skillsforcare

A guide to coordinating care

NHS
Health Education England

A guide to coordinating care

Published by:

Skills for Care
West Gate, 6 Grace Street, Leeds LS1 2RP
www.skillsforcare.org.uk

Health Education England
Stewart House, 32 Russell Square, London WC1B 5DN
www.hee.nhs.uk

Contents

Acknowledgements

This guide was commissioned by the Department of Health and Social Care.

Skills for Care and Health Education England would like to thank the following organisations who provided information, advice and feedback to help us develop this guide. Their invaluable support has shaped both the content and design of the guidance.

- Age UK
- Birmingham City University
- Health Education England - West Midlands office
- Local Government Association
- Luton Borough Council
- NHS England
- Social Care Institute for Excellence (SCIE)
- Think Local Act Personal (TLAP)
- West Wakefield Health and Wellbeing, part of Conexus Healthcare Ltd
- United Kingdom Homecare Association (UKHCA)

1. Introduction

In an increasingly integrated social care and health system that is focussed on independence, choice and control, the importance of coordinating care is growing.

Newly formed integrated care systems are exploring and testing new ways of delivering care and health services that meet the needs of local populations and provide seamless pathways of support for individuals.

The purpose of coordinating care is to work in partnership with people who access care and support, their carers and family, to advise and share with them how they might best meet their wellbeing need, so they have more choice and control over their life and are supported to maximise their own strengths and assets. It involves a single, named person who acts as a primary point of contact for people who access social care and health support.

There is much debate around whether coordinating care should be a **specialist** role done by one worker, or form part of the role of more **generic** workers. And this will depend on local needs and demand.

Therefore this guide explains **what coordinating care is** and clarifies the **functions** of coordinating care. This supports a consistent definition for those working at the interface of social care and health, so that everyone involved can ultimately provide coordinated and high quality care.

For people who access care and support this means:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

TLAP / National Voices, 2013: A narrative for Person Centred Coordinated Care

Back to contents >>

2. Who is this guide for?

This guide will support **both commissioners of services and adult social care and health employers** working in integrated care systems and working together when designing and evaluating care coordinating approaches.

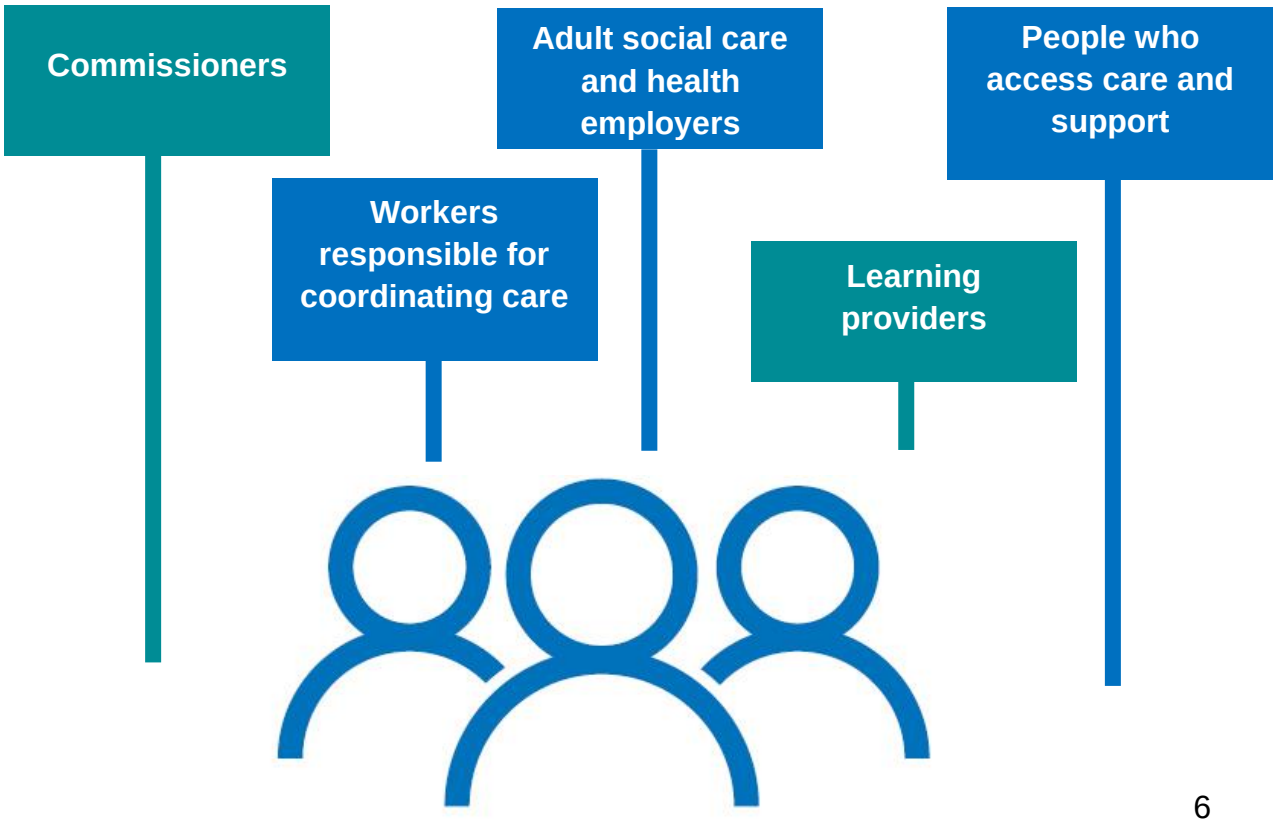
The list of functions in this guide can help commissioners of services and adult social care and health employers to write a job description and job advertisement, inform the interviewing and selection process, and identify learning and development needs for staff who are responsible for coordinating care.

It provides a 'menu type' approach so that you can select the functions that are required for your particular local service.

It can also help you to identify, plan and access learning and development for staff responsible for coordinating care. As learning is described for each particular function, it prevents a one size fits all approach where people are trained as 'care coordinators', even though their particular role does not involve all the agreed functions.

It also has a function mapping and learning and development needs matrix to support this (see appendix).

The guide might also be useful for **workers** who are responsible for coordinating care, **learning providers** and **people who access care and support**.



