HEE Coordinated Care Model: Report on four test sites from across the West Midlands

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Abstract

Four test sites were developed to understand if the coordinated care model was fit for purpose. The four sites were chosen for their diversity in coordinated care 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 summary of lessons learned attempts to synthesise key findings and consolidate insights derived from the experiences of the four test sites.

Keywords

Coordinated Care

Care coordination

Delivery of health care

Integrated health services

Health care systems

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About this document

There is a lack of clarity and confusion as to "who, what and where" when developing coordinated care competencies across the West Midlands. While we might know that coordinated care is better for individuals, we don't know the key competencies needed for the multiple roles that include coordinated care. Indeed, given the multifaceted nature of health and social care delivery, the possible actions and approaches for delivering coordinated care are numerous and ultimately, the specific mix of strategies employed varies by the context and desired goals of each organisation.

Coordinated care is a key function to achieving integrated care and an important part of multiple roles across health and social care. The "Coordinated Care: Our Forward View" model has been produced by HEE (West Midlands) to help and develop:

- Consensus around functions and competencies
- Resources to promote and support care coordination
- Create opportunities and support career progression

The model was produced after extensive consultation with key stakeholders locally, nationally and internationally. HEE hosted three coordinated care workshops across the West Midlands including a specific workshop to understand the needs of service users and patients. 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.

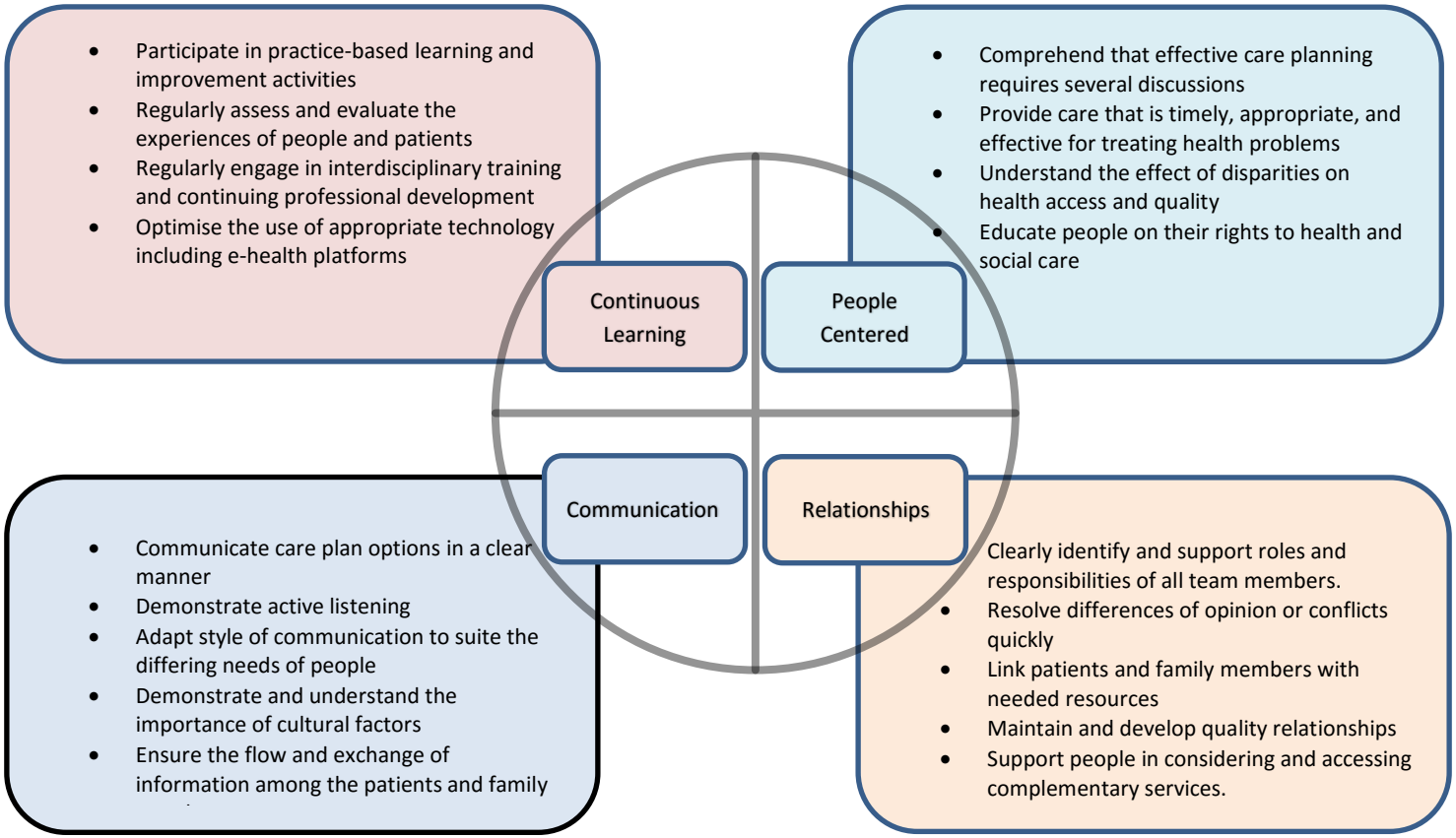
It was agreed there was a need to rigorously test the model to make sure the it's fit for purpose. It was decided to test the model with organisations who are currently using coordinated care roles to understand its usefulness and provide examples on how other organisations across the West Midlands can use the model in future development.

