Care coordination for older people in England: Does context shape approach?

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Abstract

Summary: Policy and practice developments in adult social care in England and elsewhere recognise the increasing role of the non-statutory sector. Care coordination services are central to the delivery of tailored support. This qualitative study focuses on support for older people and reports an analysis of 13 non-statutory sector services providing care coordination, grouped into four service types. Semi-structured interviews explored the influence of service context on the nature of practice.

Findings: Particular elements of care coordination (e.g. assessment) were found to be shaped by the specific aims and purpose of each service type, such as extent to which they had a commissioning or provider role and the nature of their target group. Aspects of a range of case and care management approaches were in use throughout the sample, varying in relation to the distinct features of the service type. A set of overarching standards was found to be relevant to all services considered. Third sector services were found to provide innovative support which both complemented and sometimes substituted for the statutory sector.

Application: Findings point to the continued importance of social work values and methods to the work of non-statutory sector services providing care coordination and to current limitations in relation to what the sector can provide. These are issues which employers and service commissioners need to address in order to ensure the capacity of and standards of practice within the non-statutory sector services are able to meet the demands made of it. Further areas of research are identified.

Key words:

Case management, older people, qualitative research, social work, voluntary sector

Introduction

The system in which care coordination in England is delivered is diversifying with an enhanced role for the non-statutory sector into this arena as a result of changes in policy direction (Home Office, 2010; Office of the Third Sector, 2006; Department of Health, 2016). Care co-ordination encompasses a series of tasks, such as assessment and care planning, completed to support individuals to locate and access the health and/or social care services they need in line with their aspirations and preferences. The non-statutory sector is defined as existing outside the state and being non-profit distributing (Kendall & Knapp, 1997). This article considers the delivery of care coordination for older people, a richly varied population category, by the non-statutory sector; for which there is currently little evidence. It aims to describe the features of and approaches to care coordination practice and to explore the reasons for any differences found. Prior to outlining the study background and methods in detail, a brief overview is provided of three areas relevant to this paper: care coordination through the lens of case and care management; the role of the non-statutory sector in the delivery of adult social care in England; and the nature of practice standards.

Approaches to coordinating care and support

Semantically, care coordination has replaced case and care management in recent years in both literature and practice settings, a symptom of efforts to integrate health and social care services, with care coordination more commonly associated with healthcare practice (e.g. Kodner, 2006). Case management originated in the US in the 1960s and care management in the UK in the 1980s (Huxley, 1993). The approaches have distinct but related histories. The coordination of support for an individual in need, however, is fundamental to both. Care coordination is consequently used here as an overarching term embracing the range of approaches noted below. Rothman (1991) described case management as incorporating advice, counselling, and therapeutic support to individuals in the community as well as connecting them with other needed community services. Care management was developed as a means of effectively targeting resources and of meeting individual needs. It aimed to support individuals with the practical steps involved in identifying needs and arranging care, using “human relations skills such as counselling and support” (Challis et al., 2001, p675) to guide and support them throughout this process. Case management includes task-centred, strengths-based and consolidated approaches to practice. The task-centred method emerged during the 1960s, was aimed at moving away from open-ended casework, and emphasised working in partnership with service users (Marsh, 2015). The strengths-based approach focuses on the strengths of individuals and communities to encourage agency and self-determination over their lives. Within the strengths-based model (Chapin & Cox 2002; Marsh, 2015) problems are identified alongside goals to be achieved with work proceeding incrementally in stages and progress reviewed regularly. Kanter (1989) described the consolidated approach to case management under four headings: initial phase (engagement, assessment and planning); environmental interventions (e.g. linkage with community and health resources, development of social networks); patient interventions (e.g. training in independent living skills); and patient environment interventions (crisis intervention and monitoring). The case manager or coordinator is consequently involved in assessing, planning, and arranging service delivery from elsewhere; and in the provision of direct service support Zawadski and Eng (1988).

A key attribute of care management was the concept of the needs-led assessment developed to counter so-called service-led assessments, which were shaped by service availability. The separation of assessment from service providers was identified as a means to achieve this. Three approaches to care management were subsequently identified, to be differentially used in relation to the nature of individual circumstances: an administrative approach for the provision of information and advice or a simple service; a coordinating approach for the majority of users; and an intensive approach for those with more complex or changing needs, requiring the allocation of a designated care manager (Challis et al., 2001; Social Services Inspectorate, 1997). Huxley (1993), comparing two of these approaches, referred to them as the difference between a travel companion (clinical) and a travel agent (administrative). Continuity was considered essential to the intensive approach with the identification of personnel responsible for each element of practice regarded as helpful in all three (Jacobs et al., 2009).

