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Care Coordination for Older People in the Non-Statutory Sector: Lessons from Research

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CARE COORDINATION IN THE NON-STATUTORY SECTOR: LESSONS FROM RESEARCH

Why	**Evidence to inform local service development**
What	**Research findings:** **Messages from the literature** **Standards to guide practice** **Service arrangements across England** **Priorities for developing quality services** **Implications for service development** **Lessons from the research**
Where	**Non-statutory sector**
For whom	**Service commissioners and providers**

Introduction

For many years the local authority was the principal provider of community care in England but this tradition is changing. Increasingly care coordination is undertaken in the non-statutory sector and this trend was confirmed in the Care Act (2014). However, little is known about the nature, form and range of care coordination activities provided by the non-statutory sector and what is required to promote its capacity to respond to increasing expectations resulting from the changed policy environment. This research sought to address this knowledge gap. The study aim was to explore and articulate care coordination arrangements for older people in the non-statutory sector. Whilst the focus of the study was on support for older people, many of the services included in the analysis also provided support to working age adults.

A broad definition of care coordination was employed in this research: the assessment of needs undertaken by a worker with specialist knowledge and the compiling, monitoring and review of a support plan by a care coordinator for older people and their ca rers. It also took into account the introduction of personal budgets for older people and self-directed support, whereby the budget required to pay for assessed support needs is transferred to individuals with assistance being made available from a support planner or broker. The non-statutory sector refers to organisational groups outside the private and public sectors, sometimes referred to as the third sector or not-for-profit sector. In this study we found the main providers were not-for-profit organisations.

The research was commissioned by the National Institute for Health Research School for Social Care Research and undertaken by the Personal Social Services Research Unit at the University of Manchester. It was conducted in partnership with staff in two non-statutory organisations: Age UK Trafford which provides advice, information and services to older people locally and LMCP Care Link which provides services in Manchester and Trafford for hard to reach groups. Evidence was collected from a variety of sources:

i. A scoping review of the literature comprising 23 papers to explore what is known about the role of the non-statutory sector in care coordination for older people
ii. Analysis of 20 existing documents describing standards to inform the practice and management of care coordination from agencies in both the UK and further afield.

iii. Consultations with 34 people with experience of or familiar with receipt of services to ask their opinions about priorities for inclusion in standards of care coordination in the non-statutory sector.
iv. A structured internet search of non-statutory organisations which identified 294 services providing care coordination to older people and working age adults.
v. A national postal survey of non-statutory organisations to examine the key determinants of service provision based on 122 responses.
vi. Interviews with managers of 17 services in the non-statutory sector to explore operational arrangements and identify emerging themes. (See Appendix 1 for descriptions of services).
vii. Consultations with 19 people with experience of or familiar with receipt of services to determine which attributes of a good quality care coordination service they found most important.
viii. A Discrete Choice Experiment (DCE) questionnaire undertaken with 120 practitioners to elicit their views through ranking and choosing between the most important attributes of a good quality care coordination service for older people.
ix. Interviews with practitioners in 17 services in the non-statutory sector to explore the focus and content of care coordination activities undertaken. (See Appendix 1 for descriptions of services.)
x. Costs per care episode were calculated from the analysis of activities completed in conjunction with the interviews with practitioners in all services.

The origins of the evidence are included in brackets in the study findings presented below. In the text below people with experience of services are referred to as lay consultees.

Messages from the literature

Papers from the scoping review were predominantly from within the UK and published in the 21st century (i). The principal findings are summarised below.

Service features

These highlight care coordination arrangements and workforce practice within the non-statutory sector.

- Services were more likely to be open to all adults than to be specifically for older people.
- A range of care coordination activities but not necessarily all were provided from solely advice and information to those providing assessment support planning and review.
- Services specifically for older people were less likely to offer self-directed support and older people choosing the latter often required more assistance than other user groups.
- Peer supporters were used in both paid and unpaid roles and volunteers sometimes substituted for paid staff.

Stakeholder views

Older people valued particular aspects of care coordination arrangements:

- Long-term support from a named worker able to visit them at home and

- Access to an individual peer support worker to manage a personal budget.

