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Care Navigation: A Competency Framework

Developing people for health and healthcare

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I must go down to the seas again, to the lonely sea and the sky,

And all I ask is a tall ship and a star to steer her by

John Masefield
(from *Sea Fever,*
Salt-Water Ballads, 1902)

Contents

1. Introduction

1.1 The word '**navigator**' derives from Latin navis - 'ship' - and agere - 'drive' - meaning 'a person who steers a ship'. Charting stormy uncertain seas requires good navigation – with purpose and direction. Similarly, most people at some point in their life may benefit from 'navigation' through encounters with different health services, agencies and professionals, across an often confusing seascape of health, social and community care. And it's not just an issue for service users, there is broad consensus from healthcare professionals that such systems can be complex and difficult to navigate.

1.2 **Effective navigation is a key element of delivering coordinated, person-centered care and support** (see Appendix 1: Key principles which underpin person-centered care and support). 'Care navigators' can play a crucial role in helping people to get the right support, at the right time to help manage a wide range of needs. This may include support with long term conditions, help with finances and signposting to a range of statutory and voluntary sector services.

1.3 **The purpose of this document is to describe a core, common set of competencies for care navigation.** These core competencies are brought together in a tiered competency framework, recognising three successive levels; essential, enhanced and expert. This will help provide a coherent benchmark or set of standards for care navigation, to help ensure relevant staff receive the necessary education, training and support to work effectively. This framework may be used by employers, education providers and individuals to inform education and training needs. It will also help lay the foundations for a career pathway framework for non-clinical staff, within primary and secondary care sectors. This is important to secure a sustainable current and future workforce, offering opportunities for development.

1.4 Navigator roles, job titles and day-to-day tasks vary depending on local context, including organisation function, peoples' existing skills and local population need. For example 'care coordinators' and 'care navigators' may work in hospitals, focusing on discharging people safely from hospital to home, or as part of a general practice in a multidisciplinary team. There is no 'one size fits all' navigation service, with variations throughout the UK and internationally. Whilst flexibility and variation to meet local need is appropriate and expected in job roles, this framework seeks to **articulate some common generic 'threads', to promote a consistent approach to training and education.**

1.5 A key concept in this work is an attempt to move away from the labels of job 'roles' or fixed 'titles'. Roles developed in isolation are difficult to sustain, and lack of national recognised competency framework can limit people to use skills elsewhere or build their careers. By instead, keeping focus on the **core tasks, purpose and core competencies** of 'care navigation', this can help promote standardisation and recognition of people providing care navigation, and open up opportunities for people from many backgrounds and in a plethora of roles.

1.6 The competencies are not intended to be all encompassing and comprehensive; depending on some areas of work and population served, there may need to be additional 'extra' or 'bolt on' modules/ curricula and training for example working

with a condition-specific group of people e.g. stroke, learning disabilities. The Framework as a whole is intended to be a guide and will undoubtedly evolve over time.

1.7 It has been recognised that through developing this framework, there is a variety of different approaches to solving local problems around coordinating and signposting patients. There are examples of different care navigation services and related navigator /signposting /coordinator roles around the UK. Roles developed in isolation are difficult to sustain. This work seeks not to replace but rather complement and support these efforts. There will be ongoing need for commitment to share, coordinate and work together across sectors and organisations to help support, provide education and training for people delivering care navigation.

2. Care navigation and why it is important

2.1 There is widespread recognition that health and social care needs are changing. This includes an ageing population, with rising prevalence of people living with long term, complex conditions and needs. There is a significant need to shift NHS service provision and professional working towards a paradigm of more sustainable, proactive and integrated health and social care.[1] People with long term conditions often need to access different health services, with numerous assessments from multiple different professionals. This can be confusing and individuals and their families can encounter problems. Moving between different care settings can be an especially vulnerable time with the risk of 'slipping through the gaps'. Often family or informal caregivers provide the only 'common thread' to access and coordinate care from a long list of health and social care providers.

2.2 These issues are not new. Care navigation is an emerging concept in the UK, intertwined with that of care coordination – which represents the idea that simply having services and trained people in place are not enough. What then matters is **how** people (individuals, teams, services and systems) then work together – in a 'joined up' way – so that people know when and how they can get access the right help, at the right time, in the right place. Indeed these themes of coordinated, person-centered care echo perspectives from patients[2] and national and global policy makers.[3,4] In times of growing economic pressure within complex, fragmented health and social care systems, it is important to use our resources wisely; these include our workforce as well as the patients, families, carers and non-traditional services for example community and voluntary sectors (See Figure 1).[5]

2.3 There is no universal definition of care navigation or a 'care navigator'; navigation at its heart is a coordination process and key ingredient to achieve integrated care provision to improve health and well-being. A person providing in care navigation is usually based in a multidisciplinary team, helps identify and signpost people to available services, acting as link workers.[6,7] The person who provides care navigation is therefore an important (though alone not sufficient) **lynch-pin or enabler** to achieving integrated care provision. Macredie and colleagues (2014) offer one definition of care navigation to be:

> **"The assistance offered to patients and carers in navigating through the complex health and social care systems to overcome barriers in accessing quality care and treatment."[8]**

2.4 **Age UK defines care navigation** to include the key components of:

- Personalisation support (assessment for social care with follow up to enable smooth running, advice and signpost personal finances e.g. personal budgets, direct to services can access free of charge)
- Coordination (re-refer to services if needed, alert health professionals needing input, help, step up care)
- Integration across health, social care and voluntary sectors.

From an individual perspective, people who provide care navigation build relationships, problem solve and help locate resources, serving as a link between community, health and social services. They advocate the needs of people, they are enabling and focused on recovery, to strengthen the work of the multidisciplinary team. A key purpose is to ensure patients experience seamless, joined up care and support.

2.5 **The pressures and workload facing clinical staff are unsustainable**; we need to change tack and work together toward realistic solutions. This has to include stepping outside of traditional 'health' and 'social' service silos to develop the multi professional workforce, with people equipped with mind-set and skills to work with patients and across traditional sector boundaries. Supporting patients to navigate health and social systems is an area where the workload in clinical practice is increasing, including secondary care and general practice. New roles and extended existing non-clinical roles (e.g. experienced GP receptionists) can offer fresh ways of sensibly sharing work and responsibility, helping to relieve front-line clinician pressures and improve overall quality of care for patients.[9,10]

2.6 **A workforce skilled in providing high quality care navigation has the potential to release clinicians from significant workload**, including unnecessary administrative burden. For example, trained non-clinical front-line staff in a general practice or A&E can help advice and signpost patients to a more appropriate service or person to best help them. Such non-clinical roles require attention to training, to develop career pathways and professional regulation frameworks for delivering new workers for general practice and the wider care workforce. Building up trust and working relationships with emerging non-clinical staff will take time; education and training are essential to enable this.

