NHS
Health Education England

BIRMINGHAM CITY University

Making sense of

Coordinated Care

Introduction

Improving coordinated care is important to stakeholders at multiple levels within health and social care systems, for example policymakers who aim to provide care efficiently to populations of patients, clinicians who aim to deliver high-quality, high-value care to individuals, and ultimately patients themselves and their families who experience the benefits or shortfalls of coordination and often play an active role in coordinating their own care, whether by choice or out of necessity.

The need to improve and develop coordinated care was highlighted in the Five Year Forward View and the GP Forward View. Coordinated care is considered a vital mechanism in supporting improved integrated care and the drive to integrate social care and health services, has resulted in a growing number of roles that need coordinated care competencies.

As coordinated care gains more significance, it's essential to continue to take meaningful strides forward to further develop and guide this growing aspect of the workforce. Structured sharing of knowledge and best practice is now essential to help people adopt new coordinated care-based roles to make the best use of the available resources.

During the past two years, HEE has worked to identify and develop the concept of coordinated care. This has clarified definitions and established connections between key coordination roles across the health and social care field. As our understanding of coordinated care continues to evolve, building on the important work already completed can help guide the iterative process of developing a coordinated care workforce that has the right skills and values and is ultimately able to improve the quality of care given to patients.

A key concept of this guide is an attempt to move away from focusing on one specific role and towards focusing on the overall competencies required for coordinating care roles. Roles developed in isolation are difficult to sustain and determining a career pathway might be challenging for people.

However, focusing on the core competencies of coordinating care can help promote standardisation and recognition of people providing coordinated care and yield opportunities for people from many backgrounds and in various roles.

This guide presents the latest insight and infomation on coordinated care. Each section is designed to be a standalone summary of a key aspect of coordinating care. If you are completely new to coordinating care, you might want to read all of this. We hope you find this resource beneficial.

If you have suggestions for new sections, please email Tom Lawrence: Thomas.lawrence2@bcu.ac.uk

What does this guide offer?

Coordinated care means different things to different people and, as such, there is no consensus regarding its definition. This is due to multiple definitions already existing with differing focuses.

Therefore, HEE West Midlands have developed a model comprising not a specific role but a common set of competencies describing the functions of coordinated care. The model is not intended for any single occupational group; its aim is to capture the principles across all professions and staff level.

The purpose of this document is, therefore, to describe a fundamental, standard set of competencies for coordinated care.
These competencies act as the overarching guide defining the key principles of coordinated care.

These core competencies are brought together across four principal areas:

- **Communication**
- **Relationships**
- **People centred care**
- **Continuous learning**

The list of competencies in this guide can help you write a job description and job advert, inform the interviewing and selection process, and identify learning and development needs of staff who are responsible for coordinating care.