Back to contents >>

What does this guide offer?

In 2016 Skills for Care, in partnership with social care and health employers, did research into coordinating care and the functions that were involved in it - this can be found at *Skills for Care (2016), Care coordination functions scoping research*.

It was clear that within the plethora of different models, there is confusion and complexity around just what coordinating care involves, what it is and what it should be called.

The overwhelming outcome of the research was a request for guidance to clarify the functions of coordinating care and to support consistency in definition.

The research showed that even where specialist roles exist in organisations, many other staff are also involved in the delivery of coordinating care - we have called them 'generic' workers for the purpose of this guide.

The guide therefore offers clarity around the **functions** of coordinating care rather than specific roles.

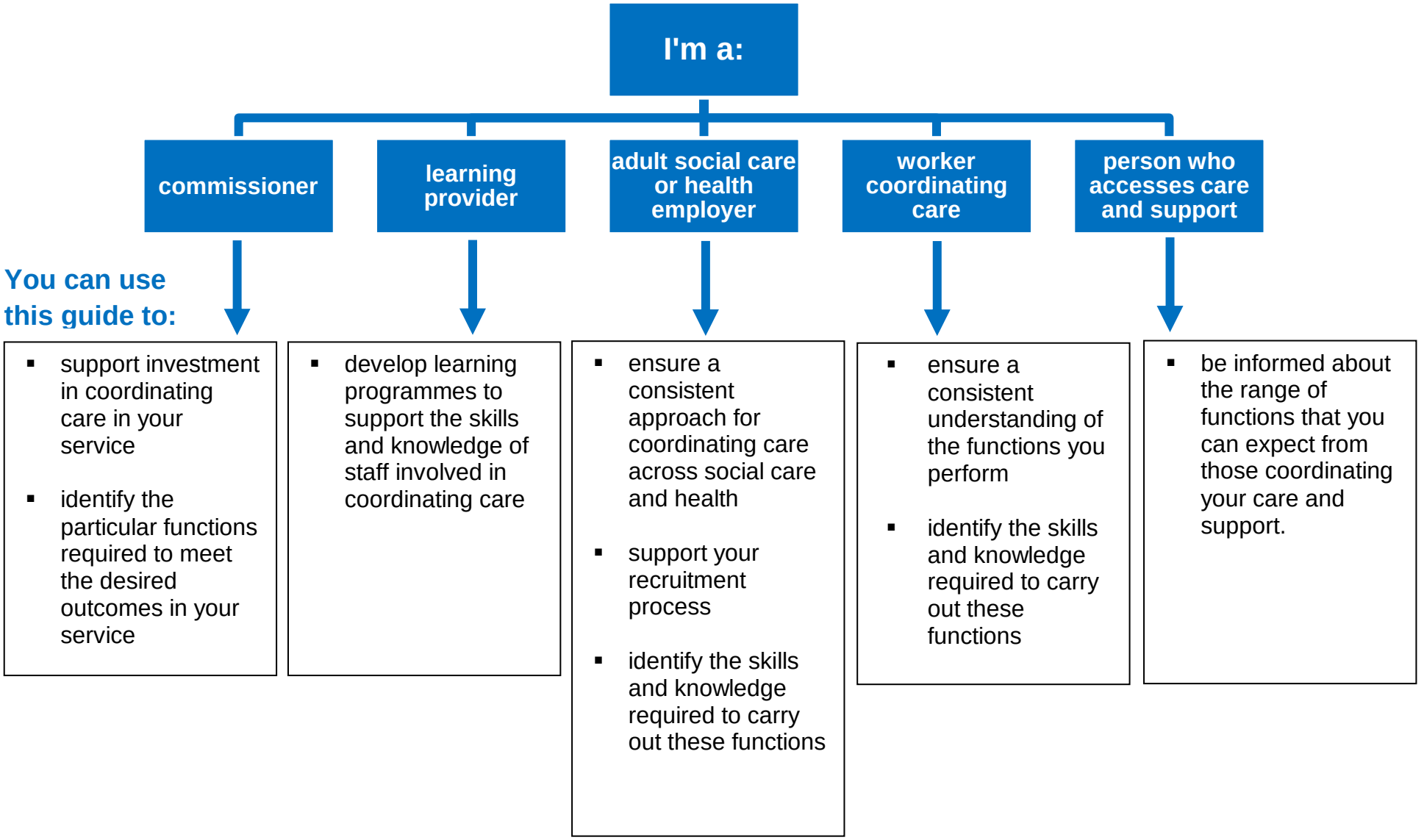
"I tell my story once.

I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time."

TLAP / National Voices, 2013:
A narrative for Person Centred Coordinated Care

Back to contents >>

How can you use this guide?



Back to contents >>

3. Background

To achieve an integrated social care and health system, coordinating care is vital.

Coordinating care in the policy context
ADASS highlight the importance of coordinating services in their 'Distinctive, valued, personal: why social care matters' guide (March 2015). It says:

"Social care has a long history of joint working with the NHS in areas such as hospital discharge, and for people with mental ill-health or with a learning disability. Much care previously provided by the NHS is now delivered through the social care system. The coordination of primary and community health and social care support are vital for many people".

NHS also highlights the importance of integrating services and providing coordinated care in their 'Five year forward view: next steps' (2017).

Underpinning these policy statements is Think Local Act Personal and National Voice's 'A narrative for person-centred coordinated care'. They did research with people who access care and support and produced this definition for person-centred coordinated care:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

There has also been local research that explores the coordinating care model in specific regions. You can read about the West Midlands approach to coordinating care here.

A background to coordinating care
The title of 'care coordinator' is commonly used to identify one worker, who would 'coordinate' the care with a person who accesses care and support from across social care and health services.

In mental health settings, this 'care coordinator' role has been described by legislation within the Care Programme Approach for some time. In most other cases it is recognised that the key element is that of 'coordinating care' - no matter what the specific role is actually called or whether it's part of a wider role. However, in domiciliary care the term's also used to describe a human logistic role of getting the workers in the right place at the right time to cover care and support needs, so their functions might be different.

The drive to integrate social care and health services has resulted in the increasing growth of a **'care coordinator'** function or role.