Figure 1. *Examples of the different sectors and organisations through which individuals providing care navigation work*

3. Who provides care navigation?

3.1 Care navigation, is, of course, an essential task for all clinical and non-clinical staff. Taking an even broader view, care navigation is in fact 'everyone's business' including the informal workforce (e.g. family, neighbours, voluntary sector workers) who already provide a significant amount of care and support. Dohan and Schrag[11] also support the **idea that care navigation is and needs to be part of all staffs' work ethos and duty, rather than restricted to a specific role.** Navigation therefore may best considered as a ***process or intervention*** **rather than a specific role for one specific person in one setting**, and needs to be able to take place across the whole spectrum of the individual's journey, a 'link worker' to enable a 'seamless' pathway. This therefore strengthens the need to define some core competencies to help characterise people who provide care navigation.

3.2 Currently there are a range of care navigation service models. Non-clinical staff who deliver care navigation in the UK tend to occupy a plethora of roles, work in many settings and have varying job titles and backgrounds such as trained volunteers, administrative staff, staff with health or social care backgrounds (see Table 1).

3.3 The idea of a navigator has emerged from different areas over time. The 'patient navigator' came from oncology care in the USA, in an attempt to remove barriers to facilitate timely diagnosis, treatment and address inequalities that existed in cancer care.[12] Patient navigators were usually nurses with oncology nursing backgrounds. Freeman and his colleagues articulated nine principles of patient navigation (see Appendices).

A care navigator is a 'go to' person who glues it all together

Carer and volunteer member of Healthwatch Havering

3.4 In the UK, the health and social navigator role in London developed as a product of NHS London's leading workforce transformation programme between 2009-2011, to help equip staff with the skills to plan and develop new and existing roles for a modern NHS. This was to ensure the workforce have flexible, generalist skills and capabilities to support people to self-care.[13]

3.5 The Patient Liaison Officer (PLO) role was developed in UK general practice to provide a non-clinical facilitative 'link' and supportive function, for communication, administration and reducing unnecessary GP workload.[14]

3.6 **Social prescribing** is developing within the UK, where services have a 'facilitator' or 'navigator' to help bridge between primary care professionals and 'social opportunities'. Within social prescribing, the facilitator role can be challenging and requires good listening skills and the ability to relate to health professionals, the wide variety of people in the third sector and the patient who has been referred. There must also be a regularly updated and accessible database of opportunities. The emerging **social prescribing UK network** are also developing

a consensus understanding and grounding principles of social prescribing.[15]

- **A link worker** – link workers have a variety of names e.g. health advisor, health trainer and community navigator. In this report it refers to a non-clinically trained person who works in a social prescribing service, and receives the person who has been referred to them. Briefly, the link worker is responsible for assessing a person's needs and suggesting the appropriate resources for them to access.

3.7 Some of the key elements of the 'link worker' include; good communication and listening skills, ability to establish trust quickly, use lay language, be empathic, motivate and empower people with skills to elicit behavior change and have up to date and in depth knowledge of services. These characteristics bear much overlap to care navigators.

3.8 In the UK, community pharmacists have been provided further training in developing navigation capability for people with dementia including signposting to key services, a primary care navigator.[16] Recognising common competencies which overlap with other traditional roles can help broaden and embrace new skills and abilities. This approach is supported by the Department of Health (2007) principles of new ways of working for healthcare professionals, where the skills of everyone are used in the most appropriate and effective manner irrespective of professional background.

3.9 Despite such a rich variety of non-clinical roles with a navigation function, with some excellent examples of practice there is a **current lack of clarity, clear consensus and coherence** in such navigation roles, and the necessary skills, attributes and training requirements. Without a clear outline of career structure, progression and competencies, these new or transformed existing roles may fail to attract or even discourage people being recruited or remaining in these roles.

3.10 This competency framework has explicitly been constructed with the **non-clinician** in mind. 'Non-clinical' includes face-to-face interactions with patients such as conversations to promote healthy behaviours as well as needs and risk assessments.

What's in a name? Some examples of titles of people who deliver care navigation in the UK

- Health and social navigator
- Social prescriber / link worker
- Community connector
- Non-clinical navigators
- Care coordinator
- Locality navigator
- Stroke navigator
- Primary care navigators for dementia

Where do navigators work?

- Accident and Emergency / medical assessment units / urgent care Centre
- General practice
- Voluntary sector and community
- Specialist hospital wards (e.g. stroke units)
- With hospital or primary care multidisciplinary teams
- In several of the above settings

Table 1

4. What is the evidence for care navigation?

4.1 In Canada a systematic literature review found care navigation to be a useful strategy to assist the transition of older adults between healthcare settings.[17] However the heterogeneity of navigation intervention models prevented direct comparisons. The authors concluded there is evidence that coordinated and integrated care provided by a navigator is **beneficial**, through helping to write and follow up a **comprehensive care plan, their knowledge and skill in working with chronic conditions and eliciting personal preferences and need**. There is emerging evidence that care navigators, in a variety of settings, can provide effective practical, social support, signposting to interventions and providing a link between community and health-social services.[19] Evidence suggests navigation services can enhance patient and carer experience, reduce unnecessary hospital readmissions and promote independent living at home.[8,20]

4.2 In one evaluation, six care navigators from voluntary care organisations worked in integrated health and social care teams across and county. They carried out up to six face to face interviews with an older person, with a unit cost of £42 (compared to £213 per visit for adult social worker). Health related quality of life measures improved by 17%, people needed to use fewer health services and the project was overall cost effective.[6,20]

4.3 **A training programme was developed by National Association of Primary Care** with Health Education England for primary care navigators (PCN), with an aim to develop the role as 'bridging a gap' to signpost people with dementia and their carers to services (locally and nationally).[16] This was piloted across six areas in the UK. Trainees were recruited from GP practices and pharmacies, with varying backgrounds e.g. pharmacy dispensers, healthcare assistants. Training was blended with web based resources, an interactive training day and follow up with mentor support. For the trainees themselves, **ongoing support from other peers and mentors** was the most important factor reported for success of the programme, as well as training resources and support from local services. The findings support the PCNs from the GP practice and pharmacy became more confident and knowledge to signpost people with dementia after the PCN intervention. A **case study** of a practice showed positive benefits of the training programme to fulfil administrative tasks such as dementia screening, and support patients follow up patients after hospital discharge. PCNs developed a directory of services in the local area to tap in to and inspired neighbouring practice to also develop the role. Therefore the PCN role **can enable GPs and nurses to focus more on managing complex care** including medical care, where PCN provide continuity and spend longer, less pressurised time with patients and carers. **Barriers** reported to implementing the education intervention included a lack of awareness in some cases by other health professionals and therefore utility of the new role. A lack of time to fulfil navigation duties was reported by those with other day to day job duties. This model of training and development the PCN role within South London has now been extended to include people with diabetes and other long term conditions.

