Co-ordinating care and support – how can we do it better?

Looking again at care coordination

Over the past decade, we have made many changes to the way in which we organise the core statutory adult social care functions of assessing people's needs and finding solutions for them, and our joint arrangements for working with community-based health services, including case management for NHS continuing healthcare and mental health aftercare for people who have been detained in hospital. Last summer, we started a review of how well our current arrangements are working, which confirmed our sense that we need to stand back and look again at how well some past changes have worked, and consider whether a new approach might be better.

We think our current arrangements may have gone too far in aiming for efficiency through specialisation and standardisation, at the cost of making service users' experience more fragmented.

This paper sets out the questions which we are considering, and our provisional views about the answers to these questions. It is intended as a starting point for an open discussion with staff and partners about what we are trying to achieve, how well it is working, and what we might do to make the system work better.

A series of meetings open to all staff working in adult social care and related services are taking place during May. Details of these meetings are being communicated separately, and at www.tinyurl.com/howbetter, which will keep updated as things progress. We are also arranging meetings to discuss these issues with partner organisations.

If you would like to make written comments or queries about anything in this paper, please send them to how.better@northumbria.nhs.uk.

What would a good system be like?

Our starting point is two familiar principles: where we can, we should prevent people from needing care and support services; when people do need care and support, it should be personalised.

In more detail, we think this means a system with:

- **Strong links to the wider community**. People with care and support needs need many more things than care services, and may not need care services at all if (for instance) they live in housing that supports their independence, get the benefits they are entitled to, and know what support is available from community groups and businesses in their area. Helping people with these things is part of our core business.
- **An outcome focus**. The primary objective of the system should be to achieve the outcomes that matter to people. Our organisational task is not to determine people's eligibility for standard services, nor to allocate them to standard pathways. (Pathways may be appropriate for evidence-based treatment of well-defined conditions, but not for helping people to live the life they want as well as they can.)

- **Integration**. Health and social care should work together as a single system for supporting people with care and support needs.
- **Clear coordination**. Each person should have a named coordinator (whatever we call them – care manager, case manager, key worker…), who knows about all the community services the person is or could be supported by, and can take responsibility for making sure that the person is getting coherent support.
- **Continuity**. There should be as few handoffs between professionals and services as possible.
- **Expertise**. Care coordinators should wherever possible have experience and knowledge of working with people with similar health conditions/disabilities and life circumstances to each person allocated to them – and where this is not possible, should have easy access to advice and assistance from professionals who do.
- **Workers trusted to make decisions**. Front-line workers should usually be trusted to use their judgement, rather than being performance managed on their compliance with standard processes. (But to achieve this, we do need to make sure workers have the right skills and support.)
- **Learning**. Inexperienced workers need opportunities to learn from experienced ones, and workers at all levels need opportunities to learn from each other (including County Hall staff learning from front-line workers). All of us need to learn from case audits and by analysing what happened when things go wrong, without assuming that someone must be to blame.
- **Proportionality**. There should be no more bureaucracy than there needs to be.

Questions

Q1. Do you disagree with the objectives on the list, or think any of them get the emphasis wrong?

Q2. What else should be added to the list?

What is working well at present?

Our initial list of things which are working well, and which we would aim not to undermine when we make changes, is:

- We have a stable and well-motivated workforce, with a wide range of skills
- Our intertwined management means that we mostly make major decisions with a good understanding of their implications across health and social care.
- We respond well to pressures on acute hospitals, with delayed discharges still rare in comparison with most of the country, and mostly when they happen linked to issues about the care market rather than to delays in assessment and care planning

- Providing case management for people needing CHC using the same processes that we use for social care minimises disruption when people move between funding streams
- Our support planners can link people to a wide range of sources of support in the community
- We look good measured by most of the nationally collected performance indicators

Questions

Q3. Are we more satisfied than we should be about some things on this list?

Q4. Are there other aspects of our current arrangements which are working particularly well but are not on the list?

What is not working well?