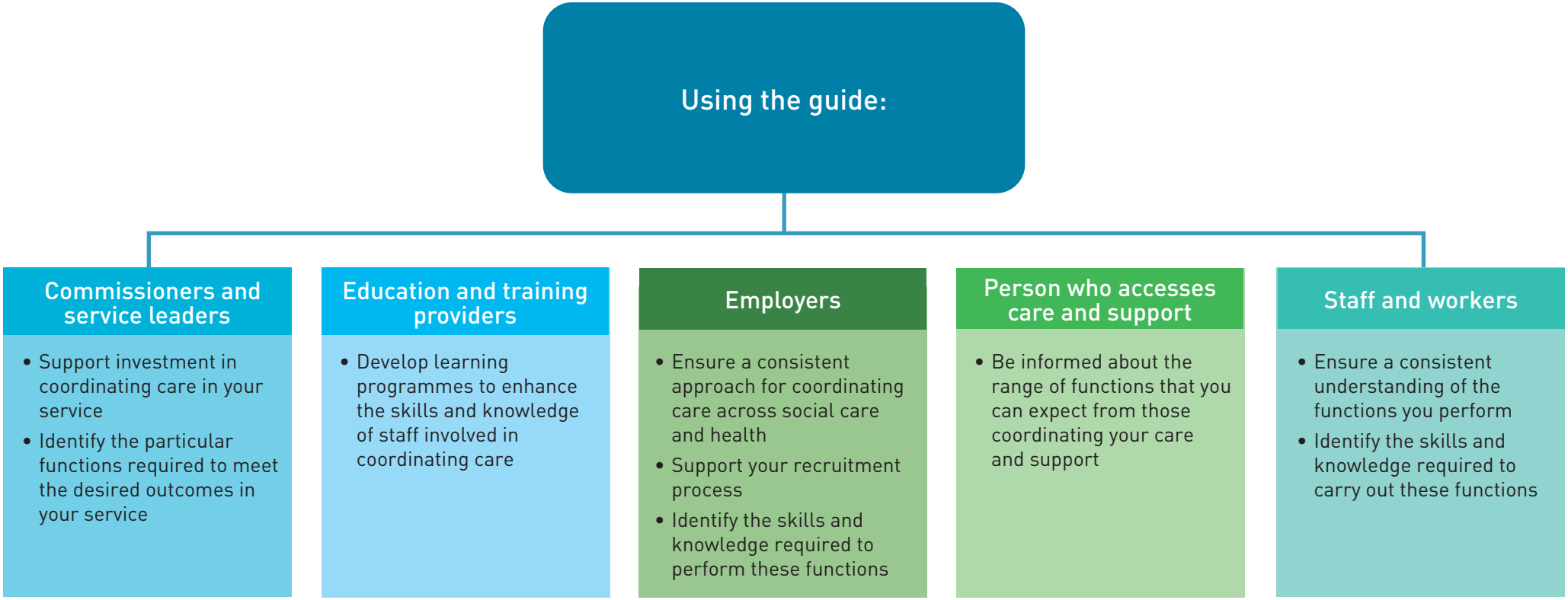
The guide provides a 'menu type' approach so that you can select the competencies that are required for your particular local service, allowing unique roles to be formed according to need.

Although each role might be bespoke, this model supports a consistent approach to reaching an agreement regarding what coordinating care entails across social care and health, regardless of what the role might be.

It can also help you identify, plan, and access the suitable knowledge sources and develop material for training staff responsible for coordinating care.

How can this guide help me?

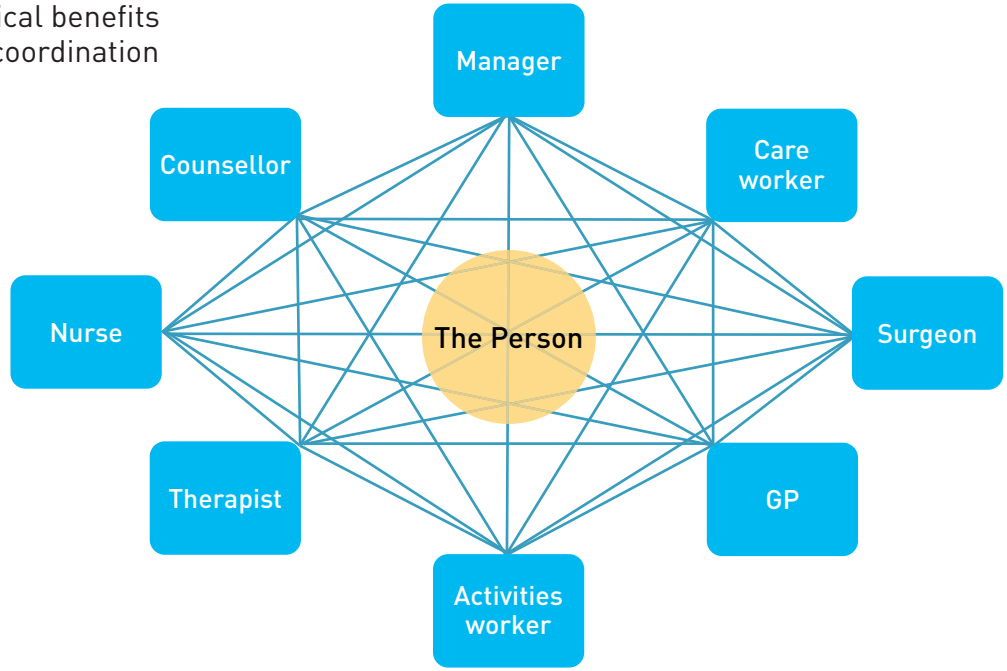
This guide and the model serve to assist numerous groups in several ways:



