NHS
Health Education England

Training Toolkit for Coordinated Care

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 purpose of this document is to provide a coordinated care training toolkit. These toolkit acts as an overarching guide to the key principles of coordinated care.

The training toolkit will evolve. Comments and contributions are welcomed and the toolkit will be updated regularly in the light of these.

The content of the toolkit has been co-designed and tested with a wide range of stakeholders.

This toolkit should be seen as a starting point for developing tailored training for your organisation.

Using the toolkit

We recommend reading the document as a whole to get a full understanding of the resource.

However, we have structured the document to make it easy to go straight to sections of particular interest if you prefer.

Across all chapters there are callouts to help point out specific information that you might find useful:

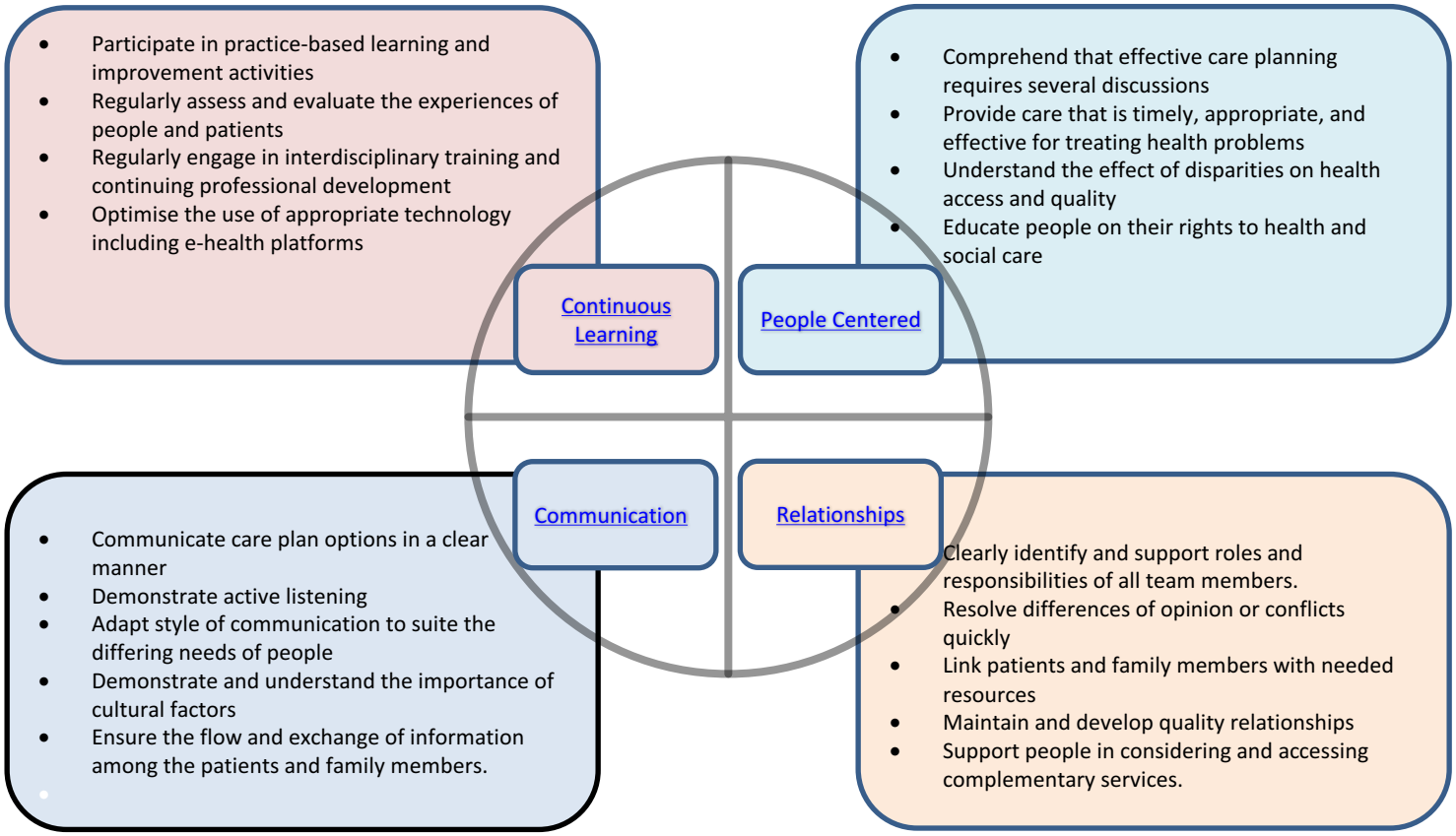
- **Training Directory:** These are either coordinated care tools that can help with further understanding coordinated care.
- **Essential Skills:** These the key skills coordinated care workers should have.
- **Case studies:** These are best-practice examples from elsewhere that might be useful to keep in mind.
- **Profiles:** These are stories of staff who currently work in coordinated care roles.
- **Forum:** This section has further information on joining the coordinated care forum.