4.4 The **Barnsley care navigation and telehealth service** offers a tailored personalised support service led by NHS nurses. They offer personalised information and health coaching/motivational interviewing

to support behaviour change. Evaluation of the service across two GP practices examined the impact of service, demonstrating a 50% reduction in GP attendances six months after accessing care navigation/health coaching pathways, with 64% reduction in community nursing emergency face to face contacts.[21]

4.5 Across **Bradford, Airedale Wharfdale and Craven** service user, carer and provider (heath social and voluntary sectors) perspectives on navigation services were surveyed.[8] Though a small sample (52 service users, 18 carers, 36 professionals) most patients were positive for the navigation support from, reporting better understanding their condition (72%) and an increased contact with key services to manage condition (80%.) More timely support (88%) and greater understanding of conditions (100%) were reported by carers as a result of the intervention. Clinical professionals mostly supported navigation support, helping them carry out their own clinical role more effectively and seeing the benefits for patients.

4.6 An evaluation of community dwelling **stroke survivors** demonstrated that a four month intervention by a community stroke navigator was associated with an improvement where people felt more able to cope and manage day to day their lives at home. The stroke navigator 'intervention' included determining the need of individuals, providing emotional support, coaching, advocacy and case coordination.[22]

4.7 Anderson and Larke reported a navigation model for people with **mental health and addiction problems**, to facilitate timely access to assessment, appropriate referral, and information.[7] This was within a rural community setting in British Columbia, where connection between community organisations, and service providers are important. The service model was built upon local priorities and principles, after discussion with community committee, which included an easily accessible service ('every door is the right door'), client-centered service (non judgemental, respectful and person-centered) seeing the person's strengths and resources, service flexibility, ethical and transparent communication. Key activities included connecting clients to services, having clear boundaries not to engage with therapy per se (though in reality the support provided may ultimately be experienced as therapeutic), communicating with clients and other professionals and providing education of services.

4.8 The published literature for care navigation and service models mostly comes from North America, and is at present sparse within the UK. Published evaluations of care navigation education or intervention programmes are currently few and variable. However there is emerging evidence that care navigation can:

- Improve patient and carer experience
- Help reduce unnecessary hospital admissions and GP attendance, without necessarily incurring higher costs.
- There is the possibility for navigators to help professionals work more effectively by sharing key information and workload, avoiding duplication and inefficiencies for the practical aspects in getting people timely help based on their holistic needs.

5. What is the purpose of a competency framework?

5.1 A competency framework is a structure, which sets out and attempts to define the key knowledge, skills and behaviours required for an individual to be able to perform a particular task or job. They may be used as a flexible tool to help individuals, managers, employers improve performance to work more effectively, and help to shape and design education programmes.

5.2 A focus on competencies, rather than roles, allows a greater flexibility in developing people. Laying down such foundations also helps to create a 'line of sight' and a coherent approach to career opportunities for staff. Creating unique roles in specific organisations can limit the potential for people to move from one organisation to another, or move on to other areas (i.e. on to clinical careers such as nursing). This competency framework serves to guide a number of groups in several ways:

- To help individuals, employers/managers and other important parties (including primary care, third sector or secondary services) to **identify training and education needs** for those entering non-clinical jobs with care navigation components.
- Guide employers in drafting and devising **job descriptions** for people in care navigation roles.
- Help guide employers in development of **workforce planning** for integrated and coordination of care initiatives.
- Provide a benchmark for support individuals in their **own developmental needs**.
- Serve to **inform commissioning** and provision of appropriate education and training care navigation programmes at all levels.
- Provide a guide for **education providers** when devising care navigation programmes.
- Provide some **broad consensus**, **common language** and understanding of the **current and future training needs** of care navigation/coordination roles.

5.3 This framework aims to support the education and development needs of a wide range of post holders, recognising the level of knowledge and skills for each individual will be different. The framework has also been developed to allow for as much flexibility as is necessary by:

- Recognising the skill set staff already have.
- Defining competencies that can be learnt, including within the workplace and identify individual development.

5.4 A competency framework is not a recipe to be followed step by step; more a guide which organisations and individuals will need to adapt in accordance with their local context and needs, and as work settings and roles evolve over time.

6. How the framework was developed

6.1 The competency framework was developed through a collaborative approach, involving many discussions with, and feedback from, some of Health Education England's key stakeholders including:

- Community education provider networks (CEPNs) in North Central and South London. Throughout this project there has been close collaboration and 'cross fertilisation' of ideas and knowledge with Our Healthier South East London
- Current care navigation services (navigators, team leaders, project managers) across London, Birmingham and Yorkshire regions
- Primary care health professionals
- Primary care practice managers
- Patient and carer representatives
- Local Healthwatch Havering, Essex
- Secondary care acute NHS Trust clinicians and workforce development teams
- Health Education England across South London, North West England, North West London, Kent Surrey and Sussex
- Education Providers including City University, Buckinghamshire New University, London South Bank University

6.2 The main aims of this work were:

1. To understand models of care navigation/ co-ordination services and skills/tasks of people working in such roles.
2. To develop and co-design core competencies for 'care navigation' with key stakeholders.
3. To begin to build an education pathway, which outlines possible routes through which non-clinical staff may enter or progress.

Some key questions during this work included:

- What is already happening 'on the ground' with current care navigation and other 'coordinating' type services, as well as related non-clinical front-line jobs; what do they do, what training and education do they receive?
- What should a person delivering care navigation need to be able do? What training needs to be provided? Where are the gaps with current education and training?
- What are the core competencies required for purposeful function at different 'levels' or 'stages', depending on skills set and level of responsibility?
- Where and how could this fit in to an 'education pathway' whereby those who wish may progress and develop further skills, training and career advancement? Does this permit bridges in to other non-clinical or clinical routes?

6.3 The framework was informed by multiple perspectives. Through early discussions with people working in navigation services it was clear that for some services, there was a disparity between job descriptions and the lived reality of work where limitations and boundaries were sometimes unclear. Hence to try establish as accurate a picture as possible, it was important to explore not only written intended competencies in the form of job descriptions, but also hear from experience and particularly areas of practice where there were 'gaps' and need for more training and support. This information and knowledge

was used to crystallize the core competency framework components. (Figure 2. Source of information informing the competency framework).