There has been a shift from prescriptive delivery to one of independence, choice and control – for example the introduction of personal budgets, personal health budgets

Back to contents >>

and a greater degree of integrated care and support for people, necessitates coordination and systems knowledge.

In this context, coordinating care has been seen as central to enabling a good experience for people who access care and support, their carers' and relatives. It essentially means that they **see the right person, in the right place at the right time** to meet their needs, without repetition, duplication or wasted journeys.

This was the crucial element of NICE guidance, where they described the role simply as **'just one person'**, which from the perspective of the person accessing care and support would be the named 'care coordinator' who acts as their first point of contact.

Care Act guidance supports the recruiting and training of individual care coordinators who are responsible for planning how to meet an adult's needs through a number of services - especially where staff from more than one body may be involved with providing or arranging care and support.

The role of a **'care coordinator'** in relation to direct payments for personal health budgets is a legal requirement as set out in the direct payments regulations. The guidance for direct payments for health care states:

"Before a direct payment can be made, a care plan must be agreed between the clinical commissioning group and the person, their nominee or representative. This must set out… the name of the care coordinator responsible for managing the care plan."

Although the term 'care coordinator' is widely used to describe a range of roles, coordinating care will differ between area and organisation. Therefore this guide focuses on the **functions** of coordinating care rather than specific roles.

4. Definition of coordinating care

There will be local variances and guidance regarding coordinating care, but it is important that we are clear about the definition within this guide.

The social care and health 'system' can be complicated, so there should be someone who can work alongside people to make sure it works well for them. Coordinating care should demonstrate true person-centred support, ideally face to face, which is at a different level than merely navigating and signposting from an office base in front of a screen.

Definition of coordinating care

Coordinating care involves a single, named person who acts as a primary point of contact for people who access social care and/ or health support.

The activity works in partnership with people who access care and support, their carers and relatives. It should share information and advice to support them to have choice and control over their life and how they might best meet their wellbeing needs. It supports person-centred outcomes that are based on their expressed wishes and preferences.

It will normally involve the supervision of interdisciplinary care - bringing together the different specialists whose help the individual may need. In practice, coordinating care may also include assessing, monitoring, reviewing and evaluating care delivery in a synchronized approach.

The very heart of coordinating care is that the professional works alongside people accessing care and support. This is no longer 'doing to' people, but 'working with' to empower them to identify their aims and goals, and to facilitate their health and wellbeing.

"I am supported to understand my choices and to set and achieve my goals."

TLAP / National Voices, 2013: A narrative for Person Centred Coordinated Care

5 Benefits of coordinating care

The key benefit of coordinating care is that people can experience better care, led by what matters to them and supported to **'see the right person, the first time'** without having to repeat their story or have to be referred on time and again, wasting time and resource for all and risking deterioration in their wellbeing.

A robust approach in action demonstrates how integrated, seamless services can support true person centred care so that all benefit.

What can a robust coordinating care approach do for me as an individual?

- Ensure I am more informed and involved in planning my care and support.
- Reduce confusion between services and bring greater understanding of the system, simplifying and streamlining wherever possible.
- Enable me to have improved choice and control over how my care and support needs are met.
- Ensure I only have to tell my story once.
- Recognise what is important to me and support me to improve my care at 'home'.
- Recognise my strengths and interests and support me to increase my understanding of and links with my community and local organisations.
- Support me to have better use of facilities across a range of statutory and independent services and so greater choice.
- Support me to increase my independence.
- Enable me to experience a faster and better quality service with continuity.

What can a robust coordinating care approach do for me as a worker?

- Ensure the focus of my work is person-centred to help improve health and wellbeing.
- Enhance my job role to include wider functions.
- Make my job more interesting and satisfying through helping to achieve better outcomes for people.
- Give me greater confidence in my overall role.
- Improve my career prospects.

Back to contents >>

What can a robust coordinating care approach do for me as an employer?

- Ensure the right support is delivered to the right person at the right time.
- Ensure my service is focused and targeted.
- Improve my communication and relationships with other statutory and independent organisations.
- Support greater information sharing between my staff and other organisations.
- Reduce duplication of my care and support service.
- Improve my relationships with local organisations.
- Improve my business model and my overall offer.
- Improve my recruitment and retention due to enhanced job roles and satisfaction.

What can a robust coordinating care approach do for me as a commissioner?

- Offer effective and joined-up care for people who access care and support.
- Offer a sustainable solution to the provision of support services.
- Provide an economically viable service.
- Ensure effective empowerment of local community resources.
- Help meet the challenges of a changing population.
- Support market shaping.

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

TLAP / National Voices, 2013: A narrative for Person Centred Coordinated Care

Back to contents >>

6. What roles might be involved in coordinating care?

The role of coordinating care, identified by NICE, is outlined in three areas.

Preventative care and support

People involved in coordinating care have a crucial role to play in helping individuals stay as well as possible, looking beyond the list of conditions to see the whole person, and identifying and making use of the person's own network of support.

Planning and recording

Care planning is identified as a key aspect of coordinating care, but ultimately the care plan must be owned by the person accessing care and support. The named ‘care coordinator’ would be well placed to help the person to plan what they would want to happen in critical or changing situations.

Working in partnership

There is a need to form effective working relationships with others in the social care and health system, including the voluntary sector. NICE suggested that a helpful starting point is to take the time to communicate the role to other professionals, and to understand the role of others. This will help build influence and enable them to provide more effective support.

The professional involved in coordinating care should normally be someone who has regular contact with both the individual accessing care and support, and their representative or nominee if they have one.

NICE guidance states that the coordinator doesn’t need to have ‘care coordinator’ in their job title - the important thing is that they fulfil the responsibilities.

Some roles that include some of the functions identified for coordinating care, might include those who are involved in care navigation or social prescribing schemes.

Care navigation and social prescribing

Some areas employ staff to assist individuals, their families and carers to ‘navigate’ through an increasingly complex health and social care system, so they can access the service that will meet their needs best. These staff are often called ‘**care navigators**’ who have the function of ‘active signposting’.

Some areas also employ ‘**social prescribers**’ who have a similar signposting role, though there may be an element of assessment too in this role. Prescribers enable GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.

Back to contents >>

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations, and sometimes confusingly they are also called navigators. Some examples of care navigating and social prescribing can be found in the appendix.