The testing took place in the form of four case studies, each of the studies had specific needs and unique circumstances and offered a differing way of testing out the usefulness of the model.

This document aims to bring together the different experiences of organisations, taking a snapshot across activities and attempting to draw overarching lessons. The findings will ultimately inform approaches to supporting integrated care transformation across the West Midlands.

The Coordinated Care Model

Please see below the coordinated care model that is referenced throughout the report.



The Test Sites

The following four tests sites were used:

Birmingham Community Healthcare NHS Foundation Trust:

- Focus Group with: 3 x Non clinical case managers.
- Survey of 16 clinical case managers currently working in a coordinated care roles.
- Policy review of current coordinated care policy.
- Meetings and discussions with organisational leaders.

Gateway Family Services: Wellbeing Coordinator Provider:

- Focus group with two of the three Practice Navigators (Care Coordinators) and their Coordinator and Manager.
- Meetings and discussions with Chief Executive

West Midlands Dementia Framework and Competency Framework for Transition for young people with learning disabilities:

- Discussions with two organisations drafting frameworks where coordinated care was a key componenet.

Coventry and Warwickshire Partnership:

- Policy review of current coordinated care policy
- Meetings and discussions with organisational leaders

Other organisations involved in discussions about the model include: *Virgin Care, Services for Independent Living, 2gether NHS Foundation Trust, Skills for Care, WHO (Euro), Worcestershire Health and Care NHS, Social Care Institute for Excellence, Better Care Birmingham, NHSE.*

Method

The framework below was developed to cultivate an understanding about the test sites and create a robust structure for analysis. Four methods were taken: a review of documents, semi structured interviews, focus groups and a survey. Being able to draw on all four sources allowed for a better understanding of the models usefulness than if all sources had been used alone. The overarching idea was to understand *"if the model worked, for whom and in what circumstances".*

While this document does not provide simple answers to a complex issue, it does provide policy makers with a rich, detailed and practical understanding of how the coordinated care model can be implemented regionally.

