NHS

Case management competences framework

for the care of people with long term conditions

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For Recipient's Use	

A case management competences framework for the care of people with long term conditions

Joint foreword

Seventeen and a half million people in the United Kingdom report living with a long-term condition. Most are already receiving quality care, routinely, from health and social care teams across the country. However, there is evidence that many individuals with complex conditions fail to have their needs met in a co-ordinated way.

The government has set National Public Service Agreement targets to improve outcomes for people with long term conditions. Personalised care plans will be offered to those most at risk and emergency bed days are to be reduced by five per cent by 2008 through improved care in primary and community settings. These are challenging targets that will need significant changes in traditional patterns of caring for people, if they are to be met.

Many of the most vulnerable, who account for a significant proportion of emergency admissions, have multiple needs that cross the responsibilities of many organisations and professionals. Handling each component separately fragments care, fails to recognise the sum total of problems and results in inadequate and incomplete treatment plans. This can result in an unnecessary hospital admission or even premature institutionalisation.

Though each individual's combination of conditions is different, they have a common requirement for all of their needs to be brought together in a co-ordinated manner. Case management is considered the best vehicle for bringing together all of the care and treatments needed by many people with complex long term conditions. However, the term case management encompasses a range of skills and techniques. This publication describes the competences associated with case management and draws a distinction between the competences needed by the new community matrons and those required by case managers.

In setting out this set of case management competences, the document will provide a practical resource for employers, managers and health and social care workers. It will help them recruit and develop education programmes for all of their case managers and will enable them to monitor and evaluate performance.

In particular, it will help employers establish community matron posts with the right levels of knowledge and skills to offer the special input needed by very vulnerable individuals who require high level nursing care as well as case management. It will enable professionals, including those such as community matrons practising it for the first time, to influence all aspects of care and to raise standards in an unprecedented way.

The competences fit with Agenda for Change and the Knowledge and Skills Framework, and in defining those required for community matrons this document sets, for the first time, a national standard for a new role at its inception.

We hope the publication will prove invaluable in incorporating different levels of case management into the workforce so that all who can benefit from this important technique will be able to do so.

Chris Beasley
Chief Nursing Officer

David Colin-Thomé
National Clinical Director for Primary Care

Introduction

This document and the enclosed CD describe the competences associated with case management. They can be used to prepare job descriptions and person specifications to recruit different types of case managers and to develop appropriate education programmes. They will help managers to monitor and evaluate performance and assist post-holders themselves to understand their roles and assess their own work.

The case management competences framework was developed by a small team from the Modernisation Agency working in partnership with Skills for Health, with expert advice provided by representatives of nurses, allied health professionals (AHPs) and social service organisations. Although developed in England, these competences are valid for use in all four UK countries.

Skills for Health works in partnership with the Agenda for Change Knowledge and Skills Framework (KSF) Group to ensure that their National Workforce Competences and National Occupational Standards fit well with the NHS KSF dimensions and levels. Since autumn 2003 every new competence has been mapped to the appropriate point on the KSF. This principle applies to the enclosed set of competences.

The competences framework should be used in conjunction with *Supporting People with Long Term Conditions: An NHS and Social Care Model to support local innovation and integration*, (DH, London 2005); *Supporting People with Long Term Conditions, liberating the talents of nurses who care for people with long term conditions* (DH, London 2005) and *Working Differently: the role of allied health professionals in the treatment and management of long term conditions* (DH, London 2005).

The above documents together outline government policy for improving the management of long term conditions showing how the professions can contribute and highlight what changes need to be made.