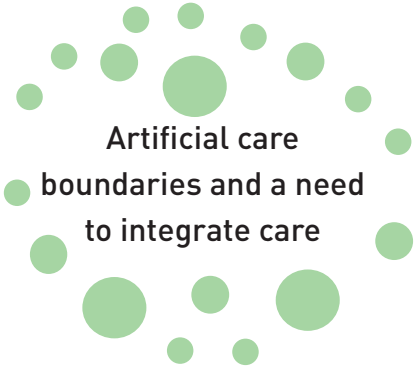
What is coordinated care?

The ability to successfully coordinate care has been identified nationally and internationally as a key strategy that can potentially improve the effectiveness, safety, and efficiency of health and social care systems.

Navigating the health and social care system, that is, finding the way to the right place, the right person and at the right time is a challenge. As illustrated in the accompanying diagram there are innumerable pathways a person could choose.
Current care systems can be disjointed, and processes vary among and between primary care sites and speciality sites.
It is essential for staff to help coordinate a patient's journey and ensure that they obtain the appropriate services across the health and social care spectrum.
Well-designed, targeted coordinated care delivered to the right people can improve outcomes for everyone including: patients, providers, and staff. However, there is a lack of clarity and confusion along the lines of "who, what and where" when developing coordinated care roles, and though no single model of coordinated care is universally applicable across patient populations, research has found economic and clinical benefits associated with various coordination interventions.



Strategic importance of coordinated care



A key function needed to solve these problems is coordinated care

Coordinated care roles are:

- Specialist

or

- Generic

There are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, and between generalists and specialists all of which can hinder care that is genuinely coordinated with respect to what people need and want.

To achieve a better functioning health and social care system, coordinated care is required. Organisations that have systems and roles designed to help improve coordinated care are likely to be more consistent.

Each of these roles seeks to reduce fragmentation and improve health care delivery through better coordinated care which is fundamental to them.

Specialist roles

- Care coordinator
- Care assessor
- Discharge coordinator
- Domiciliary care coordinator
- Local area coordinators
- Care navigators
- Wellbeing adviser
- Dementia adviser or navigator
- Case manager

Generic roles

- Social workers
- Registered managers
- Care assessors
- Care and support workers
- Link workers
- Support workers
- GP receptionists
- Customer support
- Nursing staff
- Occupational therapists

Benefits of coordinating care roles

The key benefit of coordinating care is that people 'see the right person, the first time' without having to repeat their story or having to be referred on time and again, wasting time and resource for all and risking deterioration in their wellbeing.

As a commissioner of services, why should I use coordinated care roles?

- Offer effective collabroative 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

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

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

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

- Enhance your job role to include an extensive range of functions
- Make your job more interesting and satisfying
- Help you perform your role more confidently
- Improve your career prospects

What can a robust coordinating care approach do for individuals using the health and care system?

- Ensure they are more informed
- Reduce confusion and improve understanding of the system
- Provide improved choice and control over how their care and support needs are met
- Ensure they only have to tell their story once
- Enhance their care at 'home'
- Help them better understand and link with local organisations
- Give them better use of facilities across a range of statutory and independent services and so greater choice
- Increase their autonomy
- Provide them a faster and better-quality service with continuity

What is the purpose of this model?

This model acts as a guide to ensure that the fundamental elements of coordinated care are considered and implemented effectively. It is recognised that without agreement on the core competencies, it is impossible to achieve consistency and excellence in the delivery of coordinated care.

The model presents the key competencies, skills, and behaviours required for an individual to be able to perform the primary functions of coordinated care.

These four core elements (see picture) are mutually reinforcing: good relationships promote good communication which fosters a person-centred focus and so on, forming a virtuous cycle.