Carers and users valued attributes traditionally associated with non-statutory sector services. These were:

- An informal and flexible style reflecting a person-centred approach allowing time for discussion within an interview and

- Independence from statutory organisations thereby promoting trusting relationships between users and staff.

Non-statutory sector managers commented on:

- The nature and extent of partnership working with the statutory sector and

- The adverse implications of the short-term funding of services.

Statutory sector managers reported valuing non-statutory services that complemented their own. Managers from both sectors advocated joint training as a means of improving working relationships between statutory and non-statutory partners. They also expressed concerns about mechanisms for monitoring and evaluating the performance of non-statutory sector organisations.

Standards to guide practice

Identification

An analysis of documents designed to guide practice within adult social care was undertaken. They were produced between 1986 and 2013 and incorporated five English speaking countries (UK, US, Canada, Australia, New Zealand) (ii). Content analysis revealed variation in relation to the extent to which standards were operationalised within the documents and similarity in relation to a core set of standards present in many. The most frequently cited standards were concerned with:

- A person-centred and outcome focussed approach;

- The involvement of the user and their informal networks in support planning and implementation;

- A holistic and comprehensive orientation to the user's circumstances; and

- Staff knowledge of local resources and how to access them.

Although a minority of documents presented standards as stand-alone principles, most (n=15) outlined at least some of them in relation to particular elements of care coordination practice (assessment, support planning, review etc.). Standards in all documents included a statement of purpose. However, fewer included procedures and guidelines for implementation (n=15), means of measuring implementation (n=11), or case study examples (n=6). Overall, 24 key standards were identified from the documents. These are illustrated

in Boxes 1 and 2. The majority of standards focussed on the individual practitioner rather than on the agency although most documents cited some standards from both these categories.

Box 1: Practitioner standards

	The care coordinator:
Awareness of and operation within a network of support*	*Is knowledgeable about local services*
The promotion of active user and carer participation	*Provides information to aid informed decision-making by service user*
A comprehensive and holistic approach	*Considers a broad range of areas that impact on the service user's abilities and needs*
A strengths based approach*	*Considers individual and informal carer's strengths as well as needs*
Foster independence and self-determination	*Recognises the service user's right to and limitations of autonomy*
Person-centred practice – providing choice and flexibility*	*Offers the service user a choice of options*
Accord dignity and respect*	*Respects confidentiality and privacy*
Cultural sensitivity	*Is aware of and sensitive to culturally specific needs*
An outcome focus	*Helps the service user to identify goals*
Risk management	*Recognises the service user's right to live with risk*
Conflict management	*Recognises and resolves conflicts with service user*
A relational approach	*Recognises the importance of partnership working with the service user*
Evidence based practice	*Uses theory and knowledge to enhance their work*
Budget management	*Ensures that costs of services are clear to the service user*
Structured, systematic, and transparent practice	*Uses standardised forms for assessments and reviews*
Timeliness	*Delivers a service paced according to individual preference*

* Prioritised by lay consultees

Views of lay consultees

Lay consultees were invited to prioritise the standards identified from the analysis of guidance documents, based on their personal experience (iii). They selected from the lists of practitioner and agency standards described in Boxes 1 and 2.

Most agreed that all the standards were important, particularly agency level standards which should always be met. Of these, staff development (access to training and support) was prioritised. However, the most frequently chosen standard related to person-centred practice (providing choice and flexibility). Other standards relating to practice chosen by the majority were: awareness of a network of support (knowledge of local services); a strengths based approach (services enhance users' strengths); and according people dignity and respect.

Box 2: Agency standards

	The service:
Access to be equitable and easy	*Distributes information in a range of languages and communication formats*
Eligibility to be clear and fair	*Has clearly defined eligibility criteria*
Staff to be employed who have agreed qualifications and competencies	*Has rigorous recruitment procedures*
Staff to be supported to maintain and develop through training*	*Ensures that staff have opportunities to enhance their knowledge and abilities*
Staff to be supported through regular supervision, appraisal, and workload management	*Ensures that scheduled supervision is available*
Conditions of employment (staff to be protected from harm)	*Has a health and safety policy which includes risk assessment*
Quality assurance procedures in place	*Regularly evaluates overall performance and includes service user feedback*
Operation of clear contract and funding arrangements with other agencies	*Has written contracts with service providers*

* Prioritised by lay consultees

Service arrangements across England

Features of the non-statutory sector

Most service providers identified through the internet search were affiliated to three national organisations: the Alzheimer's Society (44%); the British Red Cross (21%); and Age UK (18%) (iv). All received a postal survey (v). Findings from a 41 percent response rate revealed variation in the services in terms of their target group and range of care coordination activities. However, there was similarity in how the services operated as shown in Box 3.