Long term conditions and case management

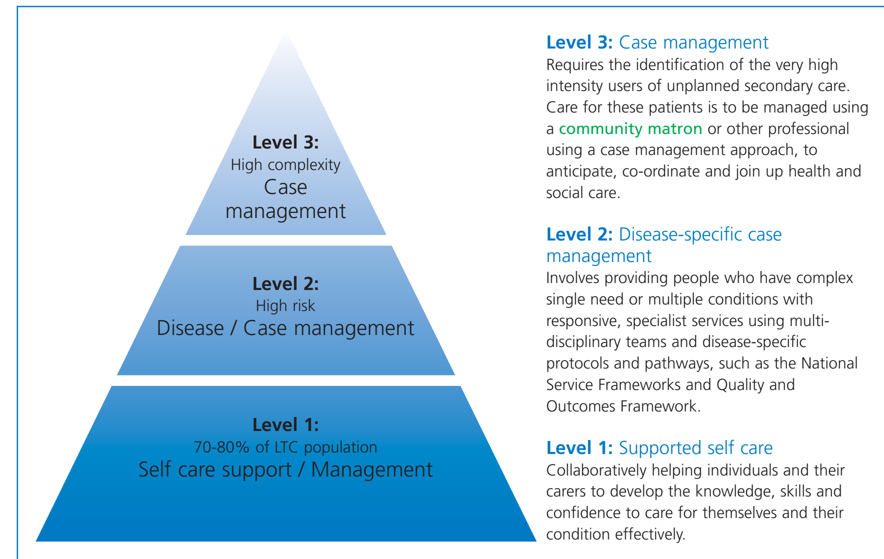
The model opposite shows how a population with long term conditions can be sub-divided according to need.

The top of the triangle represents individuals with very high intensity needs. It is this group of people who are most likely to require case management by a community matron. This is because in addition to having multiple needs, their overall health renders them likely to need nursing care. Three of the most common reasons for unscheduled hospital admission in this group of people are respiratory problems, dehydration and urinary tract infections. These are among many conditions that can be treated in the home by a highly skilled nurse, providing for example, intravenous antibiotics. It is vital that community matrons are able to draw on a broad range of competences to handle most of the presenting needs, expecially those requiring urgent intervention, and those which respond to preventative action. The community matron competences can be located on the enclosed CD.

The second tier of the triangle represents individuals considered to be of high risk because their condition is unstable or because without structured support they could deteriorate. This is a more diverse group of people who could receive case management from a range of professionals, for example from social care or allied health professionals. The competences case managers may require can be found on the enclosed CD.

At the base of the triangle can be found the bulk of people, 80 per cent of those with long term conditions, who require support in managing their own condition. These individuals may need a key worker or named professional to support them in co-ordinating and managing their own care, but they are unlikely to require a named case manager at this stage.

Criteria will be needed to determine which group of people are in the top of the triangle and need to be case managed by a community matron. Advice on establishing criteria is given in the Department of Health documents named above. Further advice will become available following publication of the Predictive Risk Project (a summary of the literature review is contained within the enclosed CD).



In the interim, it may be difficult to correctly classify individuals at the margins of each category, in which case, it is advisable to incorporate an element of professional judgement.

Documents available on the enclosed CD are:
- Community matron and case management competences
- Community matron and case management domain descriptions and competences Index
- Single assessment process documentation
- Community matron indicative areas of responsibility
- Recruiting community matrons
- Self-assessment and action planning tool for community matrons
- Role outlines and case study examples
- An introduction to the Knowledge and Skills Framework
- How to use the competences to develop a workforce and create Job descriptions to support service redesign
- Frequently asked questions
- An example of how to use the KSF and competences.

Additionally there is a range of publications relating to this area of work, e.g. the NHS and Social Care Model for Long Term Conditions; the Predictive Risk Project Summary located within the enclosed CD.

What is case management?

Case management in both the NHS and social care does not have a generally accepted common definition or shared language between the many professionals involved and this can cause confusion when trying to organise a service or when developing the workforce. At the heart of the case management competences framework is the need to be proactive and co-ordinated in identifying the most complex and vulnerable people with a long term condition and then co-ordinating and managing their care in partnership with the individual and their carers. There are several models operating successfully and many health and social care professionals are involved, examples of which can be found on the enclosed CD.

In this publication, when we refer to case management we are assuming the following underlying principles:

- Enabling each individual to have a personalised care plan based on their needs, preferences and choices
- Providing the least invasive care in the least intensive settings
- Supporting effective primary care
- Focusing on individuals that carry the highest burden of disease
- Building partnerships with secondary care clinicians and social services
- Identifying people who are at risk of unplanned hospital admissions
- Integrating and co-ordinating the individual journey through all parts of the health and social care system.

Case management should be built on a partnership that recognises that people, however vulnerable, should share in decision making and that they are knowledgeable about themselves and the effect their conditions may have on their lives. There are clear practical links between case management and the Single Assessment Process (SAP) which all case managers should be using. More information around the Single Assessment Process can be found on the enclosed CD.