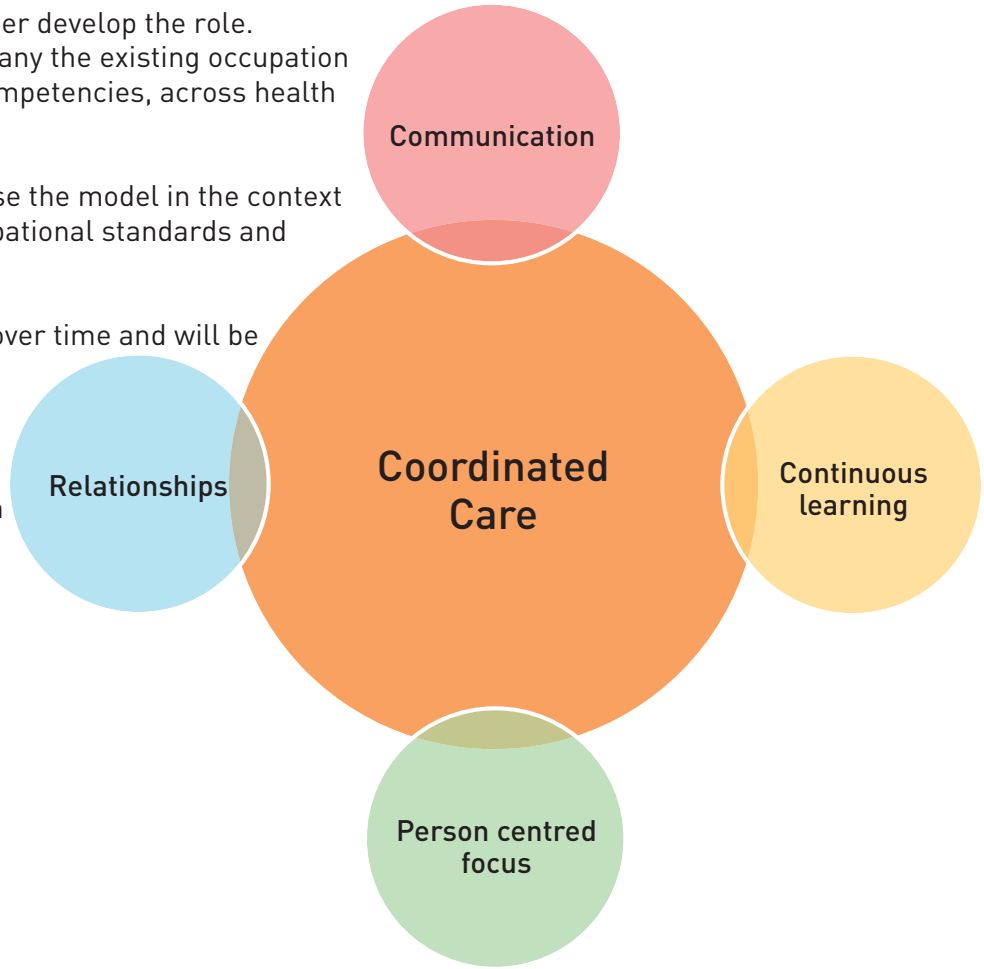
However, the reverse is also true: poor relationships hinder communication which creates tensions that further impair relationships and so on, forming a vicious cycle.

Improving awareness regarding the key competencies of coordinated care roles will improve the visibility of the role, improve consistency, help improve training, and further develop the role. The competencies accompany the existing occupation and profession-specific competencies, across health and social care systems.