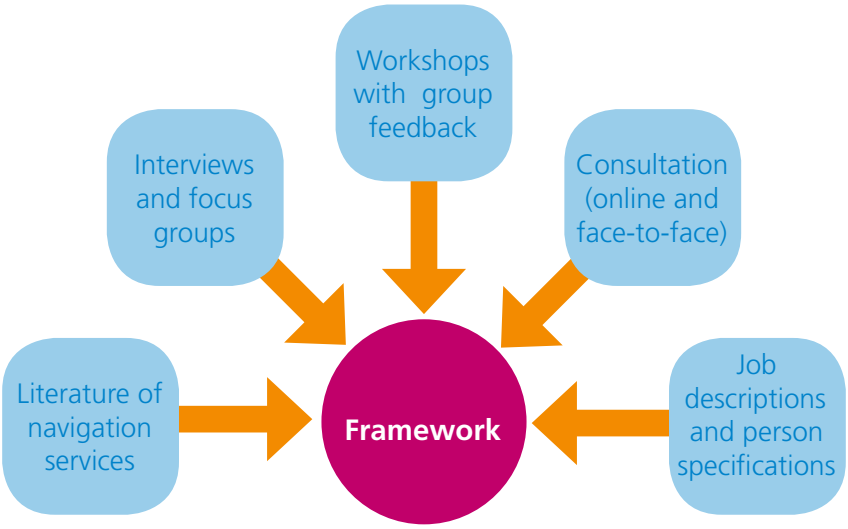


Figure 2. *Source of information informing the competency framework*

6.4 The scope for this process included information from secondary, primary and voluntary sectors. Whilst a broad scope, it was important to remain open to different sectors; navigators 'straddle' these areas and some navigation services have been developed across sectors such as Islington Age UK navigators commissioned by Islington CCG. An underlying essence of navigation is about cross-boundary working and enabling smooth transitions across services a systems approach was adopted; thus the broad inclusive scope of this work was needed to develop a framework in keeping with this principle.

6.4.1 Literature on care navigation services.

In order to identify best practice, training and education approaches, London South Bank University were commissioned by Health Education England (North Central East London) to scope and review the literature.

- Existing care navigation frameworks were sought, though there is a general lack of published literature for navigation frameworks. In the USA competency framework was developed by George Washington University Cancer Institute for non-clinical patient navigators.[23]
- Some areas of the UK have identified 'navigation' and 'coordination' competencies, some drawing on National Occupation Standards by Skills for Health. **There is evolving work on the development of a conceptual framework of care navigation. For example, principles and a model for care coordination have been developed in the West Midlands, which align with the ethos and principles of care navigation**; people

centred, relationships, communication and continuous learning.

- A National Framework for Health Trainers has been developed in England with a Level 3 Certificate by City and Guilds. Four core competences are identified drawn from Skills for Health National Occupation Standards. Some of the competences overlap in the work of people in care navigation roles, such as helping to support behaviour change through conversational techniques e.g. motivational interviewing, and developing relationships with communities.[24]

6.4.2 Interviews and focus groups

A series of interviews with individuals, groups and focus groups were undertaken between November 2015 and April 2016. These included finding out the core elements of jobs, tasks, skills, knowledge and attributes require by people in care navigation services and their teams, clinicians, workforce development managers, education providers, general practice managers, administrators. These were from both primary, secondary and voluntary care sectors the patient/carer representative group Healthwatch Havering (see Figure 2. Source of information informing the competency framework). A series of case studies were developed to capture some of the stories and experiences of people. (See Case studies)

6.4.3 Workshops with group feedback

Three half day workshops were held (November 2015 and April 2016) inviting a broad range of stakeholders across North and South London and other areas of the UK.

- The first workshop in November 2015 included discussion of a proposed training programme using the proposed tiered levels of navigation competencies. This generated discussions and ideas around the need for a broader inclusion of core competencies, more inclusive and applicable to a broader range of people providing care navigation in different job roles there are. Through this workshop initial qualitative intelligence was gathered around what are core competencies are felt to be most important for the framework.
- The April 2016 workshop brought together a diverse mix of clinicians, practice managers and navigator teams to 'test out' the proposed framework and use of the competency framework and discuss the training needs and possibilities, considering how an education pathway could be developed. A second workshop brought also education providers together to discuss the framework and identity where training and education programmes may be developed.
- The feedback from each workshop were summarised from the small and whole group discussions, and shared with the network of attendees and other stakeholders (for some examples of feedback see Figure 3. What do people think of care navigation?).

6.4.4 Online and face-to-face consultation.

- Versions of the framework were distributed via email for feedback in terms of content, usability, validity again to a wide range of stakeholders, which shaped the finalised framework version.

6.4.5 Job descriptions and person specifications

- Job descriptions and person specifications were searched online across England, for care navigators / care coordinators and non-clinical job roles which involved 'signposting' or 'linking' people to services (see Figure 4. Some elements of care navigation/coordination job functions).

Figure 3. *What do people think of care navigation? What does a person delivering care navigation look and sound like? Ideas are drawn from workshops and interviews.*

"Care navigation is about being the 'glue' in keeping it all together. You have to be assertive sometimes and always compassionate."

"They need some degree of independent working after some initial training, to help support clinicians. This takes some building up of trust."

"Receptionists do a lot of signposting on the ground I think – training could help build up our confidence and recognise what we do."

"It's a bit like the discharge coordinators about 20 years ago in hospital, someone to check the right things have happened when you are discharged. It can be frightening for people."

"When you are being stone walled – you have to find a way to climb over it."

"They need to be able to get access to services which is not always easy, take responsibility for databases and follow up care plans."