Box 3: Profile of service providers

Staffing

- Many employed small numbers of staff
- Most used volunteers
- Almost all paid staff received training in relation to vulnerable adults and dementia care

Service characteristics

- The majority were funded by contract
- Many were small size operations
- All worked to written standards
- The majority used protocols relating to confidentiality, information sharing and complaints
- User satisfaction feedback informed service improvement

Support provided

- At least half undertook some form of assessment (79%), care/support planning (64%) or case finding (50%)
- Many services provided relatively short-term support
- Most shared information with health and social care staff with user consent
- Almost all applied no charge for services

Practice in the non-statutory sector

Practitioners were typically providing assistance to older people (often over 75 years of age), most of whom were physically frail and some had memory problems. More time was spent in direct contact (face-to-face or by telephone or email/letter) with users and their carers in all activities of care coordination except receipt of referrals and brokerage. The remainder of practitioners' time was mainly spent in contact with other agencies negotiating on behalf of users and carers and office based paperwork on their behalf (ix).

Typically practitioner involvement focussed on the performance of a specific task within the care coordination process, such as compiling a support plan. Indeed some practitioners had their roles prescribed by task, for example reviewing officer. Consequently there was little evidence of continuity within the process with a single practitioner responsible for assessment, care planning and review over time. Nevertheless, practitioners recognised that social work skills, such as counselling, were important components of their role (ix). Practitioners and administrative staff also spent time providing advice and information, case finding and screening (to identify potential service recipients) and, more generally, publicising the service. Analysis of costs revealed a marked variation in each of the principal activities of care coordination. There was also variation between care coordination activities. This was largest in respect of monitoring and closure and least in respect of referral and review (x).

Managing in the non-statutory sector

Four themes were identified from interviews with the managers and the main points from these are summarised below (vi).

Partnership working

- Raising the service profile and influence with local commissioners, other providers and the general public was undertaken in a variety of ways, such as outreach events and open days.
- Developing alliances with other non-statutory providers to enhance the profile and influence of the sector.

- Good working relationships between organisations within the non-statutory sector facilitated communication and formal data sharing agreements.

Staffing

- Managers described the importance of recruiting staff from the community they served and who possessed 'the right attitude', valuing this more highly than a professional qualification.

- Volunteers were recognised as a valuable asset but investment in their recruitment and training was not always matched by their long-term commitment to the service.

- Regular meetings were identified as a means of promoting effective team working, information sharing and group supervision.

Quality assurance

- Standards provided a framework for demonstrating accountability.

- Commissioning arrangements required a high level of performance appraisal.

- User feedback was integral to continuous service improvement.

- User involvement within the service evaluation process varied between ad hoc attendance at forums or focus groups and those having a more formal role.

Links with funders

- Services were subject to a high level of internal and external monitoring which focussed on service inputs and outcomes reflecting funder requirements.

- The annual business planning cycle required by commissioners was regarded by providers as a distraction from front line service delivery.

- Short-term contracts limited service development.

Priorities for developing quality services

The views of 120 practitioners working in the non-statutory sector providing support to working age adults and older people and 19 lay consultees were canvassed (vii and viii). Both groups ranked seven attributes of a good quality care coordination service for older

people in order of importance (1 being the most important and 7 the least). These rankings are detailed in Table 1.

When comparing the list of attributes as ranked by practitioners and lay consultees, there was evidence of broad agreement between both groups in all but one. The exception related to 'cost of the service to the service user' which was ranked first by practitioners but was only ranked fourth by the lay consultees. Practitioners expressed the view that the service should be free and it could be surmised that they thought a charge might deter potential users. Lay consultees, however, did not share this perspective. Both groups agreed that 'availability of the service' was an important attribute of a good quality care coordination service. This may reflect a view that if help is needed, an immediate response is required and longer waiting times might be a deterrent to service uptake.