Coordinating care can embrace these different aspects, but it has a much wider range of functions, even though some organisations do call their care navigators, 'care coordinators'.

Here are some of the roles which might include functions of coordinating care.

'Specialist' roles with coordinating care functions and role can also be called:	**''Generic'** roles identified with significant coordinating care activity, but within other wider roles are:
▪ care coordinator ▪ care assessor ▪ discharge coordinator ▪ domiciliary care coordinator ▪ local area coordinators ▪ care navigators ▪ personal independence coordinators ▪ wellbeing adviser ▪ dementia adviser or navigator ▪ case manager	▪ social workers ▪ registered managers ▪ care assessors ▪ care and support workers ▪ link workers ▪ support workers ▪ general practitioners ▪ customer support ▪ community nurses ▪ occupational therapists.

7. Key functions of coordinating care

Due to the complexity around roles coordinating care, we refer to ‘functions’ of coordinating care rather than concentrating on the specific ‘roles’.

This allows a ‘menu approach’ for commissioners and employers, so they can choose from a list of functions to develop their own bespoke roles. This ensures the guide has a wider application and covers different roles descriptions, in different settings and different locations.

The foundation of any activity involving coordinating care is **‘communication’.** Anyone carrying out these functions will need excellent communication skills to build relationships with people who access care and support, their carers’ and relatives, and other professionals and organisations.

The Person-centred Approaches Core Skills Education and Training Framework outlines the core communication and relationship building skills workers need, to deliver person-centred care and support.

We’ve expanded on the three areas of coordinating care by NICE, to identify four headings under which the functions of coordinating care sit:

- **activities that support people**
- **information management**
- **business management**
- **local knowledge exchange activities.**

Communication

Communication skills are fundamental to coordinating care - it can only be successful if effective relationships are built between all those involved.

The key functions of coordinating care are to:

1. build strong relationships with people who access care and support
2. work with families and carers closely to ensure good communication
3. check understanding with all those the person would like involved in their care
4. respond in a timely manner in all communication verbal and written
5. do administrative work to ensure continuity, good communication and quality assurance
6. follow up to make sure referrals have happened
7. support communication between all people, relatives and organisations
8. act as a negotiator to resolve conflicts between people, relatives, carers and organisations
9. demonstrate professional assertiveness appropriately and sensitively
10. support self-care using motivational interviewing.

"I am listened to about what works for me, in my life."

TLAP / National Voices, 2013: A narrative for Person Centred Coordinated Care

The next four headings outline some of the other the functions for coordinating care.

Activities that support people to fulfil health and wellbeing aims

1. Conduct an initial assessment of needs in partnership with people who access care and support.
2. Work with people to produce plans together, to best meet their needs and preferences.
3. Support people to plan what they would want to happen in end of life, critical or changing situations.
4. Support people to choose where they receive their care and support based on what's important to them and best suits their needs.
5. Negotiate with and between organisations to ensure the best approach for people who access care and support.
6. Support people to meet the outcomes that are important to them and to manage the different elements of their care plan, including coordinating medication.
7. Review and adapt individual care plans as and when needed.
8. Encourage and develop self-care work with people, maximizing their independence.
9. Reflect on and evaluate the experiences of people accessing care and support and community facilities.
10. Act as an advocate for people within and between organisations.
11. Promote the legal rights of choice for people who access care and support.
12. Help people to access local organisations, including statutory, independent, private and voluntary organisations.
13. Support people as part of the hospital discharge team.
14. Support people in planning and managing a personal budget or personal health budget.
15. Support people to attend appointments including help to transport between services and organisations.

Depending on the setting, coordinating hospital discharge, managing personal budgets and helping with transport may not be core activities for those coordinating care more generally, but may be linked to specific settings or services.

Information management

1. Actively coordinate the flow of information between people and organisations.
2. Take and make referrals to and from other local organisations, including statutory, independent, private and voluntary organisations.
3. Signpost people accessing your service to other local organisations.
4. Complete accurate, timely and objective recording.
5. Spend time keeping knowledge of health and social care policy, legislation and local initiatives up to date.
6. Book and manage appointments for people, with their agreement.
7. Maintain a database of local services, including statutory, independent, private and voluntary organisations, to support people in their choice of provider – also known as community mapping.
8. Build strategic networks to share and access information.

"I am told about the other services that are available to someone in my circumstances, including support organisations."

TLAP / National Voices, 2013: A narrative for Person Centred Coordinated Care

Business management activities

1. Ensure effective use of resources for your organisation and others in your area.
2. Audit and reflect on the service you provide to evidence impact.
3. Investigate and evaluate experiences of people who access care and support and act on findings.
4. Help shape the services and groups to reflect the needs of the local population.

Local knowledge exchange activities

1. Support colleagues to understand the range of local organisations and networks and what they offer.
2. Support the various roles in a multi-disciplinary team including people accessing care and support.
3. Act as a catalyst or starting point for integrated care.
4. Work to avoid duplication of service provision, regardless of sector.
5. Proactively act as a link and build networks and other local agencies and groups.

Core functions for all social and health care workers

In addition to these more specialist functions, all workers need to understand their role in the context of the core functions and associated learning for working in social and health care.

These are usually seen as statutory or mandatory learning and would fall under the following categories:

- person-centred support
- values
- equality and diversity
- personal development
- safeguarding
- duty of care
- health and safety.

"The professionals involved with my care talk to each other. We all work as a team."