Organisations may choose to use any model of case management that meets the individual's needs, however the techniques chosen should always be applicable within the context of the NHS and Social Care Model that requires services to:

- Use data proactively to identify those people who are very high intensity users (VHIU) and most at risk of unplanned hospital admission, unnecessary long lengths of stay and having poor medicines management
- Having identified these individuals, redesign the health and social care systems to support personalised delivery of care
- Redesign and develop the workforce to support proactive and co-ordinated care delivery to those with long term conditions, thus reducing fragmentation
- Encourage those working in disease specialist roles to use case management techniques early to promote self management and minimise the burden of disease and identify future VHIUs.

What is a case manager?

A case manager is most likely to be a qualified nurse, a social worker or allied health professional who will work with individuals who have a dominant complex single condition but still have intensive needs, hence their care requires co-ordination.

The case manager will work as part of an integrated team and in partnership with individuals and their carers to develop a personalised plan of care. They will be responsible for planning, proactively monitoring and anticipating the changing needs of these individuals, co-ordinating their care across all parts of the health and social care system.

What is a community matron?

A community matron is a nurse who provides advanced clinical nursing care in addition to case management (as defined above) to an identified group of very high intensity users through case finding.

How are they different? How do I know who I need to recruit?

Both the community matron and the case manager can provide the same intensive level of service, it is the individual's clinical nursing care needs that are different.

What is the case management competences framework?

The competences identified in the case management framework are not intended to be exhaustive, but the competences framework does attempt to draw together and present the range of knowledge, skills and performance that are associated with case management in the long term conditions field.

The competences are grouped together in areas of practice associated with case management that are known as practice domains. The domains that are relevant to a particular case manager will be dependent on the type of individual that they are providing the service to. To use the competences to create a job description you will need to take the following steps:

i) Identify the case load and be clear about the type of service that needs to be planned
ii) When this has been done, select the most appropriate domains and the associated competences that the case manager or community matron will need to use / possess
iii) The competences can then be used to draw up a job description and development plans.

Why use the competences framework?

The framework can help to:

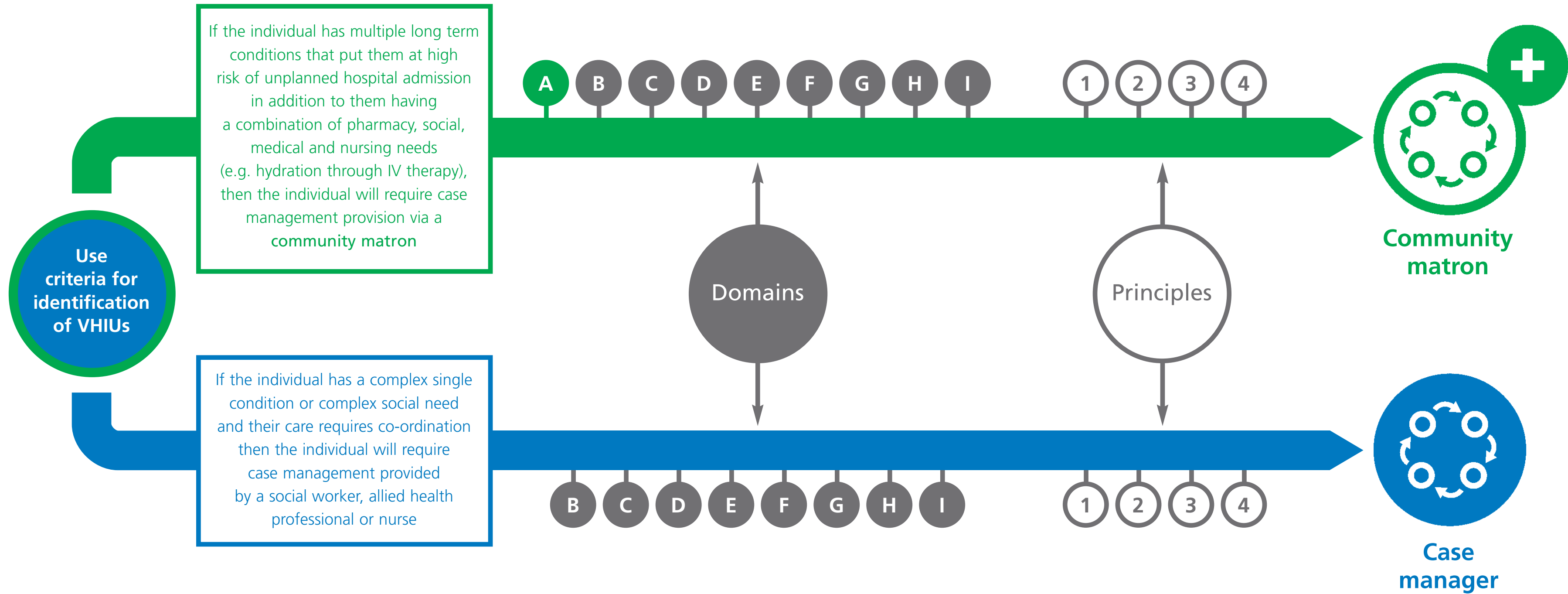
- recognise the skills staff already have
- define those competences that can be learnt in the workplace and identify individual development
- develop post outlines using the NHS Knowledge and Skills Framework (KSF)
- develop clear training plans
- ensure competences are compatible and transferable across the country
- redesign workforce and systems
- develop teams
- commission training and education.

