience feedback is easy to come by – and routinely collected in the form of feedback – it is not routinely organised, and where it is, it is rarely disseminated across the system and acted upon.[39] One challenge here is a preference for quantitative data, and a cultural belief that it is more "robust".[34] Patient experience requires engaging with qualitative complexity and listening to individual voices. Another challenge is that the department that analyses patient feedback is often different from the departments that lead quality improvement.[39]

However, despite the complexity, good examples of collaboration can generate measurable results, and it is important to seek these out.[36] In its examination of coordination of older people's care, the CQC acknowledges that, where coordination was lacking, monitoring and evaluation was often not carried out.[15]

Patient experience should feature in accountability measures, and commissioning should be based on patient experience outcomes rather than primarily focusing on activities provided.[38]

Ultimately, reform of the NHS should ensure that:

- Patient experience data is routinely collected and organised
- The data captures patients' experiences across their whole care pathway, including how care is coordinated between different services
- Data we already have is disseminated to key decision makers
- Patient experience data is used by DHSC and the CQC when evaluating the effectiveness and performance of health services
- Decision making is based on patient experience data – the data collected leads to introspection and tangible changes

A culture of collaboration

One of the most challenging barriers to good collaboration is shifting from an entrenched, self-perpetuating culture of specialisation and siloed working, with no individual responsibility to coordinate care, to one that prioritises collaboration. The new integrated models of care require organisations to exhibit high levels of trust, and work together as though they are long-established partners, which is often not the case.[36] In order to grow trust and collaboration, it is important to foster a culture of “psychological safety” [40] within and between organisations to allow connections to flourish. It is also important to create a clear shared purpose with patient experience and care coordination at its heart.[13]

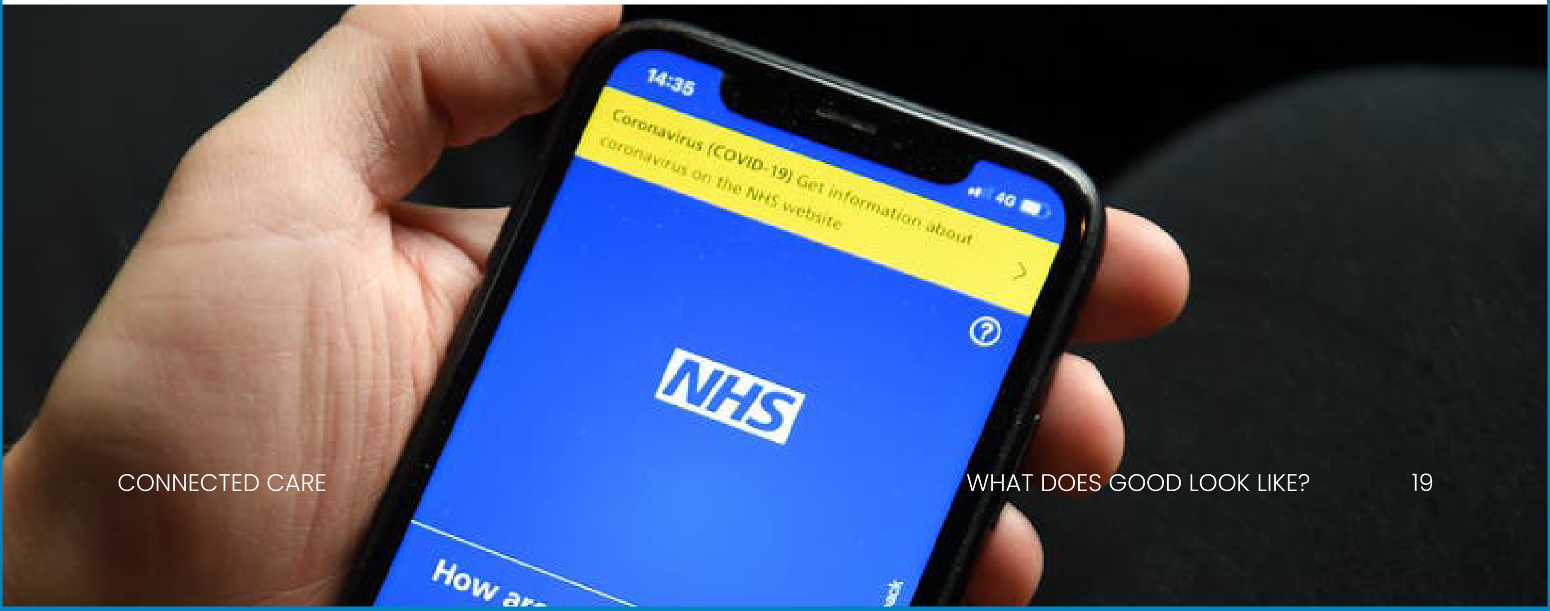
We also need to see culture change emerging from the bottom-up. Top down culture change is essential in terms of setting expectations, accountability and incentive structures, but collaboration emerges most effectively in response to local challenges. System leaders must be alive to the opportunities presented at a local level, to encourage and scale success.