Using the toolkit

There is a high variability in training time, content and methods, the toolkit seeks out the following types of training:

- Taught modules and courses.
- Best practice nationally and internationally.
- Local case studies.
- Action learning groups, an online forum and other networking events.
- Learning from and with patients and carers.

The model the toolkit is based on:



Resource	Description	Link
The High Value Care Coordination	The High Value Care Coordination (HVCC) Toolkit provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors.	https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit
Reducing Care Fragmentation: Care coordination model	It describes the principles of care coordination and how an integrated approach is crucial to effective care delivery.	http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf
Care Navigation: A Competency Framework	The purpose of this document is to describe a core, common set of competencies for care navigation	https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_FINAL.pdf

Resource	Description	Link
Every Moment Counts	A Narrative for Person Centred Coordinated Care for People Near the End of Life	http://www.nationalvoices.org.uk/node/1078
Care co-ordination through integrated health and social care teams	A Kings Fund description of care coordination	https://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/care-coordination
OneCare Vermont Care Coordination Toolkit	This Toolkit, developed by OneCare Vermont, is designed to assist health service areas to identify and implement a care coordination program for complex patients with multiple chronic conditions, or to integrate additional elements of care coordination best practices into existing programs and services.	https://www.onecarevt.org/docs/toolkit/OneCare%20Vermont%20Care%20Coordination%20Toolkit.pdf

Resource	Description	Link
The Boston Medical Center Patient Navigation Toolkit	A three-volume toolkit designed to plan and implement a Patient Navigation program. The BMC Toolkit offers case studies, tools, and resources from cancer care navigation that can be applied by program planners, supervisors of navigators, and patient navigators.	https://www.avonfoundation.org/causes/breast-cancer-crusade/patient-navigation-toolkit.html
Care Coordinators Handbook	The Care Coordinator's Handbook will provide you with: Enhanced Personal Health Care Transformation Team member role descriptions • Definitions of terms commonly used • Self-guided learning activities using Milestone topics • Links to frequently referenced sites • Information on special topics - for example, pediatric resources	https://www.ctc-ri.org/sites/default/files/uploads/pw_e224566%20care%20coordination%20tool%20kit.pdf
Care Coordination Measures Atlas	Investigation into care coordination definitions, practices, and interventions	https://pcmh.ahrq.gov/sites/default/files/attachments/Care%20Coordination%20Measures%20Atlas.pdf

Resource	Description	Link
Strengthening a competent health workforce for the provision of coordinated/ integrated health services (2015)	The paper proposes a list of competencies to be consolidated by the health workforce in order to realize coordinated/integrated health services delivery.	http://www.euro.who.int/en/health-topics/Health-systems/health-workforce/publications/2015/strengthening-a-competent-health-workforce-for-the-provision-of-coordinated-integrated-health-services-2015
The Value of Nursing Care Coordination	In order to fully achieve this potential, clear models and outcome measures are needed to specify the context for care coordination, identify nursing competencies, and value the nurse's role within the health care team	http://www.nursingworld.org/carecoordinationwhitepaper
Improving care coordination for people with long term conditions	It describes the principles of care coordination and how an integrated approach is crucial to effective care delivery.	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215948/dh_124050.pdf

Person Centred Care: Essential Skills

- **Being person-centred means affording people dignity, respect and compassion**
- **Being person-centred means offering coordinated care, support or treatment**
- **Being person-centred means offering personalised care, support or treatment**
- **Being person-centred means being enabling**
- **A short video on person cenred care. At: www.health.org.uk/person-centred-care-made-simple**

