improving care for people with long term conditions

information sheet 3

care coordination

an 'at a glance' guide for healthcare professionals

DH Department of Health

care coordination

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About this information sheet

It describes the principles of care coordination and how an integrated approach is crucial to effective care delivery.

Who should read it?

Anyone involved in delivery of healthcare to someone with a long term condition, including doctors, nurses, allied health professionals, those delivering personal health budgets and health trainers.

An integrated approach – the importance of team working and care coordination

Integration of health and social care at both strategic and individual level is critical in delivering effective care planning.

Multidisciplinary team working is crucial to ensure an integrated approach to personalised care planning, especially for those with complex care needs who are more likely to require care from a range of different agencies/health and social care staff.

Collaborative working is also vital to ensure that all staff can deliver high quality care planning services. Although challenging, this also brings opportunities for the workforce in terms of a wider understanding of individual roles and shared learning across organisations.

Language and cultural differences are two of the key barriers to making this happen, but can be overcome – it just requires the will and effort and an acknowledgement that it will not happen overnight.

Care coordination – what is it and who can do it?

It is important to individuals who have more complex needs that care is coordinated and joined up and that someone leads to make sure that this happens. For this group, care coordination is very much part of the care planning process **(see information sheets 1 and 2)**, together with joint assessment of need. It's also important to acknowledge that the term "care coordinator" may be referred to as different things such as "key worker" and "lead professional". Care coordination is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care by the appropriate agency or provider. This is not a distinct or separate function, and in many cases may already be part of an existing support role.

Care coordination is not an isolated activity but is done as part of being in a team. It works best when there is a clearly identified person undertaking this role within a multidisciplinary team. Everyone in the team knows who the care coordinator is and understands that this is a clear function. The role will usually fall to the person who has led the assessment or the staff member who has the lead in providing care.

When is care coordination appropriate?

Think about the trigger events that could initiate the appointment of a care coordinator. These could include:

- a high number of different staff groups/ agencies involved in supporting the individual;
- where intervention will be required over a long period of time;
- when the level of need increases and multiple services are required;
- those experiencing a high number of unplanned emergency admissions;
- on discharge from hospital.

An explicit conversation between healthcare staff and individuals about who the care coordinator is can take place at any given time.

The decision making around activity and services to be funded is undertaken by the lead practitioner but the scheduling of these activities and services can be led by the care coordinator.

Consider the need to transfer the care coordinator role when:

- The current care coordinator is not the most appropriate person.
- The individual or their carer has requested it.
- The professional acting as the care coordinator no longer has any involvement with the individual.

Care coordination ends when there is agreement from all concerned that the individual's needs are stable and care planning is functioning well.

Where is integration working well?

Devon PCT, working in partnership with Devon County Council, already has a well-established integrated team. Their evidence suggests that there are a number of key steps in the process of creating a joint team:

- senior managers in social services and the PCT (and potentially other organisations) agreeing a joint vision for integrated working;
- clear communication of this vision to staff and time taken to listen to concerns that staff may raise;
- joint training;
- joint case management conferences;
- pooled budgets;
- joint management arrangements for both health and social services, with a single line of accountability;
- eventual co-location of staff, once joint working has had time to embed;
- over time, traditional roles replaced with new roles and jointly funded positions.

The Tremeduna Team.* Durham County Council, Sedgefield PCT and Sedgefield Borough Council established an integrated, multidisciplinary locality team some years ago. The following highlights some of the benefits of their approach:

- staff are more understanding and knowledgeable about each other's roles;
- creates shared ownership;
- single assessment process has added value and depth to the final assessment;
- the team has become more innovative;
- this has resulted in an improved service to the individual.

*Department of Health (January 2008): Raising the Profile of Long Term Conditions Care: A Compendium of Information

Further information for healthcare professionals

Publications and other resources on long term conditions management are available at:
www.dh.gov.uk/longtermconditions

Personalised Care Planning and Information Prescription e-learning toolkits*

NHS Employers has produced two e-learning packages to help develop the skills and knowledge needed to produce personalised care plans and information prescriptions.
www.nhsemployers.org/PlanningYourWorkforce/LongTermConditions/Pages/LongTermConditions.aspx

Supporting Self Care e-learning toolkit*

This is designed for healthcare staff supporting individuals with long term conditions.
www.e-lfh.org.uk/projects/supportingselfcare/index.html

End of Life Care for All e-learning toolkit*

Enhances the training and education of all those involved in delivering end of life care.
www.e-lfh.org.uk/projects/e-elca/index.html

*Please note you will need to register with the site provider to access these toolkits

The series of information sheets is available to download at www.dh.gov.uk/longtermconditions and covers the following topics:

Information sheet 1: Personalised care planning

Information sheet 2: Personalised care planning diagram

Information sheet 3: Care coordination

Information sheet 4: Assessment of need and managing risk

Information sheet 5: What motivates people to self care

Information sheet 6: Goal setting and action planning as part of personalised care planning

Information sheet 7: How information supports personalised care planning and self care

Information sheet 8: End of life care and personalised care planning

Look out for further information sheets covering other relevant topics.

Your feedback is extremely important to us. Please send your comments/suggestions for this information sheet, or good examples of care coordination and integration within your area, to **longtermconditions@dh.gsi.gov.uk**

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