The full descriptions of the above are located within the CD.

The case management competences framework has been used to develop a national education specification for the development of community matrons. This education specification will be available as a separate document (*www.networks.nhs.uk*).

The publication is intended for strategic health authorities, workforce teams within primary care trusts, and social services responsible for developing the new model of care for people with long term conditions. It may also be relevant for use by acute trusts and by individuals. Education providers will use it to inform the development of programmes.

The case management competences framework



Domains

Select relevant competences from the following domains appropriate to the role chosen:

- A. Advanced Clinical Nursing Practice
- B. Leading Complex Care Co-ordination
- C. Proactively Manage Complex Long Term Conditions
- D. Managing Cognitive Impairment and Mental Well Being
- E. Supporting Self Care, Self Management and Enabling Independence
- F. Professional Practice and Leadership
- G. Identifying High Risk Patients, Promoting Health and Preventing Ill Health
- H. Managing Care at the End of Life
- I. Interagency and partnership working

Principles

Principles that should be applied when using the competences relevant to the role chosen

1. Additional Competences Relevant to Post
2. Acquired Through Work Based Learning
3. Accommodate Varied Levels of Practice
4. Leadership Across Health and Social Care

Principles

The principles which underpin the use of the competences framework are described below:

1 Additional Competences

The case management competences framework should be used to identify additional competences required to undertake the role of a case manager or community matron enhancing and adding to the current skill set employees already have. They are not intended to describe the total competences required of a practitioner role - for example competences associated with cultural diversity, clinical governance or information technology - as these fundamental competences should already be possessed by the individual, based on the current role they are operating within.

2 Acquired Work Based Learning

Learning should take place in the workplace wherever possible. Workplace learning involves learning from everyday situations, the care provided and the problems faced. It is concerned with improving performance and updating and upgrading knowledge from practical experiences. This is an element now considered intrinsic to professional roles.

Both case managers and community matrons may be appointed without the full set of competences required to undertake the role. If this is the case employers must be prepared to support the development of the individual to gain these additional required competences and will need to ensure that there is a system in place to facilitate, supervise and assess the learning in keeping with local governance arrangements. This will need to include protected learning time for the individual. Practitioners may want their learning formally recognised hence employers may also need to commission formal learning programmes with a Higher Education Institute.

3 Accommodate Varied Levels of Practice

The level at which a practitioner will perform case management will be determined by the complexity of the caseload for which they are responsible. The knowledge level at which the practitioner will need to perform the competences can therefore be determined locally by the employing organisation. This approach means that it is possible for employers to use the career framework to succession plan and develop the case management workforce.

4 Leadership for community matrons and case managers

Leadership to deliver a redesigned health service is no longer just about an individual's position or authority in an organisational structure, but is instead a way of thinking and behaving regardless of position or seniority. Community matrons in particular will need to function within and across organisational boundaries and build partnerships and networks, to effect change. The leadership skills needed to operate in this environment include not just effective strategic influencing, negotiation and high degrees of political astuteness but also an ability to work collaboratively and build partnerships with those who provide and those who use the services maintaining a focus on improved clinical and patient experience outcomes.

The framework recognises that competences cannot themselves ensure effective practice. Both community matrons and case manager roles will contain significant elements of leadership responsibility hence all individuals will be required to combine the competences with well developed personal effectiveness.

Within the domains are clusters of competences, as shown in the matrix held within the CD.
Additionally the CD contains each competence in its complete form, including a context statement, performance criteria, knowledge and skills required.