Method Framework

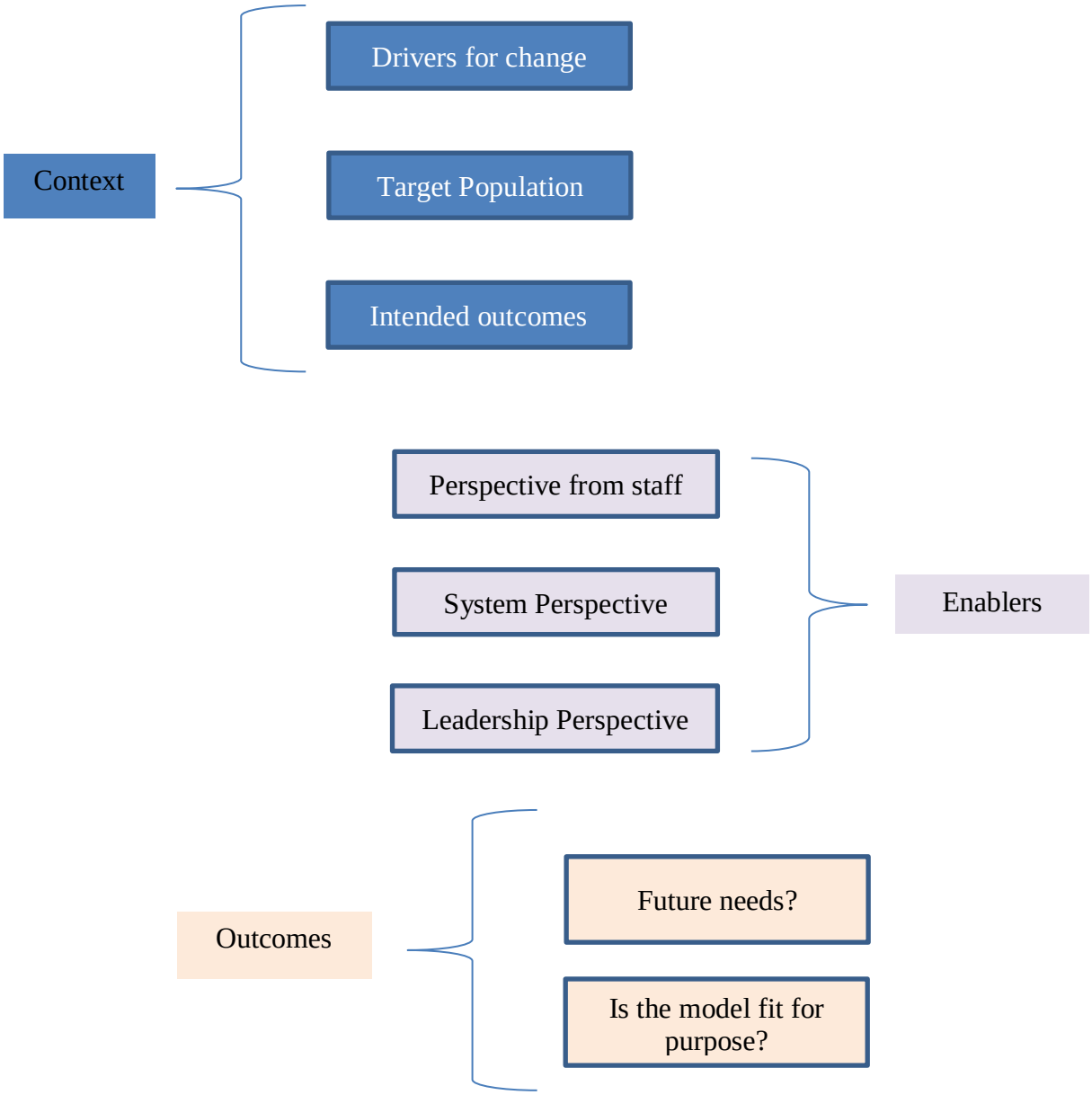
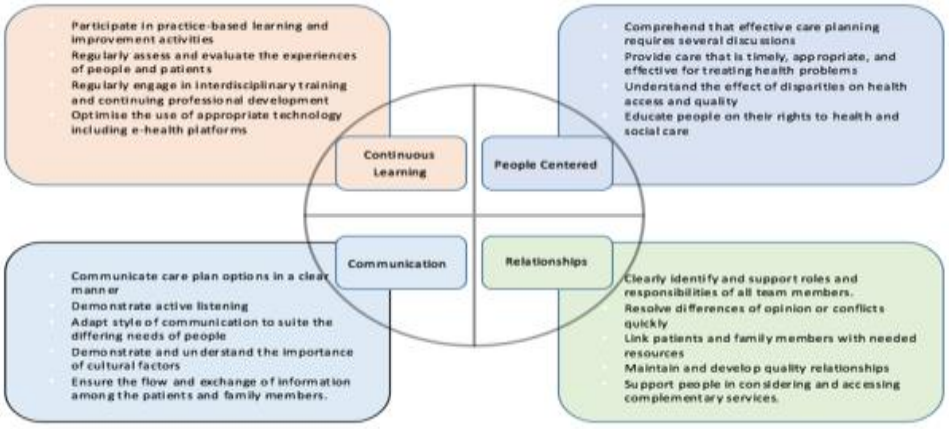


Diagram to explain the importance of Coordinated Care in the context of an integrated care agenda.

The problem:
There are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

A Key Function to solving the problem:
To achieve a better functioning health and social care system, coordinated care is needed. Organisations that have systems designed to help improve coordinate care will likely be more consistent in trying to coordinate care and in how they do it.

Key Competencies need for coordinated care:



Key coordinated care roles:
Each of these roles seeks to reduce fragmentation and improve health care delivery through better coordinated care. For each of these roles coordinated care is a fundamental function.

CARE CO-ORDINATOR

CARE NAVIGATOR

CASE MANAGER

PART OF A LARGER ROLE

Gateway Family Services

Context

Gateway Healthy Futures supports people with a broad range of social needs. GPs can refer anyone that needs non-medical help, so that includes people who have issues around housing, alcohol, finances, benefits, social isolation, and much more.

The Practice Navigators support people from the age of 18 upwards, working alongside other services and organisations across the city to provide patients with one-to-one tailored support.

Practice Navigators are skilled para-professionals who focus attention on a key group of patients who have an increased risk of attending GP appointments/A&E.

The Practice Navigator role is currently a pilot program with the hope extending the program outside of a pilot. Gateway currently have the Practice Navigators work across part time across the Birmingham area.

Gateway also have five active volunteers who offer support to Practice Navigators and a befriending service for people in isolation.

