COORDINATED CARE: OUR FORWARD VIEW

Introduction

There is a lack of clarity and confusion as to "who, what and where" when developing coordinated care roles.

Coordinated Care interventions are particularly attractive in that they have the potential to improve both efficiency and quality.

While we might know that coordinated care is better for individuals, we don't know the key competencies required and what training is needed.

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 (Peikes et al., 2009).

Coordinated care is a key function to achieving integrated care and an important part of multiple roles across health and social care. It was therefore important to develop:

- Consensus around the key coordinated care competencies.
- Resources to promote and support coordinated care.

We did this by:

- Identifying best practice – locally, nationally and internationally.
- Consultation events: 26th January 2016, 11th February 2016 and 22nd March 2016.
- Creating a coordinated care model.
- Identifying four test sites to understand if the model was fit for purpose.

Introduction

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

This is why HEE West Midlands have developed a model not for a specific role but instead a common set of competencies for the function of coordinated care.

The model is not intended for any single occupational group; its aim is to capture the principles that cross all professions and staff levels and that consequently provide a common model for all staff groups.

The model is intended to be adapted and used to develop the coordinated care function in all roles.

The purpose of this document is to describe a fundamental, common set of competencies for coordinated care. These competencies acts as an overarching guide to the key principles of coordinated care.

These core competencies are brought together across four principal areas:

- Communication
- Relationships
- People Centered
- Continuous Learning

This framework may be used by employers, education providers and individuals to inform education and training needs.

Introduction:

Most importantly, the principles and competencies presented echo what the people who use services have consistently told us about their expectations and their needs for better coordinated care.

Structure:

The 4 shared core functions are outlined in this document (page 6) but it is expected that individual teams will use these as a guide to develop their own specific competencies.

There are clear messages about how the model can be adopted at different levels across health and social care by those with responsibility for designing and developing an efficient and coordinated workforce e.g. colleagues from human resources, commissioners, managers, workforce leads, workers and education providers.

Purpose of the model

The model (page 6) shows the core competencies that have been agreed locally as an essential requirement of all individuals who undertake a role that has coordinated care as a key function.

HEE recognised that without agreement on core competencies, it is impossible to begin creating consistency and excellence in the delivery of coordinated care.

The competencies sit alongside the occupation and profession-specific competencies, which already exist for many workers across health and social care.

Expectations around the four core competency areas will vary according to a particular role and the context of activity.

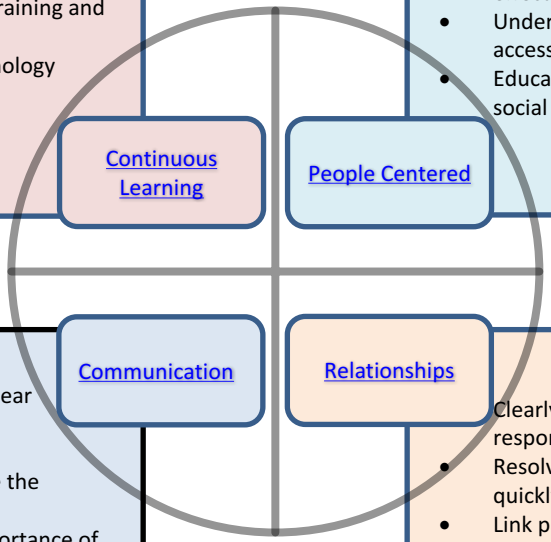
It is important to note that the competencies described in this document lay out a common foundation for potential application to all workers across the West Midlands.

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

The range of contexts in which workers need to be competent, and the level of skill they need to demonstrate, will always depend upon their degree of involvement in services and the level at which they would normally be expected to perform.

The model will be refined over time and be responsive to changes in practice and to newly developing job roles. In addition, it must remain open to continued shaping by the people who use it.

The Model



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 continuing professional development
- Optimise the use of appropriate technology including e-health platforms

People Centered

- 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

Communication

- Communicate care plan options in a clear manner
- Demonstrate active listening
- Adapt style of communication to suite the differing needs of people
- Demonstrate and understand the importance of cultural factors
- Ensure the flow and exchange of information among the patients and family members.

Relationships

- Clearly identify and support roles and responsibilities of all team members.
- Resolve differences of opinion or conflicts quickly
- Link patients and family members with needed resources
- Maintain and develop quality relationships
- Support people in considering and accessing complementary services.