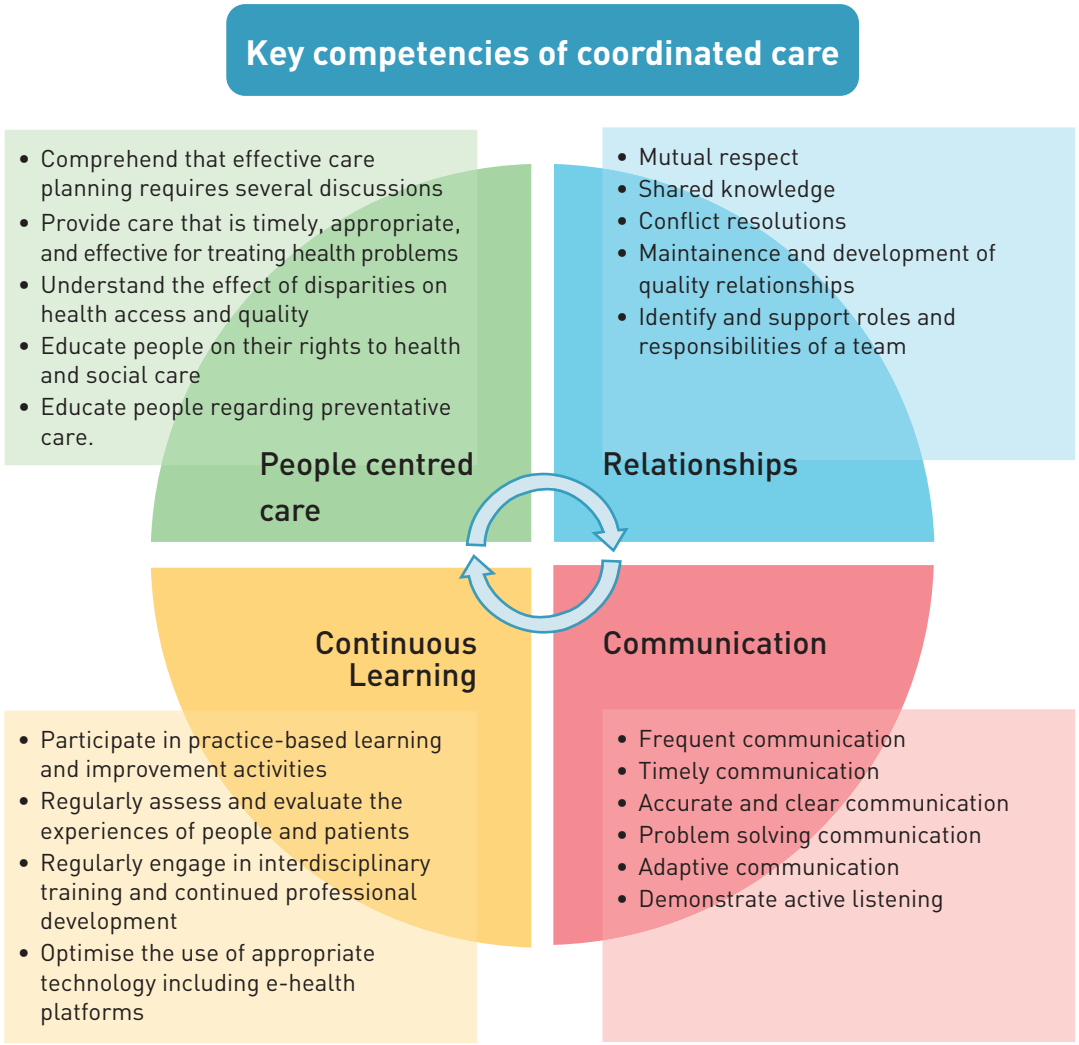
All organisations should use the model in the context of their own relevant occupational standards and requirements.

The model will be refined over time and will be responsive to changes in practice and to newly developing job roles.

Additionally it must remain open to continued shaping by the people who use it.



The model


Key competencies of coordinated care
• Comprehend that effective care planning requires several discussions
• Provide care that is timely, appropriate, and effective for treating health problems
• Understand the effect of disparities on health access and quality
• Educate people on their rights to health and social care
• Educate people regarding preventative care.
People centred care
• Mutual respect
• Shared knowledge
• Conflict resolutions
• Maintainence and development of quality relationships
• Identify and support roles and responsibilities of a team
Relationships
Continuous Learning
• Participate in practice-based learning and improvement activities
• Regularly assess and evaluate the experiences of people and patients
• Regularly engage in interdisciplinary training and continued professional development
• Optimise the use of appropriate technology including e-health platforms
Communication
• Frequent communication
• Timely communication
• Accurate and clear communication
• Problem solving communication
• Adaptive communication
• Demonstrate active listening

Communication

This describes the ability to quickly establish rapport with service users and their family members in an empathetic and sensitive manner incorporating their perceived and declared culture.
Share knowledge among participants in a person's care. Communication might occur through a wide variety of channels.