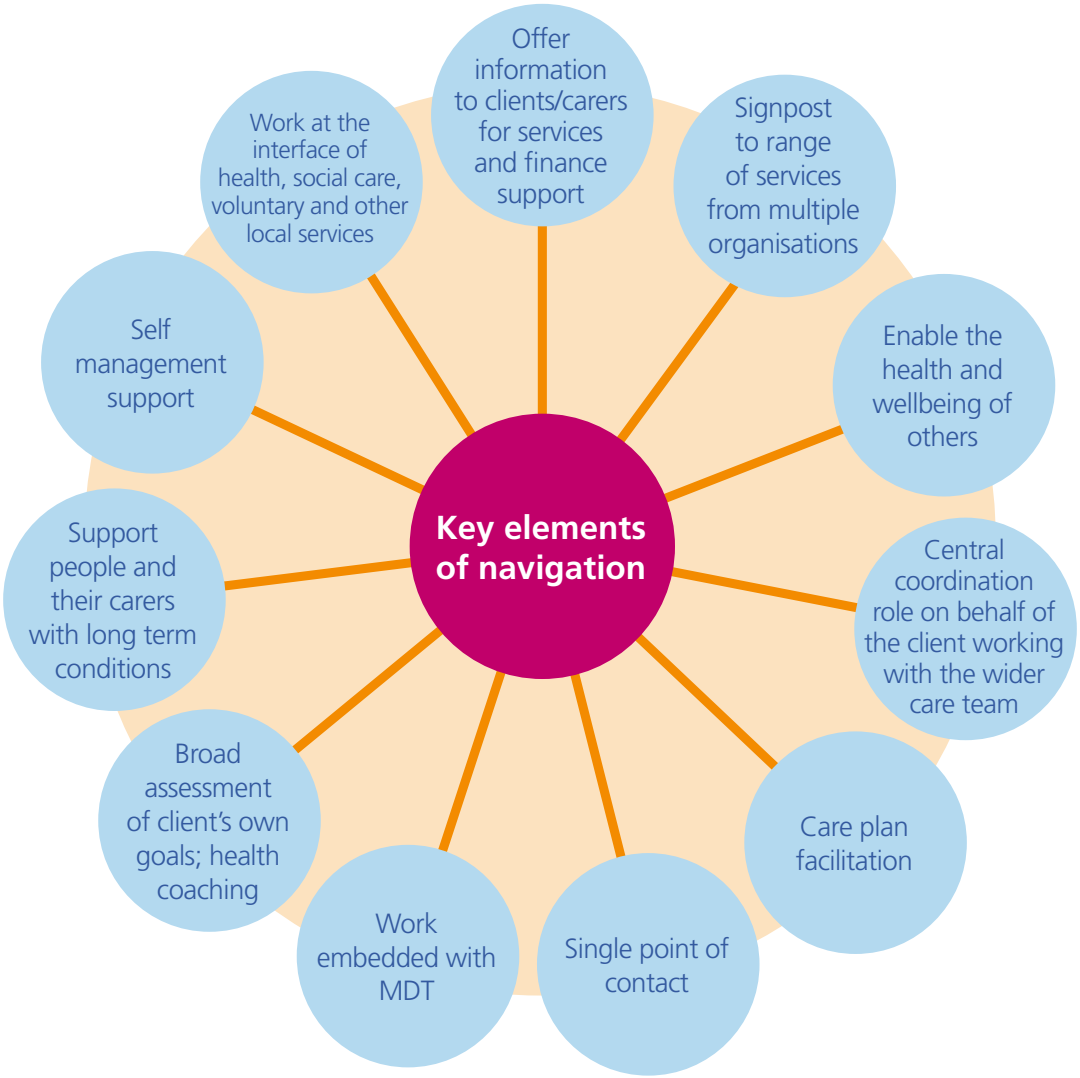
"Mental health issues are common, we see people at the end of life, dementia, people with anxiety. The whole range. We get some training but it depends on what is locally available, a lot of 'in house' training."

"There are so many roles mushrooming up now, difficult to know who does what; as long as they can help you with what you need, and you know who to contact when – feels much safer."

"We have to think outside the box quite a lot, and spend time with people to really get to the root of the what is going on."

"We need more navigators – with excellent communication skills, emotional intelligence; our navigator is so helpful and helps me manage complex patients when I have very limited face to face with patients."

Figure 4. *Some elements of care navigation/coordination job functions, drawn from job descriptions and person specifications across the UK.*



7. Framework overview

7.1 Through the information gathered, nine competency domains were developed. Each domain includes a set of integrated competencies. Integrated competencies attempt to provide a more holistic description, combining attributes (such as knowledge, skills, attitudes) and performance. One of the criticisms of competency frameworks is the danger they become too narrow and prescriptive, where 'atomisation', or the breaking down of complex activities into sub-tasks can oversimplify the whole[25].

7.2 We developed three levels or tiers for care navigation competencies: essential (bronze), enhanced (silver) and expert (gold). These levels are accompanied by Broad level descriptors: – broad statements of what an individual at that particular level should be able do and need to know, accompanied by examples of navigation-type roles at each level. These levels are progressive, where the next level up builds upon and incorporates the competencies from the previous level.

7.3 In general, the 'escalator' of progression represents increasing level of autonomous working, greater knowledge of core conditions and policy, with a greater leadership and management capability. Again this is not designed to be prescriptive nor to be used as a 'tick box' list. Some may have all or some of competencies at each 'level' (Figure 5. Overview of the tiered competency framework; essential, enhanced and expert levels with competencies).

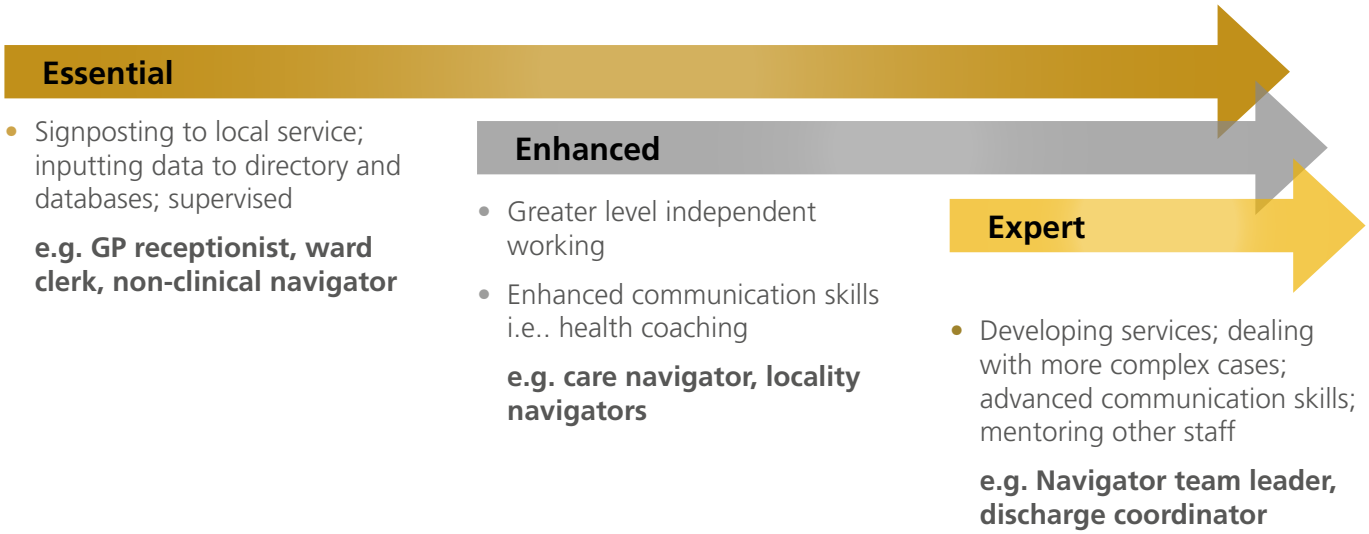


Figure 5. *Overview of the tiered competency framework; essential, enhanced and expert levels with competencies*

8. Navigating the competency framework

Broad level descriptors: (8.1) for each care navigation tier (essential, enhanced, expert), provide an overview of some of the main tasks and skills which would be expected to be demonstrated working at this level. Examples of existing job roles from a variety of sectors and organisations are identified relevant to each level. Each tier is also accompanied by a link to example job descriptions, which demonstrate how the core competency framework may be used in crafting such specifications.