Care coordination, within any of the above descriptions, involves a range of elements which follow an individual’s care pathway from referral to closure incorporating assessment, support planning, implementation and brokerage, monitoring and review (Chester et al., 2015). These elements are described in Table 1 and demonstrate how care coordination is implemented. Recent evidence suggests that where these elements are overseen by a single worker, the experience of the support system by service users is a more positive one (Schultz & McDonald 2014). This has been linked to the notion of informational, management, and relational continuity which can provide individuals with security, predictability, inter-personal trust, and in turn can lead to care, tailored to the individual (Guthrie et al., 2008). There is also some indication that such continuity can lead to better outcomes (Chapman et al., 2009; National Health Service (NHS) Benchmarking Network 2014) although this evidence remains weak (Chester et al., 2015).

The role of the non-statutory sector

The term 'third sector' is sometimes preferred to 'non-statutory', as indicating something positive as opposed to being identified as something it is not: neither statutory nor private profit-distributing (Corry, 2010; Kelly, 2007). Non-statutory is consciously used here, however, as it is the sector's relationship to the state that is its most significant characteristic within the current study.

Although a mixed economy of care, including private, non-statutory, and public sectors, has been the norm in England for some time (Means, 2012), it is only recently that policies have brought care coordination activities into the purview of the non-statutory sector (Department of Health, 2016, para 4.2). Prior to this, such activities were the domain of the state, undertaken by a range of professionally qualified and unqualified staff from within social work, nursing or occupational therapy. In contrast, non-statutory sector services have been largely providers of care, including domiciliary, counselling and advice services. The rolling back of the state to one which embodies an enabler rather than a provider function (Taylor, 2000; Wistow et al., 1992) has provided an opportunity for non-statutory sector organisations to develop new services either to complement or substitute for one-time state provision. This opportunity has been described by some commentators as coming at a time when the independence of the non-statutory sector is under attack with the state moving to bring it within its orbit of control (Carmel & Harlock, 2008). The Cross Cutting Review of the sector (Her Majesty's Treasury, 2002), for example, has been described as a watershed between the partnership paradigm that dominated relations between the state and the non-statutory sector for many years and the co-production paradigm where the non-statutory sector are service agents, doing the bidding of the state (Osborne & McLaughlin, 2004). Interdependence between statutory and non-statutory sectors has also been mooted in recent years with the latter seeking "positive interdependence rather than a freestanding status" (Fenwick & Gibbon, 2016, 233). It has been suggested, however, that commissioning arrangements have hindered the achievement of this model due to the uneven power held by the two sectors and within which non-statutory services are expected to adhere to market-style arrangements and "inappropriate performance measurement" regimes (Milbourne & Cushman 2013, 488). Other commentators have pointed to the shared values between the state and non-statutory sector outlined in the update to 'The Compact' between the state and non-statutory sector (Home Office, 2010) as an important indicator of change in the relationship with the non-statutory sector's traditional independence and role as challenger of the state under threat (Jacklin-Jarvis, 2015; Macmillan, 2013).

<Table 1 about here>

Practice standards

The role of case and care management standards in quality assurance systems have long been recognised internationally (Bulger & Feldmeier, 1998). Standard setting, implementation, and measurement are all part of a quality assurance cycle, vital to the achievement of high quality performance (Ellis & Whittington, 1993; Ovretveit, 1992). By and large the literature supports the development of standards that are precisely defined and which also provide practitioners and managers with the tools needed to support their delivery (Campbell et al., 2000; Geron, 2000). Ovreveit (1992), however, has argued for more abstraction, arguing that standards need to include statements at different levels of generalisation with a focus on outcomes rather than processes and the avoidance of prescription where 'intangibles' are present, to ensure that measurement is appropriately focused.

A recent international review (Abendstern et al., 2016a) of twenty care coordination guidance documents produced over the last 30 years identified a core group of 24 standards that had endured across time, place, and organisational location. Five appeared in all or almost all of the documents reviewed with a sixth present in four-fifths of them. These standards are detailed in Table 2 below with example indicators from the documents themselves. A rigorous definition of a standard was also developed from this review, incorporating principles (views expressed in mission statements, ethical guidelines, not tied to a specific activity) operationalised within one or more elements (for example assessment) of practice.