Person Centred Care: Essential Skills

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

Person Centred Care: Essential Skills

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

Person Centred Care: Further Links

Resource	Description	Link
Person-centred care made simple	The Health Foundation: What everyone should know about person-centred care	http://www.health.org.uk/sites/health/files/PersonCentredCareMadeSimple.pdf
Whay is person-centred care and why is it important?	Health Innovation Network: South London	http://www.hin-southlondon.org/system/ckeditor_assets/attachments/41/what_is_person-centred_care_and_why_is_it_important.pdf
Person centred Practice	ACS: Australian Approach	https://www.acs.asn.au/wcm/documents/ACS%20Website/Resources/Wellness%20Reablement/Tools/Guide%20to%20Implementing%20Person%20Centred%20Practice%20in%20Aged%20Care.pdf

Continuous Learning : Essential Skills

- A focus on getting to know the patient as a person, his or her values, beliefs and aspirations, health and social care needs and preferences.
- Enabling the patient to make decisions based on informed choices about what options and assistance are available, therefore promoting his or her independence and autonomy.
- Shared decision making between patients and healthcare teams, rather than control being exerted over the patient. Enabling choice of specific care and services to meet the patient's health and social care needs and preferences.
- Providing information that is tailored to each person to assist him or her in making decisions based on the best evidence available. Assisting patients to interpret technical information, evidence and complex concepts and helping them to understand their options and consequences of this, while accessing support from other health and social care experts.
- Supporting the person to assert his or her choices. If the individual is unable to do this for him or herself, then the nursing team or an appointed formal advocate would present and pursue the person's stated wishes.

Continuous Learning: Essential Skills

- Displays an open, curious, non-judgmental attitude regarding differences of opinion
- Remains respectful in communications and approach where disagreement exists
- Demonstrates self-reflection and solicits feedback from others regarding performance
- Identifies individual challenges and seeks opportunities to grow
- Seeks feedback from others and uses other sources of information (e.g., professional organizations, publications) to identify appropriate areas for learning
- Shows interest and pursues appropriate learning activities that fulfill self-development/learning needs
- Sets concrete goals for own activities and behavior in order to achieve desired work outcomes and meet or exceed expectations
- Applies new technical and business information/knowledge to practical use on the job.

Continuous Learning: Essential Skills

•Implement and routinely monitor patient safety standards.

•Optimize the use of appropriate technology including e-health platforms

•Show interest and pursue appropriate learning activities that fulfill self- development/learning needs

•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.

•Identify evidence to inform practice and integrated care.

Relationships: Essential Skills

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

•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

•Builds a strong network of relationships that can survive a change of direction, reporting lines or personalities
•Develops external relat
•ionships that enhance their knowledge and bring best practiceinto 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.

Communication: Essential Skills

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.

•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.

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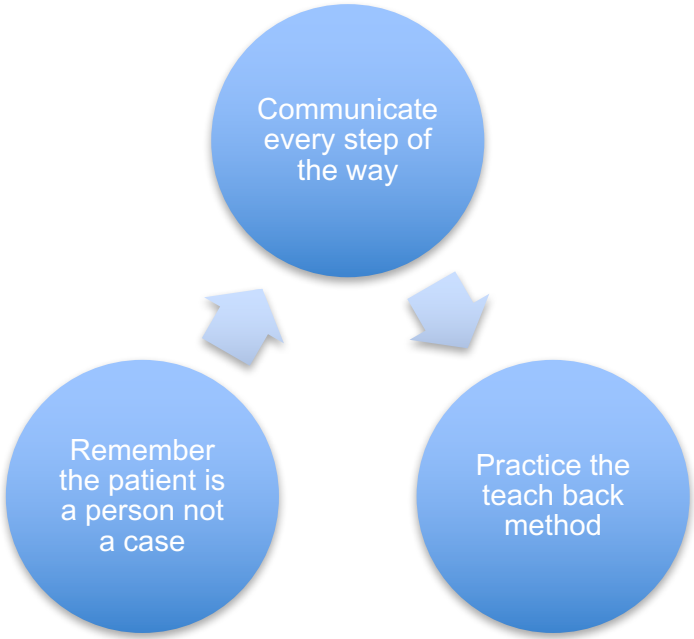
Communication: Essential Skills

- 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.