Feedback regarding the model from the focus group and conversations with senior management

Terminology - language is important and will differ from organisation to organisation. They use the term patient and feel it's appropriate.
The term Practice Navigator is confusing for the patient – especially with so many other similar roles a patient might come across.
Experience from learning from colleagues is key to the role
Overall the model is clear and shows the keys skills they use on a daily basis
Understanding the community is a key skill and being proactive with making links and understanding the local area, needs to come across more in the model.
Advocacy seen as a very important part of the role
Important to be able to react to situations and working in multiple areas
Job specification does not match actually the current work they are doing
There needs to be a clearer career structure

How the model was used and how will it be implemented in the future:

- Incorporate the model into the training they complete internally - specifically embedding the four key practices of the model and all training under each of the core competencies.

- The model will also be reflected in volunteer training

- They will use to the model to guide the creation of job descriptions

- Use the model to reflect and promote the importance of the role across the West Midlands

Coventry and Warwickshire Partnership: Integrated Neighborhood Teams (Care Navigators)

Context:

Known publically as Your Health at Home, the service is delivered by the Integrated Neighborhood Teams who work directly in the community to help frail elderly people become more independent and safer within their own homes and to ensure they are supported to live well in the community, managed at the level of care appropriate to their needs and reduce reliance on statutory agencies.

There are three deliver levels of service:

• Core Integrated Neighborhood Teams: for complex patients who need the support of a multi-disciplinary team. Teams incorporate a GP, Matron, Social Worker, CPN, OT, Physiotherapist, Administrator plus Care Navigator support

• Care Navigation – for less complex patients who need support from either statutory or voluntary services. The Care Navigator will understand their needs and support them to find the right service(s)

• Social Prescribing – for patients who could benefit new social activity or informal support e.g. gardening club, benefits advice, befriending services.

This service is provided by a third sector collaborative. It is based on a proactive case management approach with integrated working across all agencies. With a focus on joining up health, social care & public health.

How the model was used and how will it be implemented in the future:

- To help with evaluating the current care navigator role: The navigation role is in its infancy and needs guidance from a solid evidence base (i.e the Model).
- Help to develop job specifications: job specifications were previously based on what they thought would work. They will use the model to develop a clearer and more robust job specification.
- Similar roles across mental health and children's services are being developed – the model will be shared with these services to make sure a consistent approach is taken across the organisation.
- It was helpful for senior management to understand the role is being developed across the region and not just in Coventry and Warwickshire.
- Will be used as a go to guide for the enquires around care coordination soft skills.

Birmingham Community Healthcare NHS Foundation Trust:

Context

Care coordinators and the care coordination functions are an important way of working across several departments within BCHC, including:

- Non-Clinical Case Managers. Originally set-up in 2004 and under new management in 2007. The case managers are from Social Services / Housing background, well established and experienced
- Defense Medical Welfare Service (DMWS : third sector delivery partner for the Armed Forces Project. Providing primary care navigators to the Armed Forces Community in South Birmingham. Previously focused on delivering welfare support in an Acute Setting and closed environment. DMWS will benefit from an understanding of the wider role / function and competencies involved in community navigation.

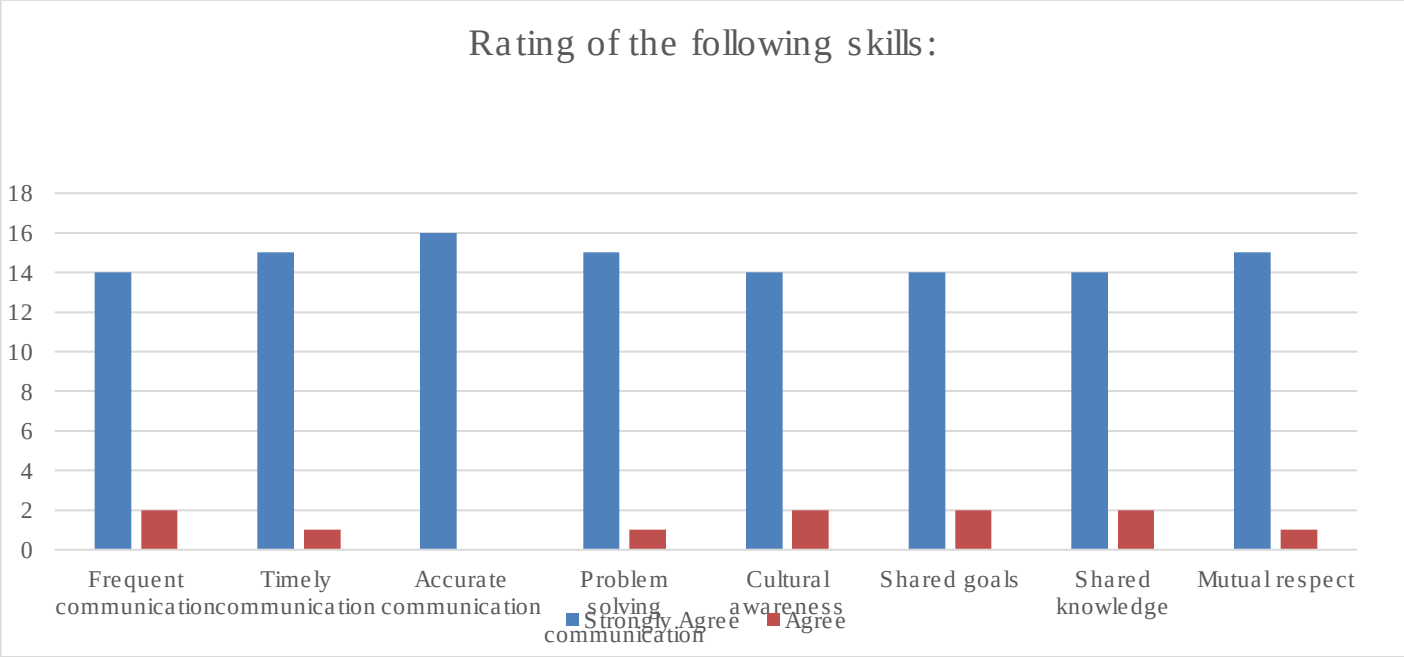
- Extensivist Model: Employment of 20+ Band 3 coordinators – new service and will be starting later this year.