Communication:

Ability to quickly establish rapport with patients and their family members in an empathetic and sensitive manner incorporating the patients' perceived and declared culture

Four overarching themes:

Frequent communication: Frequent communication helps to build relationships through the familiarity that grows from repeated interaction.

Timely communication: Communication can be frequent and still be of poor quality. For one thing, it can lack timeliness. In coordinating highly interdependent 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 joint problem solving. Hence, effective coordination requires that participants engage in problem solving.

Communication:

Further themes:

- Demonstrate active listening
- Communicate care plan options to people in a clear manner: Be able to communicate effectively with individuals and significant others and balance the information they provide about their own needs with the other information gained during the assessment.
- Adapt the style of communication that most appropriately takes into account the differing needs of people.
- Ensure the flow and exchange of information among the patient, family members.
- Provide health education that is appropriate to the communication style and literacy of the Local Health Economy
- Demonstrate and understand the importance of cultural factors.

Continuous Learning :

Continuous improvement has employees constantly questioning and evaluating the current state of work to improve the future state. Specifically, 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 technical 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.

Continuous Learning :

- Participate in and conduct research where possible, emphasising need for focus on patient experiences.
- Contribute to practice-based learning and improvement activities in a way that mobilises evidence and research as much as end-user experiences.
- Optimise the use of appropriate technology including e-health platforms which enables measurement and management of individual clinician, practice and system-wide performance on clinical processes and outcomes, e-prescription and electronic medication management, electronic health records, computer and web-based screening, assessment, and intervention tools, tele-health applications.
- Show interest and pursue appropriate learning activities that fulfill self-development/learning needs

People Centred:

People-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs and demands. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get 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

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

People Centred Care:

Key Components continued:

- Advocate for the incorporation of patient outcomes into organisational strategies with a special focus on vulnerable populations.
- Making sure there is continuity between and within services
- Understand the effect of disparities on health care access and quality.
- Making sure people have access to appropriate care when they need it
- Educate people on their right to health care and their benefits
- Respecting people's values and putting people at the centre of care

Relationships:

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

Three overarching themes for improving relationships: **Shared goals/ Shared knowledge/ Mutual respect**

Key components:

- Clearly identify and support roles and responsibilities of all team members, including patients.
- Resolve differences of opinion or conflicts quickly and without acrimony.
- Listen to opinions

Relationships:

Key components (continued):

- Builds a strong network of relationships that can survive a change of direction, reporting lines or personalities
- Develops external relationships that enhance their knowledge and bring best practice into the organisation.
- Link patients and family members (if appropriate) with needed resources
- Support people in considering and accessing complementary and alternative services
- Promote diversity among the providers working in inter-professional teams
- Developing rapport with staff and patients.
- Maintain and develop quality relationships by developing and maintaining relationships that inspire trust and respect. Building a network and being able to influence others to make things happen.

Using the model: Staff and Workers

For all workers, this model provides the basis of the 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 to improve their awareness of the skills their team needs 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 to 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 coordinated care

Using the model

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

- Education and training providers
- Service leaders and managers
- Staff and workers
- Employers

At the end of the document there are useful signposts 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 whole system reforms will bring added benefits by contributing to other policy initiatives.

Using the model: Service Managers and Leaders

Service managers will find this model helpful when developing services and practice, in ensuring that workforce planning and development is integral to their activities. It will be valuable in creating job descriptions and defining new roles. It may also be a useful tool for redesigning those 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: 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 functions 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: Employers

These shared core principles and functions form a common ground and are central to health and social care providers' ability to deliver personalised services. They can contribute to reducing costs of avoidable admissions through earlier identification and interventions 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.

Further Information: Future needs and recommendations

Four test sites were developed to understand if the care coordination model was fit for purpose. The four sites were chosen for their diversity in care coordination activities. The sites vary in their scope and stages of implementation, from early changes to initiatives at-scale. When taken together, these examples offer an insight into the effectiveness of the coordinated care model.

- A need to scale up and implement the Coordinated Care Model across the West Midlands. It is clear organisations are employing multiple people in care coordination type roles.
- Promote the model across social and health organisations within the West Midlands.
- Publish the model on-line so it is easily accessible to all organisations.
- A need to establish training across the West Midlands. Examples of training could include: Bite size learning, a knowledge bank and case studies.
- Develop a network to improve the engagement of coordinators from different organisations.

Further Information: Signposting

Health Education England: www.hee.nhs.uk

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

World Health Organisation: www.who.int/euro

NHS England: www.england.nhs.uk

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

Further Information: Request for further information

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