Four overarching themes:

- **Frequent communication:**
  Frequent communication helps build relationships through the familiarity that develops from repeated interaction.
- **Timely communication:**
  Communication can be frequent and still be of poor quality. For instance, it can lack timeliness. In coordinating highly interdepependent work, timing can be critical.
- **Accurate communication:**
  The effective coordination of work depends not only on frequent and timely communication but also on accurate communication.
- **Problem-solving communication:**
  Task interdependencies often result in problems that require collaborative problem solving. Hence, effective coordination requires that all participants engage in problem solving.

Interpersonal communication
This refers to the exchange of ideas, preferences, goals, and experiences through personal interactions. Examples include face-to-face interactions, telephone conversations, email, and letters.

Information Transfer
This refers to the flow of information such as medical history, medication lists, test results, and other data, from one participant in a patient's care to another. It includes clear and simple information that patients can understand.

Teamwork focused on Coordination
It is the integration among separate care entities participating in a particular person's care (health care professionals, care teams, or other care organisations) into a cohesive and functioning whole capable of addressing the person's needs.

Handling data and information
Accurate and accessible information and data underpins effective care navigation. Failures in communication between organisations, sectors, and patients/carers can lead to disjointed and poor care. Individuals who work to provide effective care navigation need to be able to appropriately use relevant electronic records and databases to access, input, store, and retrieve information. Data is also important for service evaluation improvement.

Link to community resources
Information should be provided on the availability of services, with additional resources available in the community that might help support health and wellness or meet care goals. Community resources are any service or program outside the care system that may support a person's health and wellness.

Continuous learning

Continuous improvement involves employees constantly questioning and evaluating the current state of work to improve it for the future state. Specifically, this is the ability to demonstrate reflective practice, based on the best available evidence, and to assess and continually improve the services delivered as an individual provider and as a member of an interprofessional team.

- Participate in practice-based learning and improvement activities that involve investigation and evaluation of patient experiences, evidence and resources.
- Apply new technique and information/knowledge to practical use on the job.
- Regularly engage in interdisciplinary training for staff.
- Regularly engage in continuing professional development.
- Implement and routinely monitor patient safety standards.
- Identify evidence to inform practice and integrated care.

People who are in care navigation roles learn significantly through experience and working within local contexts – therefore, reflection on practice, as an individual and as teams is crucial for personal as well as service development.

Professionalism

This is rooted in the ethical, moral, and legal aspects of care and support, grounded in the principles of person-centred care. Commitment to develop expertise, self-awareness, limitations of scope of practice, and working with integrity are some important features.

IT-enabled health coordination

This involes tools such as electronic medical records, patient portals, or databases, to communicate information about patients and their care between health care entities (health care professionals, care teams, or health care organisations) or to maintain information over time.

People centred care

People-centred care is the approach of thinking and doing things that considers the people using health and social services as equal partners in planning, developing and monitoring care to make sure their needs and demands are met. This means putting people and their families at the centre of decisions and considering them experts, working alongside professionals to achieve the best outcomes. Person-centred care is about considering people's desires, values, family situations, social circumstances, and lifestyles, seeing the person as an individual, and working together to develop appropriate solutions.

Key components:

- Comprehending that effective care planning requires several discussions
- Taking into account people's preferences and expressed needs
- Emotional support involving family and friends
- Providing care that is timely, appropriate, and effective for treating health problems.

Medication management

This involves reconciling discrepancies in medication use in order to avoid adverse drug events associated with transitions in care. This can involve a review of the patient's complete medication regime at the time of admission/transfer/discharge, including assessing the use of over-the-counter medications and supplements, comparison across information sources and settings, or direct communication between patients and providers.

Aligning resources with patient and population needs

This refers to, within the care setting, assessing the needs of patients and populations, and accordingly allocating health care resources. At the population level, this includes developing system-level approaches to meet the needs of particular patient populations. At the personal level, it includes assessing the needs of individuals to determine whether they might benefit from the system-level approach.

Assessing needs and goal

This involves determinining the person's needs for care and for coordination, including physical, emotional, and psychological health, functional status, current health and health history, self-management knowledge and behaviors, current treatment recommendations, (including prescribed medications), and need for support services.