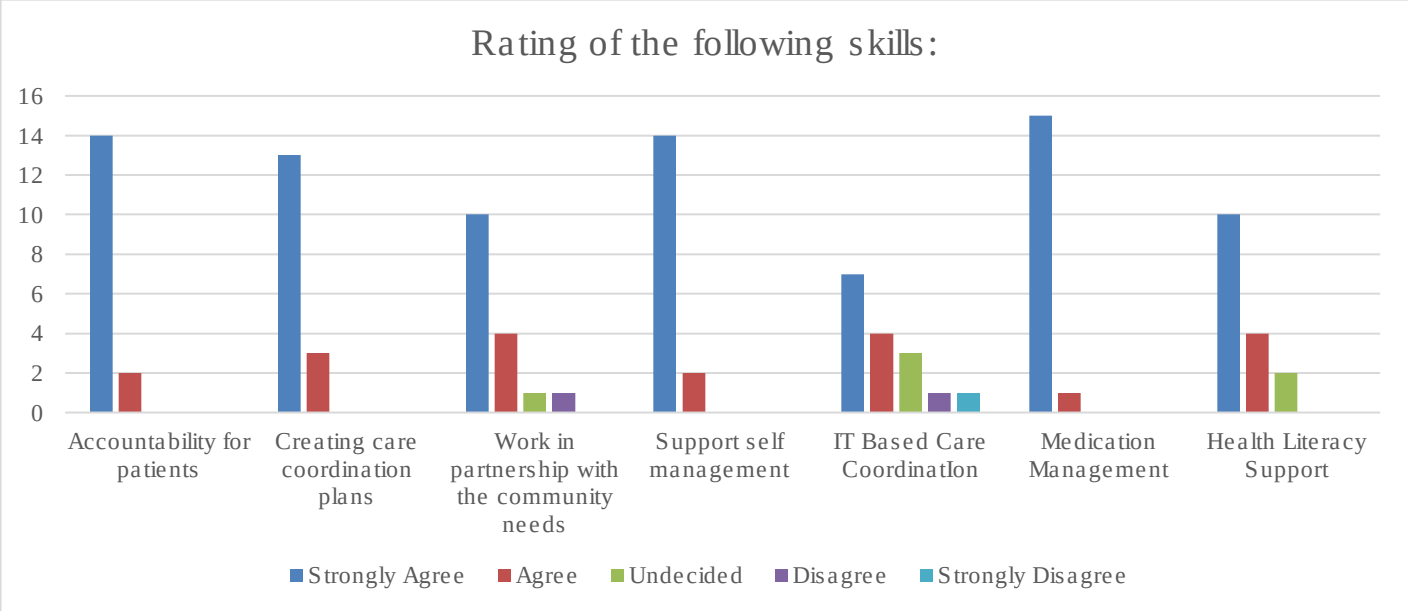
Survey Results

To obtain a snapshot from the care coordinators currently working a survey was sent to Clinical Case Managers across BCHC.

The survey asked respondents about: key care coordination skills and competencies, the care coordination model and training.