TLAP / National Voices, 2013:
A narrative for Person Centred Coordinated Care

Back to contents >>

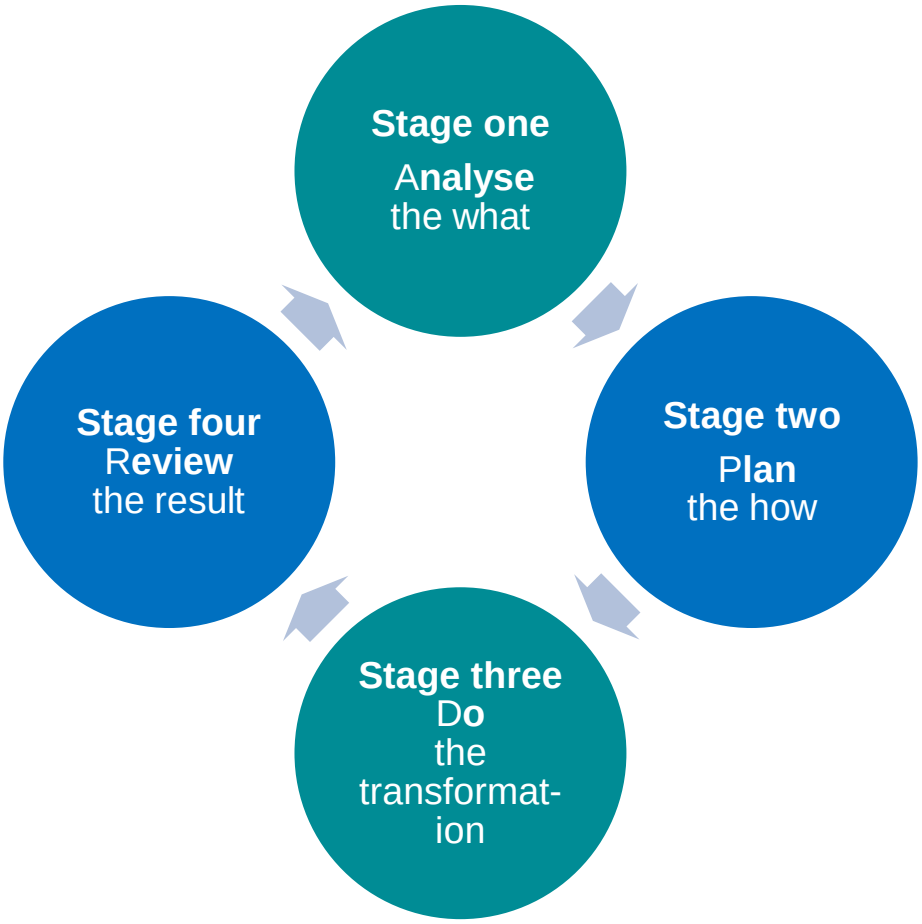
8. Commissioning coordinated care – a process for commissioners

This model will help you to strategically assess your local care coordination needs with your key partners.

As far as possible, take into account information you already have and fill in as many gaps as you can. You can then develop a full picture of how coordinated care will be achieved in your local area.

This model takes you through the four stages of commissioning coordinated care.

Analyse-Plan-Do-Review brings together all aspects of planning into a coherent, unified process.



Back to contents >>

1 Stage one – Analyse the what

Understand the national vision for coordinating care

- What is the national vision for coordinating care?

You should have a clear understanding of the national vision and the functions of coordinating care.

"I tell my story once"

"I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time."

"Coordinated care has been seen as central to a good experience for people who access care and support, their carers and relatives. It essentially means that they see the right person, in the right place at the right time to meet their needs, without repletion, duplication or wasted journeys."

TLAP / National Voices, 2013: A narrative for Person Centred Coordinated Care

Develop a local vision and strategy for coordinating care

- Do you have a clear idea of what coordinating care should look like for your local area?
- Are you clear about the scope of the provision - do you want a signposting service, do you want a navigations service, do you want to go further and have a care coordinator role for everyone who uses services, or do you want a wider coordination service?
- Have you involved the right people in discussions and planning, including people who access care and support, their carers and families, local community, existing and potential new delivery partners including health, care and support providers?
- How will coordinating care be funded - will you give this a dedicated budget or will it be built into existing service provision?

Collect data information and intelligence

- Do you have a clear understanding of the current and future coordinating care needs of your local population?
- What data do you need to gather to gain a full picture to help identify demand, scope current local provision and gaps?
- What is already happening in your local area?
- Are any of the functions described in this guide already happening in your local area – do you know the impact of these functions, do they meet your future needs, can you build on what is working well?
- Who is already involved in the delivery of coordinating care functions in your local area – what services and job roles are already available?

  Download appendix one and two, the 'Function mapping templates' to help.
- What baseline data do you have about the workforce - consider using the Adult Social Care Workforce Data Set (ASC-WDS), current contracts, appraisals, personal development plans and skills audits?
- Are there any other providers, voluntary and community organisations that could deliver coordinating care functions?

Analyse what this means for you

- How does this information impact on your vision for the future?
- Are you currently meeting the needs identified in your vision and strategy - are all coordinating care functions being delivered?
- Do you have a clear picture of what your localities current behaviours, skills, values, knowledge, capabilities and competences look like?
- Are there any changes you need to make?

2 Stage two – Plan the how

Once you have done the analysis, think about how you will share your findings and prioritise your actions.

Consider pulling together a high level coordinating care strategy and implementation plan that identifies leadership ownership and ensures reporting mechanisms are in place.

What does coordinated care need to look like in the future?

- What outcomes do you want to achieve?
- How does the local market and workforce need to change to meet the needs identified in your analysis and strategy?
- What can you build on and what are you going to do differently - can you build on existing skills to meet your outcomes?
- What, if any, new roles and new ways of working will be needed for the future?
- How are you involving partners in planning to encourage ownership of the plan?

It is important to recognise that any identified change is unlikely to be isolated to service and role redesign. A combination of coordinated changes will probably be needed to achieve the desired outcomes. Just as desired outcomes were jointly identified, planned and owned change must also be jointly identified, planned and led. Some areas where change may be required include:

- policy and process redesign – including technology
- environment and location
- improved quality of service
- improved productivity
- culture.

Back to contents >>

Are there any gaps in functions?

- What functions will be needed in the future?
- Does your current provision cover all these functions or are there any gaps?
- Could the coordinating care functions be provided more efficiently and effectively?
- Who is best placed to provide these functions?
- Will these functions sit within current commissioning arrangements - do you need to commission new provision or service, and will these include voluntary or community groups?
- What will be the impact on the current providers of coordinating care functions?
- Where should the functions be located?

What does the coordinating care workforce need to look like in the future?