Table 1: Ranked views of practitioners and lay consultees

Service characteristics	Practitioner ranking	Lay ranking
The cost of the service to the service user (free or pay for service)	**1**	**4**
The availability of the service (help straight away or waiting list)	**2**	**1**
The range of activities provided by the service (assessment or coordination of support over time)	**3**	**2**
The nature of access to a care coordinator (same person or different person)	**4**	**3**
The length of time the service is provided for (up to six weeks or longer)	**5**	**5**
The period of time for which the service is funded (short term i.e. up to 3 years or longer)	**6**	**7**
The opportunities for staff to receive supervision and staff development activities (regularly or rarely)	**7**	**6**

For practitioners the DCE offered the opportunity to make more 'real life' choices compared with the simple ranking exercise described above, reflecting the complexity of decisions inherent in providing support to users and carers. A feature of a DCE is that it permits an individual to select, for instance, their preferred service according to its different characteristics or attributes at varying levels of provision. In this exercise respondents demonstrated a significant preference for continuity of care provided by a single practitioner, which was the most valued attribute. Next was a preference for the following service features: a range of care coordination activities and regular staff supervision and development opportunities. These preferences differed from their simple ranking exercise reported in Table 1.

Lessons from the research

The findings from various elements of the study described above were subjected to a SWOT analysis, summarised in Box 4. This approach permits identification of risks associated with

developing key services in the non-statutory sector taking account of policy and legislation, and critical success factors (Hafford-Letchfield, 2010).

Box 4: SWOT analysis of care coordination within the non–statutory sector

Strengths	*Opportunities*
• Flexibility in staff recruitment • Use of volunteers • Complement other local services • Valued by users • User feedback informing service improvement	• Development of innovatory services • Fill gaps in care provision in localities • Freedom to publicise the service • Promotion of partnership working
Weaknesses	*Threats*
• Potential shortfall of capacity • Links with statutory sector under developed • Investment in volunteers not matched by long-term commitment • Excessive focus on performance data	• Commissioning, contracting and monitoring arrangements • Time limited short-term funding • Too small to substitute for statutory services

Strengths

The strengths of the non-statutory sector constitute its unique selling points in the local care economy. One of these is the ability to recruit staff with 'the right attitude' rather than professional qualification. However, this approach requires the provision of a bespoke training and development programme. Another is the ability to creatively maximise the contribution of volunteers in the multiplicity of tasks associated with service delivery.

Non-statutory organisations are able to provide services which complement statutory provision thereby contributing to a wider spectrum of care in localities. Carers and users value their independent status and the informal approach to service delivery. In terms of quality assurance, non-statutory services are able to utilise customer feedback to directly inform service improvement.

Weaknesses

A number of weaknesses of non-statutory sector organisations are related to their working practices. Some non-statutory services are small in size potentially limiting their scope. This is of relevance for frail older people since immediate availability and continuity of care in the longer term are recognised by practitioners and users as important, reflecting the wider care coordination literature. Within this context, the delivery of integrated care may be further limited by a failure to realise the potential of effective partnership working between statutory and non-statutory organisations.

As noted above, volunteers are a feature of non-statutory organisations. However, their long-term commitment to the service is not always matched by the investment in their recruitment and training. Another factor which may impede the operation of non-statutory services is an excessive focus on the collation of performance management data to meet both organisational and contractual requirements.

Opportunities

Non-statutory organisations are separate from the state and this defining characteristic provides them with distinct opportunities for service development. Historically they have played an important role in developing innovatory services in response to unmet need. They are also recognised as providers of services to groups of people with specialist needs, filling gaps and thereby complementing statutory provision. Policy initiatives which promote the involvement of the non-statutory sector in the delivery of care coordination for older people and their involvement in the commissioning process provide the means to continue and develop these traditions. Standards which guide the work of practitioners undertaking care coordination and agency procedures can facilitate this process.