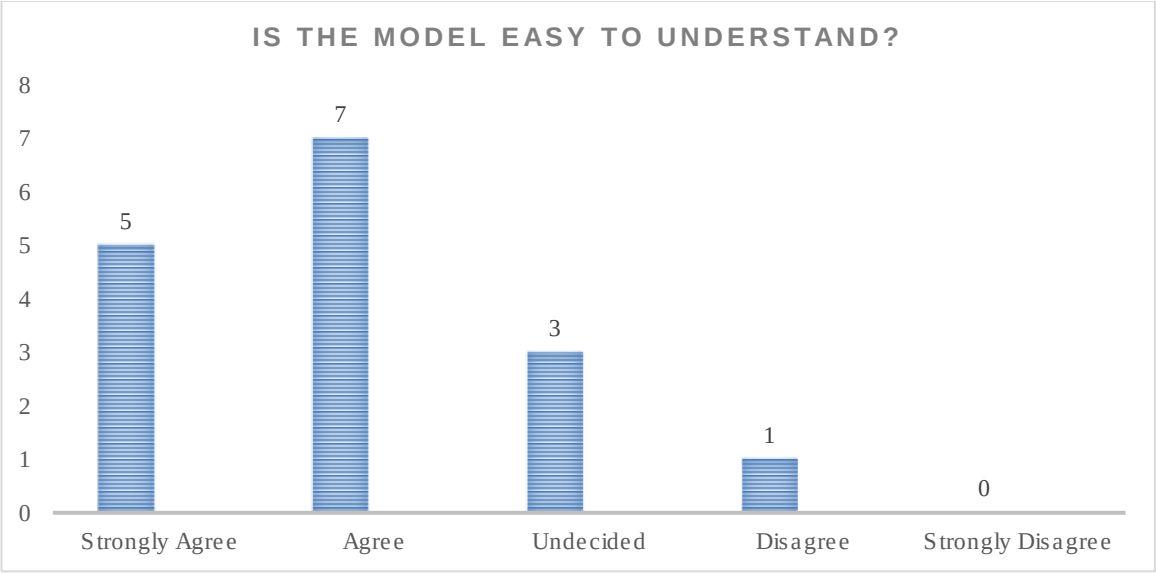
Skills and Competencies

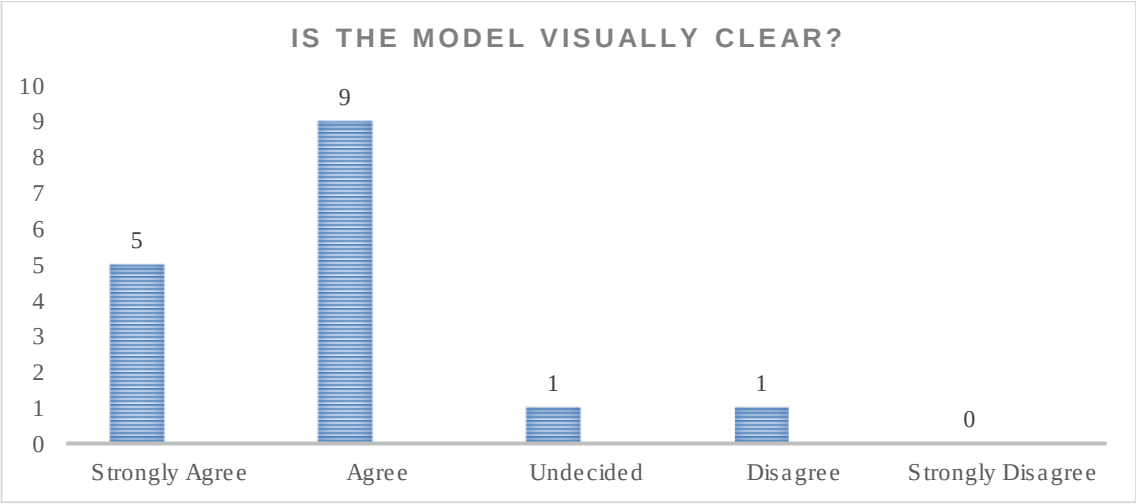


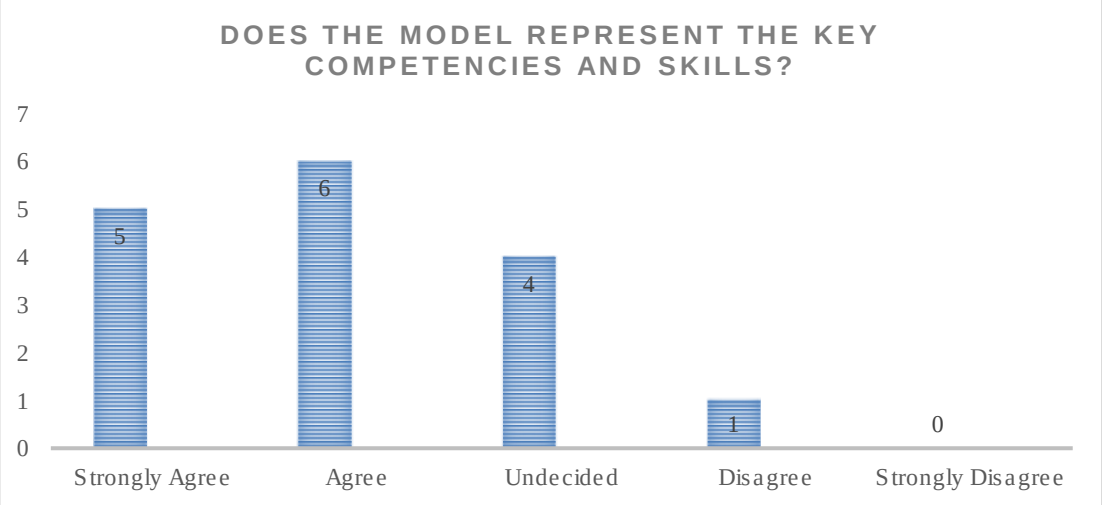


Asked what top three skills a care coordinator needed the following key words were used:

Question about the model:


IS THE MODEL EASY TO UNDERSTAND?
8
7
6
5
4
3
2
1
0
5
7
3
1
0
Strongly Agree
Agree
Undecided
Disagree
Strongly Disagree

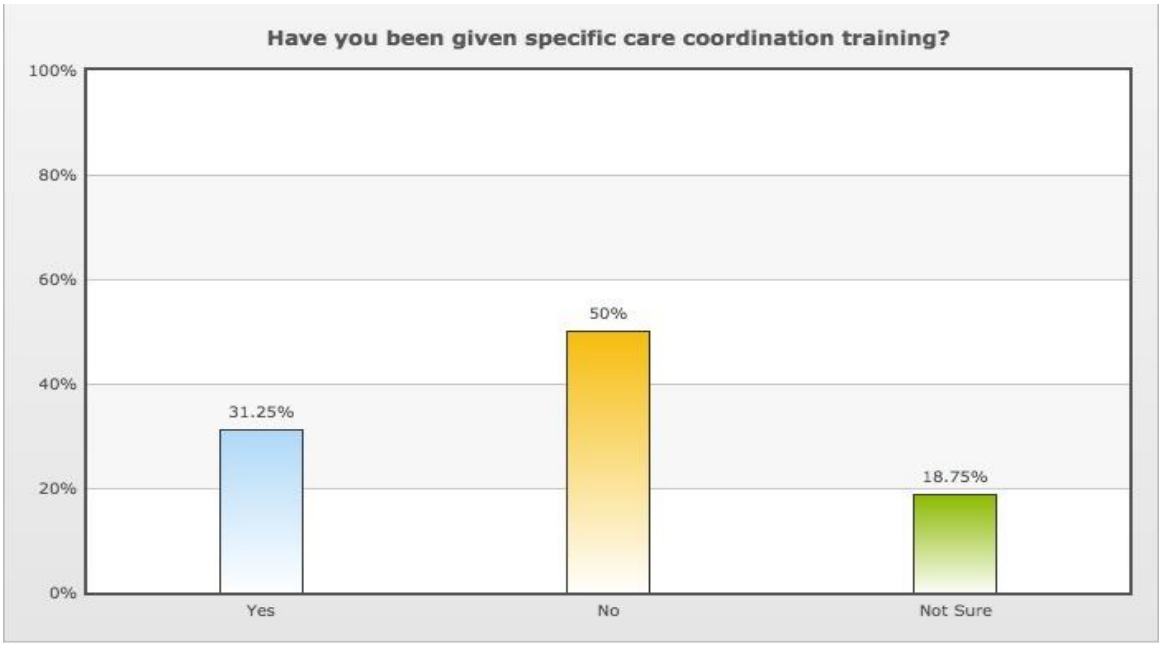

IS THE MODEL VISUALLY CLEAR?
10
9
8
7
6
5
4
3
2
1
0
5
9
1
1
0
Strongly Agree
Agree
Undecided
Disagree
Strongly Disagree



Specific feedback about the model

- Needs to be clearer whether its values or skills
- Person centered should be in the centre - Patients are at the heart of everything we do.
- This is already happening
- Communication is the most important skill and should be at the top or at the centre as all other areas of the model are dependent on effective communication.
- It should be remembered that most of the patients do not have IT access. It is difficult for elderly sick patients and their often stressed carers to have have time for computers or iPhone.
- The model looks very busy and therefore makes it look off putting to read.
- Appears too basic and literal, from an interpersonal and communicative basis. Needs some element of medical model incorporated.