Competency domains (8.2) There are nine key domains of competency for care navigation. Within each domain there are sub-core competencies described for each tier; essential, enhanced and expert. Each domain may be accessed by clicking the link:

1. Effective communication
2. Enabling access to services
3. Personalisation
4. Coordination and integration
5. Building and sustaining professional relationships
6. Knowledge for practice
7. Personal development and learning
8. Handling data and information
9. Professionalism

8.1 Broad level descriptors:

Essential

Essential (Bronze)

At this level people may have no or minimal experience of working in a health-social-voluntary care setting; or some experience already working within an administrative roles.

- Essential competencies are relevant to all non-clinical staff in contact with people, including those at the 'front-line' first point of contact with the public, whether face to face or over the telephone. In reality this encompasses a very broad scope of staff and many competencies at this tier are relevant to informal/voluntary sector workforce.
- At this level key functions will include effective signposting to appropriate local services; this requires awareness and knowledge of services/providers, how to refer and direct people toward them.
- Individuals will work with patients and families in a person-centered way, as well as with other staff in different services and sectors to help facilitate and link the person/carer to the right service.
- This will include an ability to make a basic need assessments and/or follow up and make sure multidisciplinary team (MDT) care plans are fulfilled.
- Staff will work within and closely liaise with an MDT and support clinicians to provide timely best care and support.
- Accurate up-to-date record keeping, creating and maintaining a database of local services is important.
- Excellent communication skills, with sensitively to different cultures, beliefs and communication needs are essential, making sure every contact counts.
- They will need some understanding of theory and practice principles of person-centered care, long term conditions and some 'local wisdom' on broadly how local services and systems work.
- People providing care navigation at this level require supervision and mentoring from an appropriate line manager and relevant clinical staff.

Examples:

- General practice receptionist
- Hospital ward clerk
- Health champions
- Pharmacy technicians
- Volunteers
- Non-clinical navigators in the Accident and Emergency department
- Patient liaison officer
- Primary care navigators

See Example Job Description: Care Navigator/ Patient Liaison Officer/Case Manager/ Ward Clerk/Health Champion/Emergency Medical Dispatcher on page 45

Enhanced (Silver)

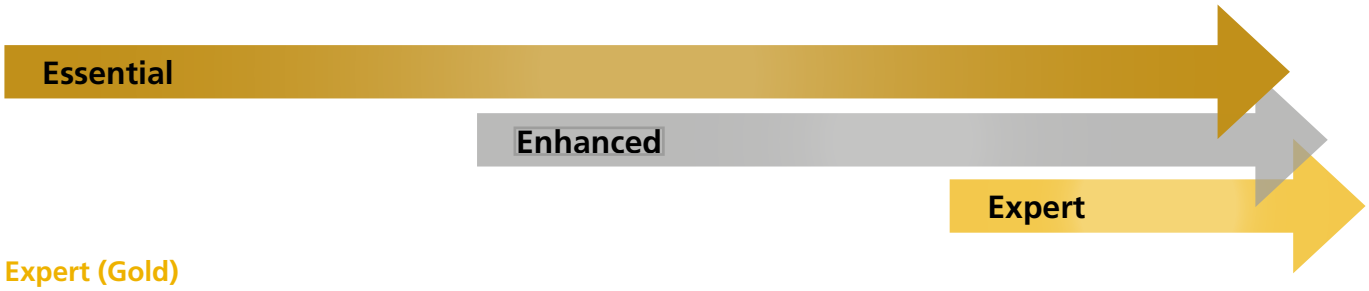
At this level people will have some level of expertise, background in health, social care and/or voluntary sector and some experience of working with people with long term health/mental health needs. Some people may progress from the essential navigation level, or may enter at this level if competencies are already achieved.

- This may include working with patients and carers more directly with face-to-face time, with a 'case management' approach. Some people at this level may provide a more detailed needs and/or risk assessment and help develop care plans. Individuals will make sure care plan action points happen, and if not will be able to liaise with relevant team members.
- Supporting and enabling healthier behaviours and self-care is more prominent here, where conversational techniques such as health coaching and motivational interviewing are important skills.
- Individuals will work across a range of service providers developing skill in forming and maintaining professional relationships and network across organisations. This is to ultimately help promote smooth, coordinated experiences for patients.
- At this level, individuals will likely need greater ability to adapt knowledge and skills to novel situations, where there may be degrees of complexity or risk.
- People working at this level will need to apply problem solving skills to help create solutions with patients and the MDT personalised ways to support people.
- People will have a sound understanding of theory and practice principles of person-centered care, long term conditions and health and social policy.
- Individuals will demonstrate excellent communication and administrative skills, including being able to use evidence and data to contribute to improve services.
- People working at this level work within a wider MDT and will have a greater degree of independent autonomous working, with supervision and mentoring from a relevant line manager/clinical staff.

Examples:

- Health and social navigators
- Senior health champion
- Locality navigators
- Case manager
- Care coordinator
- Care navigator
- Community navigator
- Medical assistant
- Social prescriber

See Example Job Description: Care Navigator/Case Manager/ Senior Ward Clark/Senior Health Champion/Personal Assistant/Medical Assistant on page 47



Expert (Gold)

At this level people will possess a greater depth and breadth of knowledge/ experience of health/social care, enabling a greater ability to support person-centered care and wellbeing. Some may progress from the enhanced navigation level or enter at this level if competencies are already achieved. Individuals will have some experience in managerial aspects of healthcare, and will need to lead a team of others in navigation-roles. At this level, individuals will mentor and supervise others in navigation-roles.

- At this level people will have greater involvement in contributions to developing services and enabling others to develop their role through mentoring / teaching.
- There will be a more sophisticated broad range of communication skills to lead and manage teams, and support behavior change including conflict resolution and health coaching.
- Individuals will have a comprehensive knowledge of local, and where relevant, national services and wider healthcare systems. They are able to network with a wide range of professional backgrounds.
- At this level people will demonstrate initiative and adaptability to complex, less certain situations, including the evolving training needs of the team in response to changing patient needs and services.
- Staff will engage and communicate with colleagues at commissioning and strategic levels, to help shape ongoing service improvement. At this level there is involvement in evaluation of navigation services.
- People at this level will be able to perform activities will be autonomous in practice or minimal supervision.