<*Table 2 about here*>

Study Method and background

Design

This paper forms part of a larger mixed-methods study, intended to enhance the understanding of the role of the non-statutory sector in the provision of care coordination for older people in England (Abendstern et al., 2016a, Abendstern et al., 2016b; Abendstern et al., 2017; Jasper et al., 2016; Sutcliffe et al., 2016). The qualitative study reported here is based on data from semi-structured interviews with practitioners in 13 fieldwork sites, grouped into four types. A descriptive exploratory approach was taken using thematic content analysis to interpret the collected data. The paper builds on the findings of a quantitative national survey (Sutcliffe et al., 2016) which is drawn on to provide relevant context for each of the included services.

The sample

Purposive sampling from 122 national survey participants (42% response rate) was used to select the fieldwork sites (Bowling, 2014). Services were selected to represent a variety of settings and organisational types, both national organisations delivering local services and non-affiliated local agencies. They also needed to provide services for individuals living at home, of whom at least 50 per cent were older people; to support a minimum of 40 service users; and to undertake at least four care coordination elements. A range of geographic areas across England, including both urban and rural districts, was also sought. Seventeen services were initially identified. Services were grouped into types reflecting their target group and purpose. Thirteen were included in the final sample, grouped into four service types. Four services were excluded as being too disparate to group.

Service context features

The four service types: adult social care, brokerage, hospital discharge support, and specialist dementia advice and support (from here referred to as specialist dementia services), are listed in Table 3 alongside other key identifiers. All were contracted to provide care coordination to older people by local service commissioners within local government or the NHS. Most, as seen in Table 3, undertook the majority of elements apart from brokerage whilst some did not monitor. Additionally, not shown in Table 3, hospital discharge services incorporated a provider role within their service, offering weekly practical support in the home.

Service types varied in relation to location, target group and length of involvement. They were situated in a variety of locations. All but one hospital discharge service was hospital-based. The outlier (Service 2) was based off site within organisation premises, taking referrals from a range of local hospitals. Specialist dementia services tended to be adjacent to the memory clinic to which they were attached. This meant both specialist dementia and hospital discharge support service types were able to see individuals ‘in situ’. Both adult social care and brokerage services were office-based, seeing people by appointment either at home, or at a local resource centre. Adult social care and brokerage service types provided support to older people with complex needs and in one of the brokerage services (13) this was specifically for people from a Black or Asian Minority Ethnic (BAME) community. Hospital discharge services supported older people (in one case classed as anyone over 55 years) with low level needs to return to independent living following an inpatient admission or to prevent one. Specialist memory services all provided services specifically to people with dementia with some within type variation relating to the level of needs supported. Input length varied between short, medium, and long-term. As seen in Table 3 within type variation existed regarding this variable in specialist dementia and brokerage services. Long-term support was offered by the adult social care services and short-term by the hospital discharge services.

Data collection

Semi-structured interviews were undertaken with one practitioner from each service. The interview schedule prompted interviewers to ask particular questions of each care coordination element provided by the service, by whom, and how long each activity took. For example, “can you talk me through a typical assessment process?” Interviews were undertaken by three of the co-authors (MA, JH, RJ) between February and May 2015. Each interview lasted approximately one hour, was audio recorded, and professionally transcribed. Practitioners were approached via their manager and those who agreed to be interviewed were provided with background information about the study and asked to sign a consent form immediately prior to the interview. Data were anonymised.

<*Table 3 about here*>

Data analysis

Both deductive and inductive data analysis methods were used, drawing on framework analysis (Ritchie et al., 2014) to move from description to interpretation in a systematic manner. Interview transcripts were transferred to ATLAS.Ti.6, to support the coding and analysis process. Service types, reflecting both what was provided by the service and to whom, were defined. A priori constructs were initially used to organise the data within each service type into the same broad descriptive codes, referring to surface features related to elements in the care coordination pathway (from referral to case closure as described in Table 1). Data on individual elements were then charted, summarised, and a second level of coding undertaken whereby concepts or themes identified from the data were noted (Gibbs, 2007). This process supported the emergence of themes both within elements of care coordination practice as well as those embedded in more than one of them. Coded data were then analysed for similarities and variations between types in relation to both the 'what' and 'how' of practice. This iterative process was undertaken by three of the authors

(MA, RJ, NL) and involved discussion, reflection and re-visiting decisions until consensus was reached.