- Are there any workforce gaps - are there any gaps in geographical location, numbers, knowledge, skills, values, behaviours and attitudes in the current workforce?
- Who needs to be involved in the workforce change process and how you will keep them informed, including:
    - people who access care and support, and their families and carers
    - current providers of coordinating care functions
    - new providers of coordinating care functions
    - senior management
    - finance, HR, IT and other internal functions
    - the workforce – paid and unpaid.
- Who needs development to support coordinating care, including the paid workforce such as senior managers, line managers, team leaders, workers coordinating care, support services, technical professional staff, and the unpaid workforce including volunteers, people who access care and support, their families and carers, circles of support, communities and partner agencies – do they have different learning and development needs?
- Ensure all parties have a clear understanding of how the identified workforce change will lead to the achievement of the desired outcome. For example develop a communication plan to ensure all parties are aware of the current and future needs of the workforce in relation to coordinating care activity.

Design cost effective workforce solution(s)

It is important to have crystal clear understanding of the workforce outcomes required before any interventions are designed. A range of workforce interventions may be required to achieve the desired outcomes. Workforce change programmes could involve:

- increasing or decreasing capacity
- workforce reassignment – change in rota patterns
- workforce redesign – job roles, new roles
- workforce learning and development– capability, knowledge, skills, attitudes, behaviours and proficiency levels
- changing your workplace culture.

- What workforce interventions are likely to achieve the desired change?

- Who will lead on the design and delivery of the interventions?

Learning and development

- What learning and development is needed to support staff involved in coordinating care?

  Complete a learning needs analysis to help you plan for any skills and knowledge gaps in the workforce. This could be done at an organisation, team, role or individual level.

  Download appendix three, the 'Learning and development needs analysis template' to help.

  This matrix can then be used to develop effective bespoke learning programmes to support those involved in the coordinating care activities.

  The benefit of establishing some consistency in identification of these functions and the associated learning helps workforce recognition and status. It also helps learning to be transferrable into other similar roles, and could help to support development of a career pathway for workers involved in care coordination.

- How will you measure success of learning and development, in terms of process, outputs and workforce outcomes?

- Is there an implementation plan which includes timescales and a mechanism for validating and monitoring interventions? Do you have a learning and development plan to support workforce learning?

Cost

- Do you know the cost of any changes you want to make?
- What resources are available?
- Do anticipated benefits justify the investment?
- Is this financially viable?

Risk

- Have you identified any risks within the changes you want to make?
- Have you considered how you might mitigate these risks?

Measuring the impact

It is important that when you commission a new approach, you develop a methodology for assessing the effectiveness of the innovation.

You need to measure the current position and the desired outcome.

- Consider using some of the baseline data you collected at the analysis stage to measure the impact.
- How will you know that you've achieved what you set out to do?
- How will you measure, monitor, review and evaluate?
- What information or data was used to identify the need for change - was it baseline data such as person-centred plans, assessment data, complaints, reviews, inspections, observation, financial monitoring, change in legislation or policy?

Change without measurable improvement is meaningless.

There are some tools that have already been developed to measure the impact of social prescribing and navigation projects, but these don't necessarily reflect coordinating care.

Social Prescribing Tool, Live Well Wakefield, 2017.

Warwick-Edinburgh Mental Well-being Scale, Warwick University, 2015.

Record the actions you are going to take

- What actions are you going to take and with whom?
- How are you going to do it?
- What will it cost?
- When are you going to achieve this by?
- How will this be communicated?

This is your implementation plan – share your agreed vision, strategy, implementation plan and outcomes to support transparency and accountability.

3 Stage three – Do the transformation

- How will you coordinate the actions that everyone has planned and contributed to - how will you make them happen?
- What timescales have you set?
- How are you supporting service providers and communities to redesign and develop their services and workforce to deliver coordinating care functions?
- How are you supporting learning and development providers to work with employers to meet the workforce gaps?

Communicate and engage with all those involved to ensure effective implementation

- How have you communicated your vision and strategy?
- How are you continuing to communicate during implementation of your plan?

Monitor and review your plans

- Are you reviewing your implementation plan regularly with everyone it affects - is it on target, are there any issues, what surprises have emerged, have any opportunities or barriers arisen that have come out of the review and are they being addressed?
- Does your monitoring indicate that you need to revise your implementation plan?

Back to contents >>

4 Stage four – Review the result

Results and impact

Did the changes you implemented achieve the desired results - did the new ways of working and new roles help to achieve the new approach?

What are the outcomes of the changes and has there been an impact on the people you support?

Have you gathered evidence to identify your key achievements - what you have learned and what you would do differently, if at all next time?

If anything, what prevented the achievement of the desired outcomes? This will help you to set future outcomes and identify further improvements. For example some reasons that might prevent this are:

- outcome was not clear to all those involved (people who use services, carers, workforce, those developing solutions etc.)
- outcome measurement was not specific enough
- required resources were not made available
- insufficient planning
- timescales were unrealistic
- progress was not monitored effectively
- people unwilling to engage
- outcome became invalid or no longer required.

Review and redefine

To continuously improve the quality of care coordination, use what you have achieved and learned to rethink the process, taking into account the needs of people who access care and support.

- Do you need to make any changes?

Back to contents >>

9. Conclusion and the need for systems leadership

We hope this guide will support you to coordinate care in your service.

Before you make any changes, consider whether a new specialist role for coordinating care is necessary or whether existing 'generic' roles could be adapted – existing roles might already include some coordinating care functions that can be amended to accommodate your requirements. We expect that coordinating care will not be a new occupation – it will be a range of 'functions' amalgamated into current roles.

You should also consider the culture and leadership in the 'system' because this is vital to embedding successful coordinated care.

There needs to be a real commitment across the system, in particular from budget holders, managers and leaders to ensure the function is effective.

Managers need to understand exactly what they are asking from the role, how it fits in with their organisation and across organisational boundaries – this relies on good relationships at a strategic level, and the skills and knowledge needed by staff coordinating care.

Managers are likely to convince budget holders of the key benefits of this approach; both economically and how it can benefit the service they offer to people who access care and support.

Please refer to the 'Enablers for embedding a person-centred approach section (page 42) of the Person-centred Approaches Core Skills Education and Training Framework.

"Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand."