Examples:

- Health and social navigators
- Senior health champion
- Locality navigators
- Case manager
- Care coordinator
- Care navigator
- Community navigator
- Medical assistant
- Social prescriber

See Example Job Description: Care navigator supervisor/Care connector/Organisation manager/Service delivery lead on page 49

8.2 Competency domains

1. Effective communication	**Excellent communication underpins person-centered care and helps build lasting, trusting relationships. Care navigation requires people to be able to communicate effectively, in verbal and written form, with a wide range of people from different cultural and organisational backgrounds, including health, social and voluntary sectors.** **Therefore an individual will be able to:**
Essential	• Communicate clearly, sensitively and effectively with patients, family members and other professionals. • Communicate in a warm and empathic manner. • Maintain a calm and sensitive approach when dealing with people in distress. • Perform a basic holistic assessment of patients' needs over the telephone and face-to-face. • Writes and maintain clear, accurate records of patient information in a variety of formats (i.e. electronic and paper). • Present information clearly and effectively when speaking with others. • Adapt communication style and method to best support patient preference and need • Demonstrate the importance of cultural factors in communicating with people. • Understand and use common social and health care terminology.
Enhanced	• Communicate effectively to support self-management and behaviour change* • Apply skills and techniques (verbal and non-verbal) to resolve conflict, reduce distress and anger. • Assert ideas and opinions in a respectful, positive way which advocates the needs and wishes of the patient. *(e.g. health coaching or motivational interviewing skills).
Expert	• Communicate effectively using a broad range of skills and tools to support self-management and behaviour change* • Present and communicate information to a wide range of audiences and agencies, within and outside the organisation. • Manage conflict within teams, with colleagues and other agencies in a positive diplomatic manner. *(e.g. health coaching or motivational interviewing skills).

2. Enabling access to services	**Care navigation involves signposting and enabling people to access appropriate services, based on their needs and preferences, from a wide range of organisations and sectors. This may not necessarily be best met by traditional health or social service professionals. The 'local wisdom' of available services should be built up by those in navigation roles and teams, with a spirit of 'persistent and positive curiosity'.** **Therefore an individual will be able to:**
Essential	• Access up-to-date, accurate information for a range of services to provide support for an individual and carer. • Understand local referral arrangements/pathways for holistic support from a wide range of sectors. • Signpost and facilitate contact for the patient/carer to appropriate services, with consent of the individual. • Demonstrate initiative in seeking contacts with relevant local services. • Take a proactive, problem solving approach in helping support people to connect and access services.
Enhanced	• Demonstrate detailed understanding of local services across a wide range of sectors. • Demonstrate persistence and resilience when faced with barriers to accessing services. • Seek appropriate help when faced with barriers to access services. • Provide timely feedback to colleagues around issues relating to access to services.
Expert	• Demonstrate detailed understanding of local and national services for holistic support across a wide range of sectors. • Demonstrate detailed understanding of referral arrangements to local providers from a wide range of sectors. • Provide timely feedback to relevant authorities at commissioning and strategic level, to help improve services. • Engage in monitoring standards and service improvement projects. • Educate and inform other staff and colleagues of service access and availability.

3. Personalisation	**Personalisation is a term more commonly used in social care, and is applicable to all service sectors. Personalisation is about taking an approach which supports a person's choice, wishes and needs as far as possible, enabling them to be in control of their own life. Care navigation seeks to provide support and care, defined by a person's holistic needs, not simply standardized to their condition or diagnosis. Support is tailored to the needs and aspirations of the individual.** **Therefore an individual will be able to:**
Essential	• Determine the patients' basic support needs accurately over the telephone or face-to-face. • Act in a way that acknowledges peoples' expressed beliefs, preferences and choices. • Help people to identify and use their strengths and resources to achieve their own well-being goals. • Demonstrate a positive, solution-focused approach to promote independence and well-being. • Demonstrate basic understanding of appropriate financial matters relevant to personalised support (e.g. personal budgets).
Enhanced	• Determine the patients' holistic support needs accurately over the telephone or face-to-face. • Identify people 'at risk' and potentially vulnerable, using appropriate methods (as determined by local arrangements). • Contribute to developing care plans to meet people's health and well-being needs, in partnership with the patient and family/carer. • Signpost patients to relevant support for important financial matters (i.e. personal budgets and benefits).
Expert	• Assist patients in appropriate financial matters relevant to personalised support i.e. personal budgets and benefits • Identify and prioritise a patients' complex health, mental and social care needs. • Refer patients with complex health, mental and social care needs to the appropriate professionals, teams and services

4. Coordination and integration	**Care navigation will involve coordination of care and support, to ensure a person's experience across health, social and voluntary services is as 'seamless' as possible. All people involved in support, including patient/carer should know who is a key point of contact for help and who is responsible for their care. This is especially important and must be timely, when there are significant changes in a person's needs e.g. sudden deterioration in health or transition of care between providers.** **Therefore an individual will be able to:**
Essential	• Share relevant information, decisions and discussions made by health and social care teams, with the patient (and carer if appropriate). • Understand the principles of integrated care and support. • Provide information on when and how the patient (and carer) can contact the relevant person/professional . • Update and share appropriate information with a supervisor and professionals/agencies in a timely manner* • Implement key action points from care plans/meetings, with supervision. • Show initiative to re-refer a person if known to services when appropriate contact has not occurred. * e.g. with the multidisciplinary team lead clinician.
Enhanced	• Implement and follow up key action points from care plans/meetings, with minimal supervision. • Effectively communicate a patients' needs within a multidisciplinary team meeting environment.
Expert	• Implement and follow up action points from care plans/meetings without supervision. • Effectively chair or lead multidisciplinary team meetings. • Oversee and coordinate an appropriate agreed pathway of support for a patient.

5. Building and sustaining professional relationships	**Care navigation is a person-centered approach, therefore if care and support truly wraps around a person's needs, integrated support must cut across boundaries and reach out to wider agencies within health, social and voluntary sectors. Relationships underpin effective inter-boundary working and are skills people in navigation roles need to develop. The ability to engage and sustain key working relationships is fundamental to work with patients, their family and with multidisciplinary team members.** **Therefore an individual will be able to:**
Essential	• Build and work to sustain trusting, professional relationships with patients and their wider support network. • Recognise when and how to close professional relationships with patients and their carers. • Maintain a clear sense of role and responsibility within a team. • Be supportive and helpful toward other team members. • Relate to and work with clinical and non-clinical staff in other organisations, building constructive relationships across sectors. • Value the roles of key others working within and beyond the organisation.
Enhanced	• Actively seek out relevant and appropriate contacts to develop a network across a wide range of sectors including health, social and voluntary sectors. • Promote the sharing of resources and information from a wider range of sources to benefit patients and their carer.
Expert	• Provide opportunities for colleagues under supervision to network and develop professional cross-sector relationships. • Identify opportunities to work in collaboration with others across networks, to benefit patients and their carer. • Act as a positive role model to team members and colleagues.