Case Studies: Introduction

The following case studies aim to bring together the different experiences of organisations, taking a snapshot across activities and attempting to draw overarching ideas for other organisations to take forward.

The case studies give a unique insight into how coordinated care is being developed across the West Midlands.

Case Studies: Gateway Services

Objectives of Gateway Services:

Two primary outcomes:

- GP/Practice Staff (Primary Care)

To free up their time by taking on the support of patients who present with issues that are of a social rather than medical nature.

- Patients

To be able to manage their social needs independently or if this is not realistic to be able to manage more effectively with support from more appropriate sources

The metric we will use to measure the impact of our intervention in a quantifiable way will be to assess how many times the patients saw the GP in the preceding 12 months and then in the 12 months since referral. Our aim will be to ensure there is a reduction..

Case Studies: Gateway Services

Process:

- ✓ Initial diagnostic
- ✓ Risk and Protective Factors model (aligned with national frameworks including the ageing well element of the life course)
- ✓ Objective of support is to eliminate/reduce the risks
- ✓ Tailored support provided, flexible in terms of time & style
- ✓ The latest in a range of Para Professional roles

Case Studies: Gateway Services

Continuous Learning
- One to one's, meeting of peer group, wider para professionals
- "real time" and post service evaluation
- Continued professional dev – Completion of level 3 qualification

People Centred
- 85% of those supported seen more than once, most between 5-10 in some cases many more
- Supported when required, time and frequency
- Financial hardship one of top 3 risks, in many cases discussed benefit entitlement, re educate re where to get help

Communication
- Training – boundaries and confidentiality, data protection, communication, equal opportunities
- Involvement of those involved in care, partner, family, GP,
- Listening, adapted communication, tried varied methods

Relationships
- Signposting a huge part of our intervention – active referral
- Clearly defined roles within the team
- Developed and maintained quality relationships, continuity, critical friend, building resilience

Case Studies: Gateway Services

Brandon's story

https://www.youtube.com/watch?v=I73UM6mRUMg

- ✓ Vulnerable adult
- ✓ Learning disability
- ✓ Unsuitable accommodation
- ✓ Financial hardship
- ✓ Social isolation
- ✓ Low reported wellbeing

Case Studies: Age UK Solihull

There are currently 14 Care Navigators, employed by Age UK Solihull, based within GP Surgeries across the borough working alongside GPs and other health professionals.

The aim of the service is to support and enable older people, who are struggling with non-medical issues that are impacting on their health and wellbeing, to navigate and access relevant services that can meet their needs.

Care Navigators provide support to older people aged 65+, and their carers, who are registered with a Solihull GP. They work with people on a 1:1 basis, normally in their own home, looking at the range of options and choices that are available, providing short-term practical interventions whilst looking for longer term solutions.

Case Studies: Age UK Solihull

Care Navigators are truly ‘all-rounders’ and work with many organisations across and beyond Solihull.

The service has been evidenced to improve older peoples’ wellbeing and independence and reduce use of health services.
It also supports people to better understand and manage their own health conditions.

A quote from someone who has used the service:
“I have found the service incredibly useful and so has my mum. There is so much out there. To have someone come to your home to point you through the maze of what is available is invaluable. Without that, we would have been less likely to nd out what is available. We would have missed out on available resources.” - Carer

Case Studies: Coventry and Warwickshire

Age UK Warwickshire (AUKW) has been commissioned by a consortium of 31 GP practices in South Warwickshire, (Warwick and Stratford districts) to develop and manage a 12 month Primary Care Navigator pilot. The pilot programme is contacting patients over 75 years of age with the aim of undertaking an assessment and supporting them to identify and access the support they want and need. The pilot is running from April 2015 until March 2016. An independent evaluation of the outcomes of this pilot programme has been commissioned. Age UK Warwickshire has embedded the provision of specialist information and advice about housing and care options into this delivery model through employment of a dedicated specialist in this field. Age UK Warwickshire provides a handyperson service, home safety checks, home improvement agency services and generalist information and advice, with a long history of providing integrated services.