Domains

A

Advanced Clinical Nursing Practice

Advanced clinical practice applies to AHPs as well as nurses. However, this domain refers to the community matron who is a nurse providing nursing care in the home, more usually associated with care offered in an acute setting.

This type of care in the home involves assessing and managing risks associated with working in isolation. The nurse must work in an autonomous manner, being able to assess, diagnose, prescribe and carry out treatments taking into account the risks that are associated with working in the home environment. The nurse will need to be competent in medical history taking and advanced clinical nursing practice. He/she will be responsible for initiating and interpreting diagnostic tests, critical reasoning, diagnosis and decision-making. The nurse must also be competent in independent extended prescribing to manage acute exacerbation of multiple long term conditions and minimise the impact of compounding co-morbidities to maximise the patient's quality of life. It is expected that the nurse will also combine the competences of managing cognitive impairment and mental well being within the overall clinical care they provide.

B

Leading Complex Care Co-ordination

The aim of this domain is to ensure that the community matron or case manager is competent in proactively co-ordinating and organising complex care packages to support personalised care plans being delivered efficiently, effectively and to the highest quality standard ensuring the desired outcome is achieved. They must monitor the care provided to those people with multiple long term conditions who are most at risk of deterioration, which may result in a hospital admission and readmission.

C

Proactively Manage Complex Long Term Conditions

The aim of this domain is to ensure the community matron or case manager is competent in enabling people with multiple long term conditions make informed choices regarding they own plan of care. The community matron or case manager will be able to identify and support the risks associated with caring for people with complex problems in their own home.

D

Managing Cognitive Impairment and Mental Well Being

The importance of these competences in relation to people with long term conditions warranted specific attention and it is intended that this domain should be integrated throughout all of the framework domains.

The aim of this domain is to ensure the community matron or case manager is competent in carrying out a basic assessment of mental health, identifying and assessing deterioration in cognitive function, recognising deterioration in mental well being so as to be able to refer to an appropriate specialist and to coordinate and support the delivery of the appropriate care.

E

Supporting Self Care, Self Management and Enabling Independence

The aim of this domain is to ensure the community matron or case manager is competent in providing care to vulnerable people with multiple long term conditions within the overall philosophy of enabling and promoting independence, dignity and choice to maximise independence.

F

Professional Practice and Leadership

The aim of this domain is also to ensure that the community matron or case manager is competent in taking responsibility for their learning to ensure continuing competent practice at an advanced level. It also includes the ability to lead and facilitate service improvements to people with long term conditions. Effective leadership behaviours are an integral part of the clinical role. This requires the individual to lead others from a base of clinical credibility in order to model and support improved practice and interagency and partnership working.

G

Identifying High Risk People, Promoting Health and Preventing Ill Health

The aim of this domain is to ensure the community matron or case manager is competent at identifying the locally defined very high intensity user (VHIU) caseload. The community matron or case manager is also responsible for promoting health enhancing behaviours and preventing the further deterioration of ill health within this caseload.

H

Managing Care at the End of Life

The aim of this domain is to ensure the community matron or case manager is competent in working with people with long term conditions and their families in planning for the future and making choices about end of life care.

I

Interagency and Partnership Working

The aim of this domain is to ensure the community matron or case manager is competent in leading and working across organisational and professional boundaries to enable personalised care to be delivered to the highest standards. It also includes the ability to provide leadership to facilitate service improvement to people with long term conditions in multiple settings with multiple stakeholders.

Summary

So what do I do now to make this really work?

- Identify individuals who fall into level three of the triangle as we know their needs are not being well met
- Decide on what type of service and workforce you want (the evidence to date tells us that community matrons are best placed to meet the needs of VHIUs)
- Develop services to enable the community matron to work effectively by being able to request diagnostics and refer to other clinicians e.g. medical consultants
- Involve stakeholders, e.g. individuals, carers, voluntary organisations, acute trusts
- Develop the workforce for community matrons and other case managers as appropriate
- Use the competences to develop job descriptions, recruit and agree personal development plans
- Use competences to commission education and training
- Consider other changes required to the workforce e.g. joint health and social care roles to reduce fragmentation and support workforce redesign
- Use the competences as a tool for personal and professional development
- Use the competences to support service redesign and performance management.

What impact will the competences have?

- Improving the quality of health and social care for a disenfranchised group of people
- Services will be more person centred across health and social care
- Developing career pathways for staff within primary and social care.