Findings

Two major themes emerged from this analysis. Firstly, variations in the approaches to care coordination were detected in relation to the contextual features noted in Table 3 (location, target group, and length of involvement) and the extent to which the care coordinator commissioned services on behalf of the service user or assisted in the process. Service location and length of involvement were also closely linked to target group. Secondly, a number of recognised standards of care coordination practice were present across all service types. The findings are divided into two sections reflecting these themes.

The influence of context on practice

The summary of care coordination elements, as depicted in Table 3, suggested a broad degree of similarity between the 13 services, despite their different foci. However, the nature of *how* they were operationalised was found to vary in relation to particular service context features, considered in turn below. The order of their reporting is linked to their impact on specific elements along the care coordination pathway from referral and initial contact to case closure as described in Table 1.

Service location

Service location had a particular impact on the nature of initial contact between the potential service user and practitioner. In the adult social care and brokerage services, initial post-referral contact with an individual usually involved a phone call to arrange a visit and was described as a largely administrative procedure. In contrast, in the hospital discharge and specialist dementia services, initial contact was often in person as staff were situated in the same premises as referred individuals. For the hospital discharge services new referrals were visited on the ward where, if the individual agreed, an assessment would be made. In the specialist dementia services, referrals were made in person directly following a diagnosis of dementia. Practitioners spoke of this process being undertaken with great sensitivity, in recognition of the impact that a diagnosis of dementia can have. One described how he and the psychiatrist he worked with handled these situations:

> The psychiatrist will give the diagnosis and then he'll introduce me … and then we'll just mention we support people with memory issues. We have usually a little bit of information … and then we'll say … we'll contact yourself or your carer, whichever you prefer, in the next week or so and we'll try and arrange a home visit (Respondent 5)

Target group

The complexity of needs and whether these were specific to a particular condition or set of circumstances influenced the nature of assessments. The aim of these, irrespective of service type, was to find out as much as possible about the service user's circumstances to appropriately tailor and implement a support plan. Assessment focus, however, varied in relation to the target group of the different service types. Brokerage services whose commissioned service began at the support planning stage for people with complex needs nevertheless undertook assessments. These were of a 'checking' nature. As one practitioner put it:

> We don't assess as such … I would read that assessment prior to the visit but I wouldn't use that as my benchmark … I would start from the beginning with the client and ask what they felt they need (Respondent 1)

The assessments within adult social care services, which also provided support to people with complex needs, were described as comprehensive; including activities of daily living (ADLs), mobility, nutrition, family and community networks, risks, and what individuals themselves were able and willing to undertake. Specialist dementia services, as noted earlier, provided support for people with both low level and complex needs. Assessments for both were described as 'holistic' in that they touched on a wide range of areas in an individual's life. They differed from the adult social care assessments in two ways. Firstly, their ADL assessments were more cursory, having a screening function aimed at finding out whether a referral to a social work team was warranted. Secondly, their focus was directed at the particular concerns likely to arise for someone with dementia and their carer. For example:

> My main aim … is to find out how they feel about the diagnosis, do they need any more information, do they understand the diagnosis, do they understand what the medication is for? (Respondent 4)

The assessments of hospital discharge services, which targeted people whose needs were low level, were narrowly focused; being aimed at assessing immediate and short-term needs and realistic goals. The former included potential difficulties or risks to the practitioner (such as aggressive pets) as well as the individual they were supporting (such as whether they could use their kettle). The varying foci of these assessments did not mean that any were superficial but that each was appropriate to the target group to which the service was offered.

Provider or commissioner role

The extent to which practitioners within the different service types had a provider or a commissioner role had a particular impact on the elements of implementation and brokerage.

Hospital discharge services differed from the other service types, as noted earlier, in that they had a more extensive role as a direct provider of assistance rather than service commissioner. Thus, individuals were allocated a worker who visited weekly to assess progress towards goals and provide help (or assistance) with for example shopping, bill payment, pension collection, making snacks, and collecting pets from kennels. In contrast in the specialist dementia services practitioners were more likely to signpost service users to other sources of advice and assistance. For example:

> We will check out whether they are getting benefits … and I will refer on if things aren't getting claimed for. I will give information on our local services and other services … I'll give out information on solicitors, how to do it yourself (Respondent 4)

Implementation in adult social care services also largely comprised referring to and negotiating with a range of prospective service providers. Brokers were specifically concerned with supporting people who had been allocated a personal budget. They were consequently involved in a range of implementation tasks from helping individuals to decide whether they preferred to employ a personal assistant (PA) or use a commissioned service and, if the former, to help them with advertising for this and with "all the employment … responsibilities that come with that" (Respondent 1). Broker practitioners stressed the labour intensive nature of this work due to the amount of paperwork involved and the complexities of explaining the pros and cons of employing a PA, particularly where the individual wanted to employ a family member.