Our initial list of things which we think we need to change is:

- There are too many handoffs, and there is too little continuity in care coordination
- Complex and risky situations are too often being allocated to workers who don't have the right experience or support to handle them safely
- We are not as closely integrated with NHS community mental health services as we should want to be
- Our links with primary care teams are not always strong
- We have too strong an emphasis on process targets, and too little on what outcomes we are achieving for people
- Our current arrangements have encouraged the perception that linking people to sources of support in the community is a specialist task rather than part of everyone's role

Questions:

Q5. Do you agree that these are problems with current arrangements?

Q6. Are there other problems that we should be aiming to address in any changes we make?

Aspects of the current arrangements that we need to review

On some other aspects of the current system, we have heard mixed views so far, and would welcome further evidence about what is working well and what isn't. For example:

- The single front end at Foundry House has lifted some burdens from local teams, but seems to have led to increasing numbers of handoffs, and people having to tell their story several times. We're clear that we need a single phone number – but we think it might be better for many contacts to be routed directly from that to a local team.

- The move in recent years towards specialist teams for different kinds of worker and for different tasks may mean that team members have more peer support with specialist tasks, but has led to a more disjointed experience for service users – for instance because of the separation between centralised teams and local teams, between social work teams and care manager teams, and between teams based on different professions. We are considering whether we could remain clear about the roles of different staff groups, while organising teams around shared responsibility for identified groups of people rather than around roles or professions.

Questions

Q7. Which of the functions currently carried out at Foundry House are best done centrally, and which could better be done by locally-based teams?

Q8. What have been the positive and negative consequences of organising teams around professions or processes? How could the positive aspects of that be maintained if instead we had mixed teams organised around shared caseloads?

A future model

Our current view is that we need to make significant changes to the way we organise care coordination. The model which we are thinking of moving towards would look something like this (but we will think again about the details following this engagement process):

- Care coordination for most people would be provided by locally-based **care and support teams**. We would expect these teams to be quite small, and to be as closely linked as possible to primary and community health services, with allocations to teams being based on primary care registration. Where possible, we would hope to see them being based in primary care premises or alongside district nurses. They would include social workers, care manager 1s, and possibly other community-based staff.
- The care and support teams could either be small groups of workers linked to a single practice or a cluster of small practices, or they could be larger and linked to the primary care "networks" which are being developed as part of the NHS Long-Term Plan, which will usually cover populations of 30-50,000 people. Small teams would maximise continuity of relationships; larger teams would be more robust. There may be ways to combine the best features of both alternatives.
- To coordinate care for people with the most challenging needs, we would create **complex needs** teams covering larger populations. These would include some of our most experienced professionals, and would work as closely as possible – ideally to the point of forming multi-agency teams – with NTW's mental health services and other specialist services, perhaps for instance including learning disability nurses, the head injuries service, and the AMHP team.

- Examples of the kind of situation which might be referred to a complex needs team would include (these are overlapping groups):
    - People with severe and unstable mental health conditions
    - People expected to need particularly complex and expensive care plans
    - People who are thought to present serious risks to themselves or others, or to be at serious risk from others
    - Children with complex disabilities who are expected to need supported accommodation when they become adults
    - Situations where there are hard-to-resolve conflicts between the person and family members or services
- Complex needs teams might retain the care coordination role for some people indefinitely, if their situation continued to call for that.
- Care and support teams and complex needs teams would need to develop a shared understanding of roles, and workers would need opportunities to move between them. We would expect there to be some dual working and mentoring arrangements.
- One possibility which we want to explore would be that almost all new referrals might be transferred immediately from our central access point (OneCall) to the care and support team attached to their GP practice. In this scenario, triage would not be carried out at OneCall, but by the local care and support team, who would decide between three options:
    - Find simple solutions to the person's problem locally. This might include linking them to local community schemes, passing them on to other professionals, or checking out the concerns leading to a referral and confirming that no immediate action is required.
    - Assess the person's (and carer's) needs, and arrange services as necessary
    - Transfer the referral to the complex needs service
- Many safeguarding referrals could perhaps be locally triaged in a similar way, though referrals suggesting that there may be serious service failures, or alleging criminal activity, would not be investigated by care and support teams.

Questions:

Q9. What do you see as the potential benefits and drawbacks of moving to a model roughly like this?

Q10. Do you have specific suggestions about how particular functions or staff groups might best operate within this model?

Q11. Some elements of this model resemble arrangements which we have tried in the past, and moved away from. Are there lessons which we should learn from that?