Evaluation

The approach that has been taken to developing this framework has been unique in the way that it has aimed to produce a national standard for competences around the case management of long term conditions generally and specifically for the community matron role. The additional use of this competences framework to develop a supporting national education specification has further pushed the boundaries of traditional working.

The competences held within this framework are kept under review and feedback is welcomed on your experience of using them. If you would like to comment on any aspect of the competences and their applications please send your comments to Skills for Health, Goldsmiths House, Broad Plain, Bristol BS2 0JP.

Contributors

The Competences Framework was developed by a team from the NHS Modernisation Agency, Skills For Health and expert advisors.

The NHS Modernisation Agency has worked with the NHS during the previous five years to help implement changes to ways of working. This work has included providing models of best practice and support to those implementing change. The long term conditions team within the Modernisation Agency has most recently concentrated on projects to help develop a workforce relevant to the new long term conditions model.

Skills for Health is the Sector Skills Council (SSC) for the health sector, and was granted the SSC license by the Department of Education and Skills in summer 2004. The organisation is supported and sponsored by all four health departments in the British Isles and its remit covers the whole of the UK health sector, including the public, independent and voluntary areas.

Skills For Health is involved with and leads on a number of major initiatives and this includes the development of National Workforce Competences which can then be used for a number of purposes including job / role design and incorporation into education programmes at all levels.

Competences development

Skills For Health undertakes an extensive annual work programme which includes the development of National Workforce Competences. These competences sit within frameworks and the frameworks are usually commissioned to sit alongside and complement key targets or Government initiatives such as National Service Frameworks.

The frameworks either follow condition specific topics or client specific areas. A number of frameworks have already been developed and examples include renal dialysis, type 2 diabetes, mental health, and children's services as well as older people's services.

Upon agreement that a framework will be developed a scoping exercise is undertaken by experts from the field, and this scoping often follows a patient pathway through the area to be developed, for example renal dialysis. Once the pathway has been mapped then some desk research is undertaken to identify existing Skills For Health competences and also relevant competences from other SSCs. This process then allows for gaps to be identified and new competences developed to fill those gaps. Expert groups from the field are drawn together to provide the technical data for the competences and the quality assurance mechanism throughout the life of the project. When complete the framework is submitted to the Skills For Health Programme Board for final approval.

Skills For Health are developing a number of electronic tools to facilitate personnel to use these competences.

The work that has been undertaken in relation to the long term conditions case manager / community matrons competences framework is a key example of how competences can be used. The DH (England) identified the need for a new role and stated that there was a need for 3000 community matrons. By working with the DH and the Modernisation Agency, Skills For Health has identified a group of competences which covers the wide and high level functions of this new role.

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All participants and staff from the seven SHA workforce pilot sites.

References

Case studies
Sidney's Story based on patient experience in Cornwall PCT
Contact: Rachel Tovey
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Essex case study
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Essex indicative Knowledge and Skills Framework
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Neuro Rehabilitation
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Tel: 01923 299112. E-mail: *sally.pollitt@watford3r-pct.nhs.uk*

Documents

1 **Supporting people with long term conditions: liberating the talents of nurses who care for people with long term conditions**, DH, February 2005. Order by post from Department of Health, PO Box 777, London SE1 6XH, Tel: 08701 555455, Fax: 01623 724524

2 **Working Differently**, published by the Allied Health Professions Federation and the DH. Available from *karen.wellings1@btopenworld.com*, Tel / Fax: 020 8768 1226.

3 and 4
Drennan., V, Goodman C., Leyshon., S & Peacock R (2005) **Supporting Experienced Hospital Nurses to Move Into The Community Matron Roles**. The Primary Care Nursing Research Unit, Department of Primary Care and Population Sciences, Royal Free & UCL Medical School, Archway Campus, Highgate Hill, London, N19 5LW, UK. Tel: 020 7288 3522. Email: *v.drennan@pcps.ucl.ac.uk*

The Primary Care Nursing Research Unit is a collaboration between University College London, Kings College London, North Central London Community Research Consortium (with its partners: Camden PCT, Barnet PCT, Enfield PCT, Haringey TPCT, Islington PCT, Barnet, Enfield & Haringey Mental Health Trust and Camden & Islington Mental Health and Social Care Trust), & Camden Primary Care Trust *http://www.pcps.ucl.ac.uk/pcnru*

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