TLAP / National Voices, 2013: A narrative for Person Centred Coordinated Care

Back to contents >>

10. Supporting resources

Background

NICE (2016), Tailored resource: The named care coordinator role for the perspective of older people

NHS England (2014), Guidance on Direct Payments for Healthcare: Understanding the regulations

Skills for Care (2016), Care coordination functions scoping research

Skills for Care, Skills for Health and Health Education England (2017), Person-centred approaches core skills education and training framework

Resources to support learning and development

Skills for Care and Skills for Health (2008) Common Core Principles to support self-care

NHS England (2016), Care Navigation: A Competency Framework

Visit our website for more resources to help: www.skillsforcare.org.uk

Skills for Care, Practical approaches to workforce planning

Skills for Care, Workforce planning and development tool

Skills for Care, The principles of workforce redesign – people, planning and performance

Skills for Care, The principles of workforce integration

11. Good practice examples

AGE UK personal independent coordinators – read more

Age UK have a team of personal independence coordinators that signpost people to a range of services and organisations that could improve people's mental wellbeing.

In one case a coordinator supported someone to apply for an attendance allowance referral, an occupational therapist assessment which resulted in adaptations being made in the home, help with balance and fall avoidance through a local initiative, and support to attend computer lessons

In another case they were involved in the coordination of the falls, occupational therapy and physiotherapy teams to support an individual with their mobility. They also supported the individual with:

- going into the local town as she had become afraid of using public transport
- sorting out an issue with her boiler
- suggesting her GP gave her a full medication review which resulted in her being less drowsy.

Local area coordination – read more

Local area coordinators are based in their local communities as an accessible, single point of contact for people with disabilities, mental health needs, older people and their families and carers.

This enables the support to be personalised, flexible and responsive, within the context of their family and community life.

They take time to get to know and build positive, trusting relationships with people who access care and support, their families and carers, and local communities.

This model is increasingly becoming more popular across England. It combines a range of existing, often disconnected, roles in a single, local point of contact.

The role's designed to:

- support people to identify their vision for a good life and their plans for getting there
- understand and utilise personal, family and community gifts, strengths and interests – support people to stay strong
- access accurate, timely and relevant information from a variety of sources choice and control
- support people to identify and develop personal networks including friends, family, neighbours, work colleagues and community
- support people to have a voice and self-advocacy, advocating alongside people or advocate for people
- support people to develop practical (non service) responses to needs
- build partnerships with and between people, families, communities and services
- support people to access and control resources or services where this is needed or eligible
- link people with existing community resources
- participate in and contribute to building inclusive communities through partnerships with local businesses, community, voluntary and third sector organisations
- identify gaps in community opportunities and form partnerships to actively develop local communities and resources community building
- promote opportunities for contribution and leadership.

West Wakefield Health and Wellbeing care navigation training – read more

When patients have health concerns they often approach their GP in the first instance – however there are other health and social care professionals who might be better placed to support them. And other colleagues in GP practices, such as receptionists, can be developed to support people with their health concerns.

Initially people had concerns that receptionists, for example, might not have the right skills and knowledge to make clinical decisions or provide specific advice.

However, we developed locally designed pathways to give patients the right choices when they contact GP surgeries with health concerns – so that clinicians and receptionists could provide care navigation support.

- West Wakefield Health and Wellbeing team worked with the wider Wakefield system to understand what services would work for people in the area. This involved:
- identifying the local services that patients can access
- identifying access criteria and red flags for each service
- prioritising the services in roll out.

By doing this, we co-developed a local model of care navigation which prioritises services and outlines the criteria against which receptionists can offer patients choices. In line with Health Education England Competency Framework 2016, care navigators are taught about the access criteria for local services and how to provide patients with information through face to face learning events and they can do online accredited training modules.

Since introducing the care navigation scheme in West Wakefield, over 270 frontline workers have now been trained and the response has been overwhelmingly positive - staff told us they feel empowered and confident in their roles.

Between 01 April 2016 and 31 March 2017, 25,582 interventions were made, saving a total of 23,647 GP appointments.

During the implementation of this programme West Wakefield were cited in the GP Forward View (NHS England, 2016) as a case study, and ‘care navigation’ (also known as active signposting) was identified by NHS England as one of ten high impact actions to reduce workload and bureaucracy.

West Wakefield is now replicating its success across the country by working with a growing number of CCGs/ GP Federations, covering over 10% of England’s patient population. We’ve developed an accredited training and consultancy programme to support this.

Appendix 1: Organisation coordinating care function mapping matrix

Area:

Date:

Please complete of all organisations involved in coordinating care in your local area. You can use this information to identify what coordinating care functions already exist and what gaps you have, to inform future planning.

	E.g. Age UK															
Communication																
Build strong relationships with people who access care and support																
Work with families and carers closely to ensure good communication																
Check understanding with all parties																
Respond in a timely manner in all communication verbal and written																
Administrative work to ensure continuity, good communication and quality assurance																
Follow up to make sure referrals have happened																

Back to contents >>

Support communication between all people, relatives and organisations																
Act as a negotiator to resolve conflicts between people, relatives, carers and organisations																
Demonstrate professional assertiveness appropriately and sensitively																
Support self-care using motivational interviewing																
Activities that support people																
Conduct an initial assessment of needs in partnership with people who access care and support																
Work with people to produce plans together to best meet their needs																
Support people to choose where they receive their care and support based on what is important to them and best suits their needs																
Negotiate with and between organisations to ensure the best approach for people.																
Support people to meet the outcomes that are important to them and to manage the different elements of their care plan, including coordinating medication																
Review and adapt individual care plans as and when needed																
Encourage and develop self-care work with people, maximizing independence																
Reflect on and evaluate the experiences of people accessing care and support and community facilities																

Act as an advocate for people within and between organisations																
Promote the legal rights of choice for people who access care and support																
Help access local organisations (statutory, independent, private and voluntary)																
Support people as part of the hospital discharge team																
Support in planning and managing a personal budget or personal health budget																
Support people to attend appointments including help to transport between services and organisations																
Information management																
Actively coordinate the flow of information between people and organisations																
Take and make referrals to/from other local organisations (statutory, independent, private and voluntary)																
Signpost people accessing your service to other local organisations																
Complete accurate, timely and objective recording																
Spend time keeping knowledge of health and social care policy, legislation and local initiatives up to date																
Book and manage appointments for people, with their agreement																
Maintain a database of local services (statutory, independent, private and voluntary) to support																

people in their choice of provider (community mapping)																
Build strategic networks to share and access information																
Business management activities																
Ensure effective use of resources for your organisation and others in your area																
Audit and reflect on the service you provide to evidence impact																
Investigate and evaluate experiences of people who access care and support and act on findings																
Help shape the services and groups to reflect the needs of the local population																
Local knowledge exchange activities																
Support colleagues to understand the range of local organisations and what they offer																
Support the various roles in a multi-disciplinary team including people accessing care and support																
Act as a catalyst or starting point for integrated care																
Work to avoid duplication of service provision, regardless of sector																
Proactively act as a link and build networks and other local agencies and groups																

Appendix 2: Role coordinating care function mapping matrix

Name of organisation:

Date:

Please complete of all roles involved in coordinating care in your local area. You can use this information to identify what coordinating care functions already exist and what gaps you have, to inform future planning.