Questions asked about current training



Type of training previously received

The whole DN training prepared me for this role or coordination
A full individual assessment of needs, communication, listening skills. Advanced communication skills.
Case management of patients. Effective referral pathways How to become a good advocate. Excellent clinical skills (Anatomy and physiology and clinical decision making skill) Diagnostic skills to determine a differential diagnosis. Presentation skills
An example of 1 external multi- day training, was based in Cambridge at Cambridge University. The faculty a selection of professionals from various professional bodies and councils has well has expert service users and carers. Topics on long term conditions, multiple co-morbidities & disease.
Role of care co-ordinator, research on different models and outcomes.

Focus Group Feedback on the model

- When I look at this I don't see a person but I see a set of skills. This isn't a person, it's a way of working"
- The Model is just words – doesn't say much else.
- Doesn't think it goes far enough - they are not personal qualities, there is a mixture of what we want them to be
- Continuous learning is not a personal quality but communication skills ect are
- Need to identify the core philosophy of the person and then what are the core skills of that person are
- What approach would you want someone to take and then the personal skills.
- Key ideas but lacks information such as reliability of a person and the day to day needs of a person
- Need to focus on assessment of the complex person
- Role Definition is important and needs better understanding so operationally organisations can demonstrate the importance of the role to wider health economy
- The type of things on daily basis will a person be doing - the model does not show this

Focus Group Feedback on future needs and training

- Outcome measure - how do we measure what we do and the value of the role. We don't know what would happen if we didn't come in - all we know is they are now less at risk. Important the role has more recognition. The model does not help with this.
- Organisation has let the role down, still unclear about role definitions, what should be included in a job and still vague.
- Need to improve mentoring for junior care coordinators – the role is about improving continuous learning.
- Building relationships takes time and very hard to measure. As a new care coordinator you would know the system but you wouldn't know the go to people in that area.
- Confusion in titles - same soft skills care needed regardless if the role is clinical or non clinical.
- Training needs, extensive period of training needed and the area needs to be explored more.

How the model was used and how will it be implemented in the future:

- To underpin future job descriptions for care navigator and care coordinator roles.
- Help formulate interview questions for the new role they are developing.
- Inform future training and the type of training needed.

Using the model to inform the West Midlands Dementia Framework and Learning Disabilities Transition Pathway Competency Framework

Context:

The West Midlands Dementia Framework aims to be truly person-centered, by prioritising the person and not the disease, is value and competency based, utilising lived experience narrative to focus discussions between manager or trainer and their team. The framework sets the benchmark to understand the skills and knowledge that care providers should aspire to and it is therefore a tool to work 'towards' not to work to.

This Learning Disability Transition Pathway Competency Framework has been developed by Health Education England, working across the West Midlands in partnership with Skills for Health. The framework supports the development of successful transition teams, new roles and the identification of the components of effective education and training for those working with young people in transition.

How the model was used and how will it be implemented in the future:

- The model was used to inform and develop both of the frameworks.
- Both frameworks clearly set out skills and functions to ensure that coordinated care was a key theme.
- Examples of each of the frameworks can on the Health Education England website. Both have clearly used the model to inform their own frameworks.
- The workshops hosted earlier this year helped to clearly map out the importance of coordinated care in their frameworks.

Is the model fit for purpose?

- ✓ Multiple organisations (listed previously) have agreed there is a need for a clear understanding of the key skills and functions of coordinated care based roles. The model offers a clear overview to support the design and delivery of coordinated care for health and social care.
- ✓ It was agreed the model was overall: clear, represented the key coordinated care competencies and easy to understand.
- ✓ The model was tested across several organisations with differing levels of need. All organisations found the model useful for developing their coordinated care workforce.
- ✓ There is an intention from organisations to continue using the model.
- ✓ Current care coordinators indicated the model closely reflects the key competencies of the care coordination role.

Key learning points

- ✓ A need to be clearer regarding how the model is supposed to be used.
- ✓ Varying coordinated care based job titles cause confusion e.g. Practice Navigator, Care Navigator, Case Manager. The imprecise use of the term care coordination is distorting the importance of the role.
- ✓ Continuing to make sure links are developed outside of healthcare and reinforce the importance of care coordination across social care and voluntary organisations.

Recommendations and future needs

- ✓ A need to scale up and implement the Coordinated Care Model across the West Midlands. It is clear organisations are employing multiple people in coordinated are type roles (both as the full time roles or as a significant part of their role).
- ✓ Promote the tool 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 coordinated care training across the West Midlands. Examples of training could include: Bite size learning, a coordinated care knowledge bank and coordinated care case studies.
- ✓ Develop a coordinated care network to improve the engagement of staff from different organisations.
- ✓ Make clearer how the tool can be used e.g – developing a job descriptions/informing frameworks.