Experiences of people who access care and support are investigated and evaluated and the findings are acted upon. This helps shape the services and groups to reflect on the needs of the local population.

Relationships

The relationship with the patient is the most important role in the application of coordinating care. Relationships with clinical team members are critical for care coordinators but also important are the relationships that they develop with people outside the practice who might be caring for
their patients. The spread of relationship-centred care coordination has resulted from the need to develop and nurture these relationships. Improving relationship competencies will enable staff to strengthen the safety and improve the care for their patients. If effective coordination is to occur, participants must be connected by relationships of shared goals and mutual respect.

Establish accountability or negotiate responsibility

- Clarify the responsibility of participants in a patient's care for a particular aspect of that care.
- The accountable entity (a health care professional, care team, or social care organisation) will be expected to answer for failures in the aspect(s) of care for which it is accountable.
- Specify who is primarily responsible for key care and coordination activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants.

Facilitate transitions

Facilitate specific transitions, which occur when information about or accountability for some aspect of a person's care is transferred between two or more care entities or is maintained over time by one entity. Facilitation might, be achieved through activities designed to ensure timely and complete transmission of information or accountability.

Create a proactive plan of care

Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team, which outlines their current and longstanding needs and goals for care and/or identifies coordination gaps.
The plan is designed to fill gaps in coordination, establish personal goals for care and, in some cases, set goals for providers. Ideally, the care plan anticipates routine needs and tracks current progress toward personal goals.

Monitor, follow up, and respond to change

Collaborate with the patient/family to assess progress towards care and coordination goals. Monitor for successes and failures in care and coordination. Refine the care plan as required to accommodate new information or circumstances and to address any failures. Provide necessary follow-up care.

Support self-management goals

Tailor education and support to align with a person's capacity for and preferences about involvement in their own care. Education and support include information, training or coaching provided to people or their informal caregivers to promote their understanding of and ability to carry out self-care tasks, including support for navigating their care transitions, self-efficacy, and behavior change.

Building and sustaining professional relationships

Collaborate with the patient/family to assess progress toward care and coordination goals. Monitor for successes and failures in care and coordination. Refine the care plan as required to accommodate new information or circumstances and to address any failures. Provide necessary follow-up care.

Using the model

This section now outlines the examples of how the model can help realise the benefits of care coordination when used by:

- Education and training providers
- Commissioners and service leaders
- Staff and workers
- Employers

At the end of the document, there are useful signposts leading to further notable work that has been undertaken to develop relevant competences, pathways, and frameworks.

The model is consistent with a wide range of policies and initiatives in health and social care, e.g. The Five Year Forward View, The GP Forward View, Framework 15 and the implementation of the new models of care.

This means that using the shared core principles to support workforce development and entire system reforms will bring added benefits by contributing to other policy initiatives.

Using the model: education and training

Education and training providers can use these principles as a checklist for curriculum design and delivery to ensure that the workforce has the required skills and attitudes to work effectively.

To secure maximum benefits, the principles can be used to:

- Provide education and training that is in harmony with the values and philosophy of local employers.
- Promote such educational packages to both local employers and commissioners.
- Develop training and assessment courses in partnership with service users to ensure that training delivers what is really wanted 'on the ground'.
- Provide a standard core model for induction courses to raise knowledge and skill levels and to promote opportunities for career progression.

Using the model: Commissioners and service leaders

Service leaders will find this model helpful when developing services and practice, in ensuring effective workforce planning and development which is integral to their activities.

It will be valuable in creating job descriptions and defining new roles. It might also be a useful tool for redesigning services which already provide care coordination

To secure maximum benefits, you can use the model to:

- Support new ways of working which enables high quality care coordination.
- Design roles and job descriptions that centre on service user needs.
- Improve staff delivery of quality and safe care.
- Formulate appraisal tools and identify individual and team training needs.
- Inform supervision models.

Using the model: staff and workers

For all workers, this model provides the basic values and beliefs that will support their common purpose of delivering truly coordinated services. Workers can use the model to support their continuing personal/professional development. This will help them improve their awareness of the skills their team needs in order to build trusting relationships within new working environments and also with service users.