Length of contact

Length of contact impacted on the nature of whether and how service types conducted monitoring, reviewing and case closure elements. Two distinct, and at first glance contradictory, features were identified in relation to approaches to monitoring. On the one hand, longer-term services were more likely to have a monitoring role than shorter-term ones. However, monitoring was a fundamental part of three of the hospital discharge services, although they provided only short-term support. This seeming anomaly was linked to their provider role which was described as including a “constant monitoring” function within each visit (Respondent 15). Monitoring in these services was undertaken face-to-face as part of the weekly service for its six week duration. In contrast, where it occurred in all other service groups, monitoring was reported to be a minimal, irregular and informal task, undertaken either by phone or through contact at drop-in or group services. Minimal monitoring was also regarded by some practitioners as tallying with their service’s approach to self-determination.

Reviews of the circumstances of service users and their length of contact with services were linked. They were reported to be conducted by all services although at varying intervals dependent on case complexity and statutory obligation. They were described as reassessments in more complex cases: reviewing needs and goals, finding out if further support was required and altering support plans as necessary. Such reviews were undertaken face-to-face. In less complex cases, for example in the specialist dementia services, a brief phone call might suffice. The hospital discharge services described their final meeting with the service user as a review – revisiting the goals they had hoped to achieve at the beginning. Although mention of flexibility to extend their service for one to two weeks was made, the standard practice was to close the case with a referral to another service where required.

Clear closure procedures were set out with service users from the outset and no direct re-referral to the service was available:

> I give them a … working week and give them a ring - “are you getting on ok, is everything ok?”, then shut, close them down (Respondent 16)

Two service types described cases being closed and re-opened for reviews (adult social care and brokerage). Adult social care, brokerage and specialist dementia services all described a workload management system whereby cases that were inactive but that might require further input at a later date were closed on the internal system but without informing the service user that the case was closed. Records were consequently readily available for the planned review and/or when the service user or carer contacted them again. This approach was said to be preferred by users of services than being told that their case was closed even where direct re-referral was possible. For example:

> We’ll reach a point where we have to just close that on the system … I normally send a letter … don’t forget that we’re here if you need us … So that they feel that … that door is always open and I haven’t used that dreaded phrase, case closed. But it is as far as we’re concerned internally (Respondent 6)

Standards of practice

Standards guiding practice across care coordination elements were seen within these services in the form of continuity; person-centred; and strengths-based approaches with a focus on goals, and on self-determination. Operating within a network of support was also evident. Some evidence of advocacy on behalf of individual service users, defined here within the relational approach standard, was also seen. All service types strove to provide continuity of support in the form of a named worker. This was regarded as valuable for a service user's sense of comfort and security. For example:

> It might take five weeks before you are getting to know somebody so it is better for that person if they have got one person going (Respondent 6)

In three service types continuity was from referral onwards. In contrast, in the hospital discharge services, two members of staff were involved, the first undertaking the initial hospital-based assessment and support plan and the second taking on the case from the first home visit, undertaking further assessments with the individual, refining the support plan as required and providing information, advice, and practical support.

Being led by the individual, going at their pace and placing them at the heart of practice were also regarded as standard approaches in all services. Person-centred and strength-based approaches were emphasised by practitioners in relation to the way they spoke to people. Although the use of standard assessment tools was commonplace, practitioners stressed that their approach was nevertheless informal and conversational and "not just a box thing" (Respondent 10). The example below illustrates this alongside recognition of the importance of focusing on strengths as well as needs. The practitioner stated that their approach to assessment was to:

> Talk me through your day. So that isn't focusing on any negatives because during that day, people will say what they can do … We have a conversation about somebody's day and from that conversation we usually determine what support the individual will require to meet their needs (Respondent 9).