The government needs to approach coordination from a behaviour and culture change perspective, ensuring that all staff have the capability, opportunity, and motivation[41] to effect change.

The role of digital

Digital can be an important accelerator of change, but the human side of collaboration needs to come first.[36] Ultimately, good coordination originates from strong personal and organisational relationships, with clear roles and responsibilities in place. Once these are in place, and as culture change starts to embed, digital systems can act as a facilitator to tighter collaboration.

The NHS app holds promise as a central hub for patient/healthcare professional communication. Patients can experience particular frustration accessing aftercare and remaining engaged following an appointment.[3] The app could provide a way to track and manage personalised care plans, and to see upcoming appointments across the NHS. It is important, however, that digital means of patient communication are always optional, to avoid excluding patients who are less comfortable with digital communication.



A focus on transitions

Across our charities, we have heard examples of patients struggling with transitions between primary and secondary care.[4,6] Each delay is more time spent in ill health, waiting for treatment. Each delay erodes trust in the wider system and increases the risks of not engaging in the future, or taking a less efficient route to care, for example presenting at A&E. These transition points should be a major priority for the new government. There is a lot of potential in assigning a named care coordinator to people with long-term and complex conditions. Care coordinators act as a first point of contact and coordinate care by ensuring that referrals are made and actioned, engaging local community health and voluntary sector services, and ensuring continuity of care.[42]

NICE's evaluation of the care coordinator role demonstrates that the role can help build relationships across the health landscape, and deliver a more attentive, holistic model of care.[42] Primary care networks are already seeing the value of the care coordinator role and have hired more care coordinators through the Additional Roles Reimbursement Scheme (ARRS) than any other role.

Involving the voluntary and community sector (VCS)

NHS budgets have been constrained for some time now, and the VCS has, by necessity, expanded to fill the gaps left by statutory services.[43] Given that a large influx of new money into the NHS is unlikely, the VCS is increasingly an essential service provider for millions of people with long-term and chronic conditions. It is important that the VCS is recognised as a valuable service provider and partner, but it should not be relied upon to fill gaps in provision. However, given the current reality, it is critical to involve the VCS in decision-making, and to ensure that health systems are aware of what they offer and how to refer into VCS services.