To secure maximum benefits, you can:

- Ensure that a thorough understanding of the rationale and benefits of the principles are built into personal objectives.
- Discuss the principles with supervisors and/or line managers to ensure a shared understanding of the implications for job roles and working practice.
- Self evaluate, plan and undertake training on the principles.
- Promote the principles among colleagues.
- Challenge practice which is not consistent with the principles.
- Recognise how the core principles can improve job satisfaction by clearly meeting service user needs via effective coordinated care.

Using the model: employers

These shared core principles and functions form a common ground and are central to health and social care providers to deliver personalised services. They can contribute to reducing costs of avoidable admissions through earlier identification and intervention and by supporting options for care closer to home. They can help contribute to key targets e.g. for promoting independence, choice, and self-care for people, many of whom have long - term conditions.

To secure maximum benefits, you can use the principles to:

- Show how they reflect the values and priorities of the organisation.
- Monitor individual, team, and service performance against the principles.
- Help recruit and develop staff with requisite knowledge, skills, and attitudes.
- Shape appraisal and supervision frameworks.
- Embed and highlight the principles in governance frameworks, policy documents, and corporate objectives.
- Show staff how adherence to the principles will help achieve service targets.

Checklist for developing a coordinated care service

We hope this guide will support you in developing care coordination across health and social care services.

Common to all coordinated care roles are the key competencies referred to on page 9 of this document. This section highlights aspects to consider when setting up a coordinated care role to give the position the best chance of success.

Are you clear about the coordinated care service you are developing?

- 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 care coordination functions that can be amended to accommodate your requirements.
- Target specific conditions or populations - how are you identifying the people that the coordinated care scheme is aimed at?
- Do you know the type of coordinated care role you want to develop? It might be worthwhile to map out your idea of the role.

Effective partnerships

- A necessary first step is to take stock of what is already in place and then identify gaps and develop a partnership action plan.
- Have you set up a steering group involving all stakeholders who will be involved in the role? The earlier the different stakeholders can come together and work in partnership, the better the chance of success for the coordinated care scheme.

Strategic fit

- There are many initiatives to improve how services in different sectors can be more effectively integrated. How are you ensuring that the role links with the local integration agenda?
- There needs to be a real commitment across the system, particularly from budget holders, managers, and leaders to ensure, the function is effective.
- Managers need to understand exactly what they're asking from the role and 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.

Appropriate and reliable resourcing

Coordinated care roles vary between organisations, which is why they offer a truly local and personalised support. Ensuring that the appropriate amount of resource is available to sustain a successful coordinated care role is critical.

Training and continuous development?

When determining the appropriate methods of training and delivery, the following will need to be considered:

- Target coordinated care modules and courses.
- Seek out best practice nationally and internationally.
- Develop and seek out local case studies.
- Action learning groups, an online forum and other networking events.
- Learn from and with patients and carers.

Further reading

Birmingham City University:
www.bcu.ac.uk/health

Coordinating Care Online Resource
www.coordinatingcare.org

Health Education England, *Care Navigation Framework:*
www.hee.nhs.uk/hee-your-area/north-central-east-london/our-work/attracting-developing-our-workforce/multiprofessional-workforce/care-navigation-competency-framework

Health Education England, *Integrated Care Toolkit*:
https://learning.wm.hee.nhs.uk/node/898

Health Education England, *Strategic framework*
https://www.hee.nhs.uk/our-work/strategic-framework

NHS England Five Year Forward View:
https://www.england.nhs.uk/five-year-forward-view/

NHS England:
www.england.nhs.uk/gp/gpfv

Relational Coordination:
https://heller.brandeis.edu/relational-coordination/

University of Westminster, *Making sense of social prescribing*,
https://westminsterresearch.westminster.ac.uk/download/f3cf4b949511304f762bdec13784425103107269 7ae511a462eac9150d6ba8e0/1340196/Making-sense-of-social-prescribing%202017.pdf

World Health Organisation: *Strengthening a competent health workforce for the provision of coordinated/ integrated health services*:
http://www.euro.who.int/__data/assets/pdf_file/0010/288253/HWF-Competencies-Paper-160915-final.pdf

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