All service types also stressed the importance of supporting people to recover or enhance their independence and self-determination through undertaking things for themselves and that their interventions should be the least invasive. Examples included giving people choices through the provision of information and advice (including possible charges and where to get financial advice), or helping a service user to implement their own support plan through signposting them to a range of relevant services and agencies to which they could refer themselves. The latter can be regarded as evidence of the standard: working within a network of support. Advocacy was also regarded as part of such practice when individuals were not equipped to act for themselves. Examples included speaking up for those whose services had been cut or who wanted a different service. This type of practice was noted in two service types. In the specialist dementia services examples were provided of practitioners ‘fighting’ to have statutory services reinstated or tailored more appropriately to the individual’s needs. Brokers were also found, as noted earlier, to see it as part of their role to advocate for service users where the latter were not happy with the support plan or personal budget agreed by the local authority. For example:

> I will go to the family and … say “this is what has been approved”, if they have any issues … I would have to go back to the social care assessor who approved it to say, - “can you please change it?” (Respondent 13)

Practitioners spoke in terms of enabling service users to take control of their lives, albeit with their support. This was not always the easiest option for practitioners who sometimes noted that this was a difficult balance to strike:

> I have to think, “I’m not managing, I’m setting up”. I can get confused with that sometimes (Respondent 13)

Finally, a focus on goals was evident within all services but most prominent in relation to hospital discharge support where goals were emphasised in the assessment process.

Discussion

This paper has provided a unique insight into the practices of non-statutory services operating within the field of care coordination for older people. It has addressed an evidence gap highlighted by a literature review (Abendstern et al., 2017) that reported a lack of data regarding the specifics of practice. Qualitative methodology has made it possible to get below the surface of practice, for example, unpicking the nature of monitoring in different services, to make sense of the variations found. A number of key messages emerge from the study. First, case and care management models are relevant to care coordination practices in the non-statutory sector. Second, over-arching standards applicable to all services, irrespective of their design are evident. Third, the findings indicate an opening up of opportunities for social workers to work in a range of settings where the core values of the profession continue to be germane. Fourth, they point to a gap between policy goals and non-statutory sector capacity. These issues and their implications are considered in more detail below.

Service context and observed approaches

This article has explored the nature and content of social work activities through the medium of care coordination. The practices of the current sample suggest that services adopted an amalgam of care coordination approaches appropriate to their service users and setting (Howe, 1979). There was some evidence of the strengths-based approach across service types in relation to assessments which often included questions about strengths and abilities as well as needs and deficits. A consideration of the strengths of the individual’s informal family and community networks was most noticeable in the brokerage services where PAs might be drawn from within such networks. Hospital discharge services demonstrated aspects of a task-centred model through their short-term involvement, a goal focus from the outset with frequent reviews of progress, and a partnership approach based on respect for the service user’s views and good communication (Marsh, 2015). Specialist dementia and hospital discharge services came closest to the consolidated approach to case management with direct involvement in a range of activities including the provision of both practical and emotional support (patient interventions) as well as initial and environmental phases.

These findings are indicative of a pragmatic approach to practice rather than a rigid adoption of a single model and chimes with earlier commentators who suggested that whilst models provide a set of “assumptions, methods, structures, and tools” (Rapp 1998, p. 364) they are also rarely replicated fully in the real world, being adapted to suit the context in which they operate. Challis (1994) wrote that the effective implementation of a model requires:

> “A coherent logic which clarifies the relationship between structure, location, target group, practice models, and likely day-to-day pressures and incentives and expected outcomes” (p. 21)

The influence of location, target group, role as commissioner or provider of services to the individual, and length of support were all seen in the current sample to influence particular elements of care coordination rather than to affect the service approach as a whole. Service location was found to impact on the nature of the initial contact. Whether the service targeted people with low level or complex needs, impacted in particular on the content of assessments. The extent to which services were commissioners or direct providers of services for individuals influenced implementation practices in particular; and length of contact had an effect on monitoring, reviewing and closure procedures.

Overarching standards

Some evidence of the operation of practice standards was found in the current study with an observed link between a number of these and some of the care coordination approaches outlined above. In particular this was seen in relation to the focus on goals, on strengths as well as needs, and functioning within a network of support. All those observed were closely aligned to the core standards identified by earlier research and noted in Table 2 above (Abendstern et al., 2016a). The earlier review found standards to be unevenly operationalised across the elements of care coordination. In contrast, although the evidence from the current study is not substantial it hints at their presence throughout the care coordination process. Additional research into this area would help to further illuminate this important issue. A national survey of non-statutory sector care coordination services for older people (Sutcliffe et al., 2016) found that all responding services had operational protocols to inform their practice. The absence of sector-wide standards has also been noted (Dickinson et al., 2012). The current study suggests that such guidance could support good practice in a range of settings. The level of specificity at which these should be set remains to be decided with a requirement for measurability that does not impede innovation and flexibility (Manthorpe et al., 2014).