Partnership working which facilitates information sharing between organisations within the non-statutory sector provides a means of improving the user experience. More generally, the promotion of services in local areas ensures that those for whom they are appropriate are aware of them and have the opportunity to use them. This takes two forms, each with cost implications. The first is through publicity and direct marketing in public places (for example GP surgeries) and the internet. The second is through direct contact with professional intermediaries (for example nurses and social workers).

Threats

Both the scale of local non-statutory services and the commissioning arrangements which govern their activities may compromise their long-term prospects. In respect of scale, the small size of many non-statutory services limits their potential to develop their capacity to both complement and substitute for statutory provision. Short-term funding can make it difficult to recruit and retain staff and more generally contribute to uncertainty within the work environment. Furthermore, it threatens continuity of care and long-term support to users and carers.

With regard to commissioning, contracting and monitoring arrangements it is important that these reflect and are proportionate to the service provided by the non-statutory organisation. Additionally, standards which inform practice and agency structure should facilitate day-to-day operations. Costs associated with contract monitoring incurred by providers within the envelope of funding allocated by commissioners may impact on capacity to deliver front line services. Therefore a balance is needed between the requirements of commissioners and support to users which reflects the scale and nature of the service. Measures of performance for contract monitoring should not be assumed to be the sole determinants of service quality and, more generally, of appraisal associated with contract renewal.

Concluding comments

Overall, findings from this research study deliver several important messages relating to the provision of care coordination arrangements for older people by organisations within the non-statutory sector. The strengths of the sector in this respect are derived from their independence from the state and flexible approach to staffing. Their weaknesses relate to their small scale and sometimes limited range of care coordination tasks undertaken. Nevertheless, opportunities exist for non-statutory organisations to provide specialist

services primarily but not exclusively for older people and to work in partnership with other local agencies. The threats to their longevity are associated with fixed-term funding and the uncertainties consequent on commissioning processes.

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Further information

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Appendix 1: Service descriptors including care coordination (CC) activities

Site ID	CC activities*	Target Group	No. of staff undertaking activities related to CC	Length of active contact**	Nature of service	Use of volunteers***
1	A, SP, I(+B), M, R, C	Older people	Less than 10	Short-term	Substitute	Yes (2)
2	A, SP, I, R, C	Adults and older people discharged from hospital	10 or more	Short- term	Substitute	Yes (2,3)
3	A, SP, I, M, R, C	People with dementia	Less than 10	Medium term	Complementary	Yes (2,3)
4	A, SP, I, M, R, C	People with dementia	Less than 10	Short-term	Complementary	No
5	A, SP, I, R, C	People with dementia	Less than 10	Short-term	Complementary	Yes (2,3)
6	A, SP, M, R, C	People with dementia	Less than 10	Medium term	Complementary	Yes (3)
7	SP, C	Adults with disabilities and older people	Less than 10	Short-term	Substitute	Yes (1)
8	A, SP, I, M, R, C	Adults with disabilities and older people	Less than 10	Short-term	Complementary	No
9	A, SP, I(+B), M, R, C	Adults and older people	10 or more	Short-term and long-term	Substitute	No
10	A, SP, I, M, R, C	Adults with disabilities and older people	10 or more	Long-term	Substitute	Yes (2)
11	A, SP, I, R, C	Adults and older people with sensory impairment	10 or more	Short-term	Substitute	Yes (3)
12	A, SP, I, M, R, C	BME**** adults with disabilities and older people	Less than 10	Long-term	Complementary and substitute	Yes (3)
13	A, SP, I(+B), M, R, C	BME older people	Less than 10	Long-term	Complementary and substitute	Yes (3)
14	A, SP, I, M, R, C	Adults and older people discharged from hospital	Less than 10	Short-term	Substitute	Yes (3)
15	A, SP, I, M, R, C	Adults and older people discharged from hospital	Less than 10	Short-term	Substitute	Yes (1,3)
16	A, SP, I, R, C	Adults and older people discharged from hospital	Less than 10	Short-term	Substitute	Yes (3)
17	A, SP, I, M, R, C	Adults and older people discharged from hospital	Less than 10	Short-term	Substitute	Yes (1)

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