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Case Studies: Coventry and Warwickshire

The target group is people over 75. Age UK Warwickshire has a team of care navigators based in GP practices in the area and a specialist housing and care advisor as part of the First Stop network to support the service in relation to housing issues.
As well as this service Age UK Warwickshire has an established triage service called Gateway. Referrals come from hospital staff, Warwickshire County Council's Contact Centre and Community Health and Social Work teams. Referrals are frequently people who are being discharged from hospital or have been identified as at risk, but usually
do not meet the FACS criteria. The Gateway service undertakes a telephone assessment through which daily living needs are identified and advice given or arranged to improve people's lives. It is an established step towards helping people to navigate the complexity of community services

Further information: http://careandrepair-england.org.uk/wp-content/uploads/2015/10/AgeUK-Warwickshire-Case-Study.pdf

Profile: Claire Johnson

What's your name and current position? - Claire Johnson Care Navigator

How long have you been in this position? - 17 months

Can you give me a brief overview of what it is you do in your work?

Triaging referrals from GP's, hospital and specialist services, ensuring that the patient is supported by the appropriate professional,

Supporting the patient, family and carers throughout their journey, making referrals to outside agencies,

Taking telephone call from relevant people involved in the patient journey, dealing with their concerns/request made or signposting them to the appropriate area, making sure that the patient is on the right pathway.

Participation in MDT meeting to ensure MDT approach with their journey. Liaising and supporting professionals with any needs the patient may have.

Being first point of contact for the patient, carers and family to support with their worries and concerns and ensuring that their needs are being met in a holistic approach.

Profile: Claire Johnson

What led you to this job?
Being in a role where the patient mattered and there needs were important
What key skills do you think you need to do your job well?

What key skills do you think you need to do your job well?
Communication, flexible, adaptable, good listener, empathy, strong character, kind and caring, compassion, reliable, professional

What would you say most motivates you to do what you do?
The satisfactory of knowing the patient is being care for and that their needs and wishes are being listen to. Knowing that we are making differences to their lives, ensuring that they are safe and being care for were appropriate.

What's next for you in your role?
To continue to build the role to ensure we are able to continue to make a different and make the role

Profile: P. Conroy

What's your name and current position? - P. Conroy Care Navigator

How long have you been in this position? - 1 year 5 months

Can you give me a brief overview of what it is you do in your work?

Triaging referral from GP, hospital and specialist disciplines. Making referrals to outside agencies.
Supporting the patient, family and carers through their journey.
Taking phone calls from relevant people involved in the patient's journey and dealing with the concerns/requests made, or signposting to relevant areas.
Ensuring that the patient is on the correct pathway.
Participation in MDT meeting and furnishing information collated on patient to members of MDT meeting to ensure collaborative working. Liaison and supporting professional with any needs that the patient have.
Being the first point of contact for patient, family and carers to support with worries or concerns and ensuring that patient's needs are met with a holistic approach.
Co-ordinating care of the patient to ensure

Profile: P. Conroy

What led you to this job?
I had an interest in the social side of nursing and wanted to move into an area which would incorporate this.

What key skills do you think you need to do your job well?
Communication, Flexibility, Adaptability, Good listener, Empathy, Strong character , Kind, Caring Compassionate, Reliable, Professional

What would you say most motivates you to do what you do?
The satisfaction of helping the patient to manage their daily lives safely and independently. Knowing that the patient has someone that will support them and champion their needs and knowing that they have someone who cares.

What's next for you in your role?
To continue to shape the role and to enable me to carry on making a difference to people's lives.

Coordinating Care Forum

- The Coordinating care forum has been set up for people in coordinating care roles.
- The forum is place for people to discuss topics such as:
    - Examples of best practice
    - How to overcome difficult issues
    - Promote organisations and resources
    - Ask questions
- The other key purpose of the forum is to create a peer support network. The online network will allow staff to talk openly and honestly about their roles.
- The ethos of peer support is: sharing stories and ideas with compassion, honesty and empathy.
- We would like in the future to promote regular face to face forums across the West Midlands.

Coordinating Care Forum

How can I get involved?

- You can apply to become a member of the Forum if your role has an aspect of coordinating care.
- Please click on the following link
- The forum is for people who work in either health or social care.