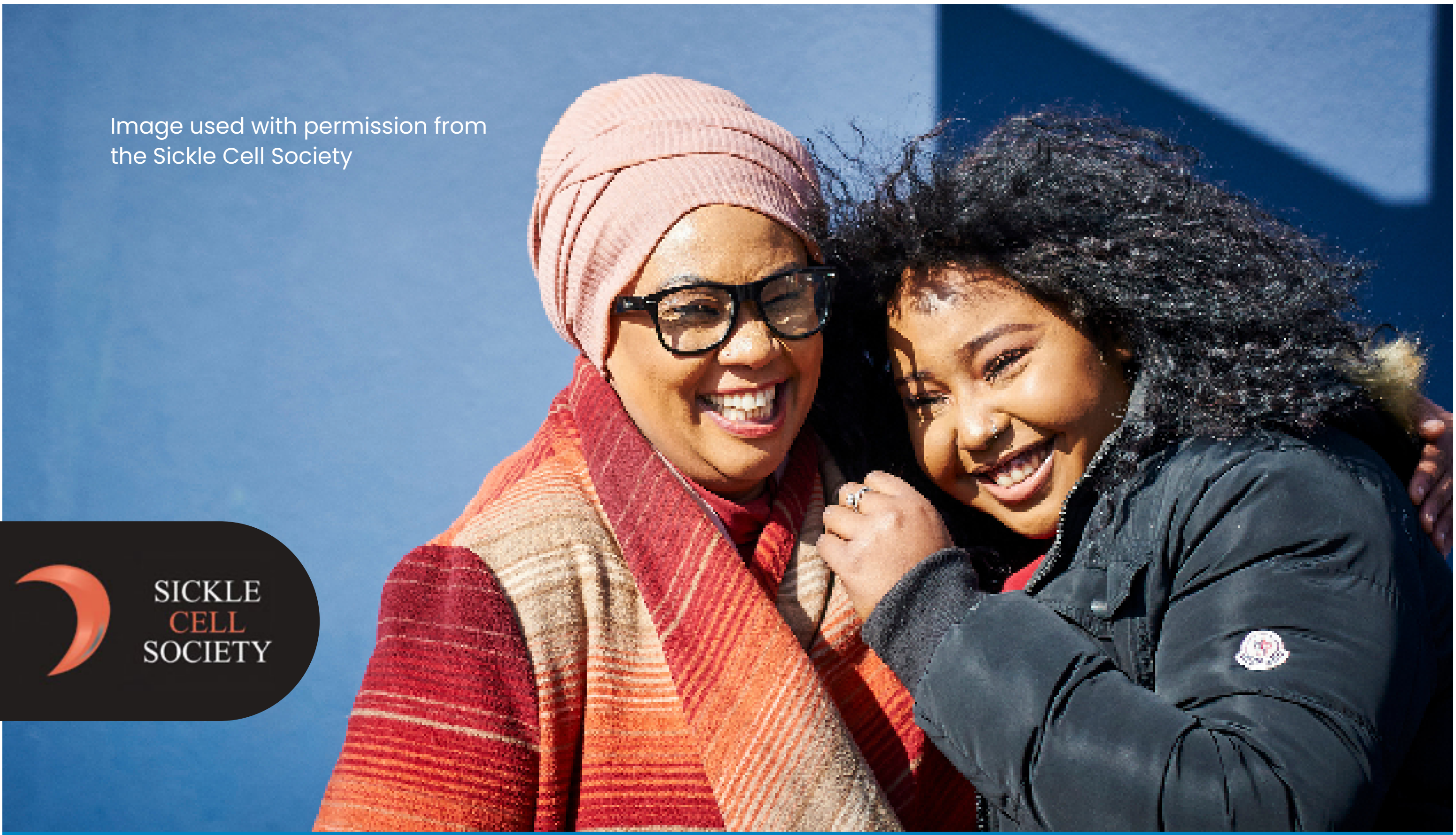


Image used with permission from the Sickle Cell Society

CASE STUDY: Sickle Cell Society

The Sickle Cell Society (SCS) led a pilot model of social care using peer-to-peer mentoring for children and young people with Sickle Cell Disease, initiated in 2017.[5] An effective example of care coordination and integrated commissioning; the City and Hackney Clinical Commissioning Group (CCG) set up the programme through their Innovation Fund, which was delivered and led by the SCS.

This partnership illustrates how integrated, patient focused initiatives, that work across the NHS and VSC, can deliver significant patient experience improvements. The programme focussed on emotional, social and physical wellbeing, including confidence building and promotion of self-management to improve knowledge and access to educational support structures.

Of those responding to the feedback questionnaire (45%), 100% found the mentoring programme had been a positive experience, adding they felt they had better control over their health and reported increased confidence in navigating health and social care services. An effective example of patient activation; patients feel empowered to advocate for their care, which improves patient outcomes and length of stay. Data collected from the programme reflects this, with a reduction in emergency department visits (77%), inpatient episodes (76%) and length of stay (77%), as well as cost savings for the NHS.

This project demonstrates that collaborative working between patients, healthcare providers, community organisations, and patient groups can positively influence patient experience and outcomes, and is likely to be cost effective in the longer term.

CASE STUDY: Fight Bladder Cancer - Transition from Hospital-Based Care to Post-Treatment Support:[6]

For patients recovering from bladder cancer surgery, the transition from hospital-based care to post-treatment support is a critical period. Effective continuity of care can dramatically influence both physical and emotional recovery.