Implications for social work practice

Evidence from this study shows that a variety of care coordination tasks, traditionally the remit of social workers in adult social care within the statutory sector, are now also being undertaken by staff working in the non-statutory sector. This is in line with government policy in the UK and elsewhere, changing the balance between statutory and non-statutory sectors as providers of social care services (Anheier, 2004; Department of Health, 2016; Defourny & Pestoff, 2008; Gray et al., 2003). The implications of this are unclear. On the one hand it might indicate an undercutting of professional social work by unqualified practitioners. One English national survey reporting on non-statutory care coordination in 2014, for example, found a minority of care coordinators had professional social work qualifications (Sutcliffe et al., 2016). Conversely, the shift toward the outsourcing of social work activities could lead to greater opportunities for social workers to practice in a wider range of settings. Given the evidence of dissatisfaction among social workers working in adult services due to the bureaucratisation of their role within the statutory sector (Lymbery & Postle, 2010; Postle, 2002), opportunities to work in a sector recognised to be less bureaucratic (Abendstern et al., 2017; Anheier, 2009), might be welcomed. In particular, the current study suggested an opportunity to reinvigorate social work support in hospitals and other health settings such as memory clinics. Integration remains the aim of health and social care service planners (Wistow, 2012). Non-statutory social care coordination services working in partnership with statutory health providers may be part of a strategy to achieve this end.

Implications for commissioners and non-statutory sector providers

A mixture of substitute and complementary services was seen within the sample although, perhaps surprisingly, the majority were substitutional. These were services that would otherwise have been provided by the statutory sector. Complementary services, in contrast were those which offered new or additional services to those provided by the statutory sector. This is significant given that the non-statutory sector has traditionally stressed its advocacy role and as such has been reported to be uncomfortable with being placed in the role of alternative to the state (Craig, Taylor & Parkes, 2004). Current English legislation however now clearly positions them as equals alongside the statutory sector in the development of welfare services (Anheier, 2009; Department of Health, 2016). As noted in the introduction, this status might affect the extent to which non-statutory sector services can maintain their traditional advocacy role on behalf of individual service users, where they are potentially in dispute with a co-producer, although current evidence suggests otherwise. Additionally, the current sample demonstrates how their inclusion has produced innovative practices, regardless of their substitute or complementary position. So, whilst multidisciplinary hospital discharge teams have been a feature of statutory services for some years (Bauer et al., 2009; Bull & Roberts 2001), the services offered by the non-statutory sector were of a different and innovative order, providing support for people with low-level needs as well as operating as a direct service provider. Equally, specialist dementia services were situated within an organisation that also provided a range of direct group services, a feature which enabled them to link people to support within their organisation to which they were often personally connected. Together with specialist advice and support, and availability to individuals and their carers over the long-term, this made them both complementary and innovative. A gap, however, exists between current policy and the capacity of the non-statutory sector to fulfil this core role. In the current sample, services were designed to meet specific needs and fill specific gaps, yet broader generic services are also required. The ability of the sector to take on more mainstream service provision will be shaped by commissioning practices, particularly length of contracts provided.

Limitations of the study

The study had a number of limitations which must be acknowledged. Firstly, the inclusion of 13 adult social care services with variation in the needs targeted between and within each of the four service types places limitations on the comparisons made. Secondly, the data was gleaned from only one source, practitioners in the field, and can therefore only claim one perspective. Thirdly, only one practitioner was interviewed from each service. Fourthly, the richness of the data varied between elements and this is reflected in the findings with some aspects more fully explored than others. Finally, the included services were based on a purposive sample, potentially limiting the generalisability of the findings, although this has been offset by the analysis by service type.

Conclusion

Different bundles of features and approaches, forming hybrid systems, have been found within the non-statutory sector care coordination services investigated here. Variation is desirable if services are to support a range of individuals with a variety of needs. As identified earlier, older people are not a homogeneous group and those with dementia will require a different type of support from those who, for example, require ‘a little bit of help’, to return to independent living following hospitalisation. In juxtaposition to this, the production of a set of core care coordination standards could be relevant as a quality marker and useful to a range of non-statutory sector services irrespective of contextual features. The practice of care coordination within the non-statutory sector offers a potential growth area for social work. However, policy, commissioning, and practice need to coalesce for this to be achieved.