	E.g. Social worker															
Communication																
Build strong relationships with people who access care and support																
Work with families and carers closely to ensure good communication																
Check understanding with all parties																
Respond in a timely manner in all communication verbal and written																
Administrative work to ensure continuity, good communication and quality assurance																

Back to contents >>

Follow up to make sure referrals have happened																
Support communication between all people, relatives and organisations																
Act as a negotiator to resolve conflicts between people, relatives, carers and organisations																
Demonstrate professional assertiveness appropriately and sensitively																
Support self-care using motivational interviewing																
Activities that support people																
Conduct an initial assessment of needs in partnership with people who access care and support																
Work with people to produce plans together to best meet their needs																
Support people to choose where they receive their care and support based on what is important to them and best suits their needs																
Negotiate with and between organisations to ensure the best approach for people.																
Support people to meet the outcomes that are important to them and to manage the different elements of their care plan, including coordinating medication																
Review and adapt individual care plans as and when needed																
Encourage and develop self-care work with people, maximizing independence																

Reflect on and evaluate the experiences of people accessing care and support and community facilities																
Act as an advocate for people within and between organisations																
Promote the legal rights of choice for people who access care and support																
Help access local organisations (statutory, independent, private and voluntary)																
Support people as part of the hospital discharge team																
Support in planning and managing a personal budget or personal health budget																
Support people to attend appointments including help to transport between services and organisations																
Information management																
Actively coordinate the flow of information between people and organisations																
Take and make referrals to/from other local organisations (statutory, independent, private and voluntary)																
Signpost people accessing your service to other local organisations																
Complete accurate, timely and objective recording																
Spend time keeping knowledge of health and social care policy, legislation and local initiatives up to date																
Book and manage appointments for people, with their agreement																

Maintain a database of local services (statutory, independent, private and voluntary) to support people in their choice of provider (community mapping)																
Build strategic networks to share and access information																
Business management activities																
Ensure effective use of resources for your organisation and others in your area																
Audit and reflect on the service you provide to evidence impact																
Investigate and evaluate experiences of people who access care and support and act on findings																
Help shape the services and groups to reflect the needs of the local population																
Local knowledge exchange activities																
Support colleagues to understand the range of local organisations and what they offer																
Support the various roles in a multi-disciplinary team including people accessing care and support																
Act as a catalyst or starting point for integrated care																
Work to avoid duplication of service provision, regardless of sector																
Proactively act as a link and build networks and other local agencies and groups																

Appendix 3: Learning and development matrix

Complete a learning needs analysis to help you plan for any skills and knowledge gaps in the workforce. This could be done at an organisation, team, role or individual level.

This matrix can then be used to develop effective bespoke learning programmes to support those involved in the coordinating care activities.

Organisation:

Name:

Date:

Function	Identified learning need	Activity to support learning	Comment
Communication			
Build strong relationships with people who access care and support			
Work with families and carers closely to ensure good communication			
Check understanding with all parties			
Respond in a timely manner in all communication verbal and written			
Administrative work to ensure continuity, good communication and quality assurance			

Follow up to make sure referrals have happened			
Support communication between all people, relatives and organisations			
Act as a negotiator to resolve conflicts between people, relatives, carers and organisations			
Demonstrate professional assertiveness appropriately and sensitively			
Support self-care using motivational interviewing			
Activities that support people			
Conduct an initial assessment of needs in partnership with people who access care and support			
Work with people to produce plans together to best meet their needs			
Support people to choose where they receive their care and support based on what is important to them and best suits their needs			
Negotiate with and between organisations to ensure the best approach for people			
Support people to meet the outcomes that are important to them and to manage the different elements of their care plan, including coordinating medication			
Review and adapt individual care plans as and when needed			

Encourage and develop self-care work with people, maximizing independence			
Reflect on and evaluate the experiences of people accessing care and support and community facilities			
Act as an advocate for people within and between organisations			
Promote the legal rights of choice for people who access care and support			
Help access local organisations (statutory, independent, private and voluntary)			
Support people as part of the hospital discharge team			
Support in planning and managing a personal budget or personal health budget			
Support people to attend appointments including help to transport between services and organisations			
Information management			
Actively coordinate the flow of information between people and organisations			
Take and make referrals to/from other local organisations (statutory, independent, private and voluntary)			
Signpost people accessing your service to other local organisations			

Complete accurate, timely and objective recording			
Spend time keeping knowledge of health and social care policy, legislation and local initiatives up to date			
Book and manage appointments for people, with their agreement			
Maintain a database of local services (statutory, independent, private and voluntary) to support people in their choice of provider (community mapping)			
Build strategic networks to share and access information			
Business management activities			
Ensure effective use of resources for your organisation and others in your area			
Audit and reflect on the service you provide to evidence impact			
Investigate and evaluate experiences of people who access care and support and act on findings			
Help shape the services and groups to reflect the needs of the local population			
Local knowledge exchange activities			
Support colleagues to understand the range of local organisations and what they offer			

Support the various roles in a multi-disciplinary team including people accessing care and support			
Act as a catalyst or starting point for integrated care			
Work to avoid duplication of service provision, regardless of sector			
Proactively act as a link and build networks and other local agencies and groups			

Skills for Care
West Gate
6 Grace Street
Leeds
LS1 2RP

T: 0113 245 1716
E: info@skillsforcare.org.uk

skillsforcare.org.uk