Before surgery, the patient was connected to two experienced Bladder Buddies through Fight Bladder Cancer. One Buddy had opted for a neobladder, while the other had a stoma following their own bladder cancer treatment. Their shared experiences helped the patient understand the practicalities and realities of both options, enabling them to make an informed decision about which surgical path to choose. This personalised support was invaluable in navigating the emotional and practical aspects of such a significant decision.

After the surgery, the patient continued to receive personalised guidance from one of the Bladder Buddies throughout their recovery. In addition, the patient joined Fight Bladder Cancer's Online Support Group, which provided further emotional reassurance, shared experiences, and practical advice from others facing similar challenges.

OUR RECOMMENDATIONS

Care coordination is a vital enabler that lies at that heart of all three of the 10 Year Health Plan's 'big shifts' in care. Care in the community relies on efficient and effective communication and coordinated care between all stakeholders. Prevention requires a coordinated response to the wider determinants of health, engaging stakeholders outside the health system. On an individual level, we contend that secondary and tertiary prevention for individuals already experiencing illness also benefits from enhanced care coordination. The final 10 Year Health Plan shift from analogue to digital must have coordination at its heart to realise the efficiencies that this shift promises.

The new NHS 10 Year Health Plan is an opportunity for renewal and change. Even in tough economic circumstances, we need to be ambitious about improving the healthcare services we offer. And, by making care better coordinated, we can bring efficiencies, reduce failure demand, and provide a better quality of care.

Action taken as part of the new NHS 10 year plan must:

1. Measure patient experience and act on the data

DHSC

DHSC should ensure that patient experience data is routinely collected across NHS services and collated by a patient experience team that makes recommendations to act upon this data. This data should be considered on a par with other measures of clinical excellence, while avoiding making this data into a scorecard by which to compare services. In addition to patient experience of services, DHSC should ensure that it is capturing patient's experiences of their holistic experience of care across the NHS, with a focus on coordination of care. This data should be used to identify where coordination is breaking down, with a view to remedying the situation. DHSC should host a patient experience dashboard, with regularly updating data on patient experience hosted on a single webpage. This data should be used to inform a new incentive structure that encourages better collaboration and coordination.

Local health systems

ICSs should identify opportunities to measure patient experience across their region and services. This data should play a central role in developing five year plans, and be widely disseminated across the system. It should be clear who within the ICS holds responsibility for acting on patient experience data and there should be a clear understanding of what patient experience data is already available, and recorded framework for acting upon it.

2. Make communication between healthcare professionals and patients simpler, quicker, and more efficient

DHSC

DHSC should review healthcare professional communication with patients, with a view to making it simpler, more efficient, and, where possible, digitally enabled. DHSC should consider the NHS app as a potential central hub for healthcare professional/patient communication, while respecting people's preferences for non-digital options. Further, DHSC should review the language and tone of communications, aiming to make it clearer, medical jargon-free, and easy to understand for all patients.

3. Proactively build a culture of collaboration

DHSC

DHSC should use a behaviour change approach to establish a culture of collaboration across the health system, using successful examples within existing collaboration networks such as ICSs, PCNs, and local examples of best practice as a starting point. DHSC should be mindful that there is not a one-size-fits all approach, and focus on building a culture that allows collaboration to thrive in a variety of scenarios. DHSC should investigate the barriers to collaboration identified in this report, and remove the perverse incentives that continue to support siloed thinking.

NHS

The NHS should have a lead for care coordination who is responsible for ensuring that care is effectively coordinated across the NHS, and who can propose new policies to improve care coordination.

Local health systems

ICSs should grow and scale examples of good collaboration within their region. ICSs should ensure that the VCS is considered in all relevant policy fora, and are fully integrated into the care system.

4. Take a holistic approach to care for long-term conditions

DHSC

DHSC should ensure that treatment pathways for all long-term conditions consider all aspects of the patient's needs, including mental health. The NHS should favour multidisciplinary teams where possible, with a single point of contact for a patient that can coordinate care between the different disciplines.

Local health systems

People with long-term conditions should have a named care coordinator who is responsible for ensuring that their care is coordinated across all services that they use.

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PP-UNP-GBR-11997 April 2025