Future research is required that addresses these themes. In particular it would be helpful to track the development of care coordination services for older people in the non-statutory sector to discover whether they expand into the mainstream and at what cost to their creativity and relative independence. The nature of their relationship with the local and national state is situated within wider public discourse and will again require research to test the nature of this relationship and its impact on practice in the future. Finally, further research to assess whether particular models of care coordination can be more widely identified and whether any can be linked to quality standards will be important to promote good practice in a future which looks set to transfer more responsibilities from the statutory to the non-statutory sector.

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Table 1: The core elements of care coordination

	Element	**Definition**
1	Referral	Determining eligibility through initial assessment
2	Assessment	Collection of in-depth information on and with the involvement of an eligible individual regarding functioning, needs, existing support, aspirations and goals
3	From assessment to support planning	Discussion of needs, wishes and preferences and type of support available to meet them
4	Support planning	Information gathered during assessment is translated into a package of services or supports incorporating both informal networks and formal services
5	Implementation/brokerage	Arrangement of service provision through: (i) Contacting services identified in the support plan and sharing service user information collected during assessment with them (ii) Signposting and supporting an individual to arrange services themselves
6	Monitoring	Continuing contact with service user and providers to ensure that services are provided in accordance with the support plan and that they continue to be relevant to meeting the individual's needs. Can involve service changes
7	Reviewing	Scheduled examination of the service users' situation and functioning to identify changes and measure progress toward desired goals
8	Closure	Based on nature of service (pre-determined length) or individual service user's situation (no longer requiring support or requiring more intensive support than available within the service)

Adapted from: Applebaum & Austin, 1990; Challis et al. 1995; Reilly, Hughes & Challis, 2010.

Table 2: Core standards of care coordination

Definition	**Example indicator**
A comprehensive and holistic approach	A comprehensive and accurate assessment will be produced of the person's abilities, resources, goals and needs (Ministry of Health, 1994).
The promotion of active user and care participation	Ensure that informed consent is continued so that the person remains an informed decision making participant (National Case Management Network, 2009).
Person centred practice – providing choice and flexibility	The assessment should identify the person's care needs beyond the presenting problem in the areas of physical, cognitive, social, and emotional functioning as well as financial and environmental needs. It should also include a detailed review of the person's current support from family, friends, and formal service providers (National Council on the Aging, 1988).
Awareness of and operation within a network of support	Case manager will be knowledgeable about services that are accessible and relevant to consumer interests to provide up to date information (Ontario Government, 2005)
An outcome focus	Intervention should be based on goals and objectives that have been identified and negotiated with the service user (Case Management Society UK, 2009).
A relational approach	The interaction and relationship between the case manager and the service-user is an important therapeutic tool ensuring effectiveness and continuity of care. The case manager is counsellor, mentor and advocate on behalf of the service-user (Rosen et al., 1995)

From: Abendstern et al 2016a.

Table 3: Service types and nature of provision

Service type	ID[#]	Care coordination elements undertaken								Location	Target group	Length of involvement*
		Re	A	SP	I	B	M	R	C			
Adult social care	9	√	√	√	√		√	√	√	Community office	Older people with complex needs	Long-term
	10		√	√	√		√	√	√			
Brokerage	1	√	√	√	√	√	√	√	√	Community office	Older people with complex needs	Mix of short and long-term
	13	√	√	√	√	√	√	√	√			
Hospital discharge support	2	√	√	√	√			√	√	Community office	Older people with low level needs	Short-term
	14	√	√	√	√		√	√	√	Hospital		
	15	√	√	√	√		√	√	√			
	16	√	√	√	√			√	√			
	17	√	√	√	√		√	√	√			
Specialist dementia advice and support	4	√	√	√	√		√	√	√	Memory clinic	People with dementia. Mix of low and complex needs	Mix of short and medium term
	5	√	√	√	√			√	√			
	3	√	√	√	√		√	√	√			
	6	√	√	√			√	√	√			

[#] Service ID numbers are those used in the original evaluation and are used here to maintain consistency of reporting across publications. Re = Referral, A = Assessment, SP = Support planning, I = Implementation, B = Brokerage, M = Monitoring, R = Review, C = Closure. * Short-term: up to and including 6 weeks / Medium term: 7 to 12 weeks / Long-term: 13 weeks or more.