6. Knowledge for practice	**Care navigation is a person-centered approach, therefore if care and support truly wraps around a person's needs, integrated support must cut across boundaries and reach out to wider agencies within health, social and voluntary sectors. Relationships underpin effective inter-boundary working and are skills people in navigation roles need to develop. The ability to engage and sustain key working relationships is fundamental to work with patients, their family and with multidisciplinary team members.** **Therefore an individual will be able to:**
Essential	• Demonstrate awareness and basic understanding of safeguarding vulnerable adults, end of life care, the needs of older adults and mental health conditions and symptoms (including dementia). • Be aware of the concept of mental health crisis, potential impact on a person's behaviour and seek timely appropriate help. • Demonstrate awareness of common long term physical and mental health conditions which impact on a person's well- being. • Understand the basic principle of self-care for people with long term conditions. • Appreciate where the organisation fits within the broader of the NHS context and social care systems. • Understand the importance and purpose of health promotion.
Enhanced	• Provide basic advice to promote healthy lifestyle behaviours and activities. • Demonstrate knowledge and awareness of national and local policy of long term conditions and integrated care. • Recognise important symptoms and behaviour which may indicate a mental health crisis and seek timely appropriate help. • Demonstrate knowledge and understanding of relevant mental health legislation (e.g. Mental Capacity Act).
Expert	• Demonstrate understanding of public health issues, both at local and national levels. • Shoe comprehensive, up-to-date understanding of long term conditions, integrated health and social care policy (local and national). • Maintain up-to-date knowledge of policy and practice relating to adult health and social care issues.

7. Personal development and learning	**Individuals need to be committed to lifelong learning and enthusiastic to apply new knowledge and skills. People who are in care navigation roles learn significantly through experience and working within local contexts – therefore reflection on practice, for the individual and as teams are of core importance to personal as well as service development.** **Therefore an individual will be able to:**
Essential	• Demonstrate willingness to learn and develop within the role. • Show responsibility for self-reflection and personal development. • Understand and engage with the process of appraisal.
Enhanced	• Promote own role and navigation services to others working within and outside the organisation. • Provide supportive and constructive feedback to other staff. • Contribute to delivery of education, training and supervision of others.
Expert	• Contribute to the planning and delivery of education, training and supervision of others. • Identify training needs of current and future staff. • Coordinate and conduct appraisals of other navigation staff. • Give supportive feedback about the learning and assessment in practice. • Act as a positive role model to others.

8. Handling data and information	**Accurate and accessible information and data underpins effective care navigation. Failures in communication between organisations, sectors and patients/carers can lead to disjointed and poor care. Individuals who work to provide effective care navigation need to be able to appropriately use relevant electronic records, databases to access, input, store and retrieve information. Data is also important for service evaluation improvement.** **Therefore an individual will be able to:**
Essential	• Access, input to and use data from appropriate electronic records, databases and spread sheets. • Use appropriate technology and resources to find and process information. • Apply the principles of data protection working within legal limitations with access and storage of data. • Understand and adhere to data standards and confidentiality specific to the organisation. • Prioritise workload using time and resources effectively. • Understand the principles of audit and quality improvement. • Be organised in performing administrative tasks (including appointments, diaries, patient registers) • Maintain an up-to-date 'directory' of local services.
Enhanced	• Manage and maintain an electronic up-to-date 'directory' of local services. • Demonstrate analytical skills in using data and information processing. • Research and interpret relevant information from a range of resources. • Analyse and present data and information to teams and commissioners. • Participate in audit and quality improvement
Expert	• Assess and evaluate impact of a service to inform improvement of local services and demonstrate impact. • Research and critically appraise information from a range of resources • Use audit and other approaches to monitor standards and propose improvements when required. • Evaluate the validity and potential bias of information. • Contribute to strategic planning issues. • Evaluate data including patient experience and outcomes to improve navigation services and participate in quality improvement

9. Professionalism	**Professionalism can be challenging to describe or define. For care navigation, core competencies which attempt to capture some essence of professional behaviour, attitudes and attributes are summarized here. These are rooted in the ethical, moral and legal aspects of care and support, grounded in the principles of patient-centered care (see Figure 7: Principles of person-centered care). Commitment to develop expertise, self-awareness, limitations of scope of practice and working with integrity are some important features.** **This domain features cross cutting competencies at all levels (essential, enhanced and expert) for care navigation.** **Therefore an individual will be able to:**
Essential	• Demonstrate a non-judgemental and respectful attitude toward others. • Act in ways to promote values of equality and diversity. • Be emotionally resilient and remain calm under pressure. • Manage stress with healthy coping mechanisms.
Enhanced	• Uphold the principles of confidentiality. • Recognise own limitations and work within the boundaries of the role, seeking help when needed. • Be honest and open consistently with patients and colleagues.
Expert	• Identify when a patients needs urgent help and intervenes appropriately by alerting relevant professionals. • Show consideration and compassion toward others.

9. Education and training

9.1 Conversations with people from a wide range of care navigation roles, showed a **high variability in training time, content and methods**. Some reported training through local induction, informal mentorship and 'in-house' 'on the job' training by the organisation. One community based care navigation had contacted and invited the hospital palliative care team to the practice, to deliver some teaching sessions about the end of life issues. Some teams attended locally provided courses to develop communication skills, including motivational interviewing and goal setting skills. Many individuals reported taking their own initiative and responsibility to attend local or online courses, especially to fill common 'knowledge gaps' such as issues around mental health or dementia training.

9.2 Some examples of **taught modules and courses**, specifically created for care navigation workforce were reported. This included the primary care dementia navigators, with a blended approach of e-learning, a day workshop with some follow up mentor support.[16] There are other emerging examples of training programmes in similar posts, for example in West Wakefield a two part training course has been devised to support primary care health champions to help signpost people in person and over the phone, as well as extending existing roles (i.e. the GP receptionist).

9.3 The opportunity to **meet, share stories and network** with others in navigation roles at the workshops was reported by many to be highly valued and 'inspiring'. This is supported by the findings of other care navigation training programmes.[16] Sharing information and collective learning and developing shared identity forms the basis of the **community of practice** concept; this would provide a valuable and powerful enabler for sustained learning and development. This is beginning to happen to some extent – in one locality for example the senior navigator contacted a stroke navigator from another part of London for advice for a gentleman who had had a stroke, who needed advice around return to employment. By seeking a contact with access to knowledge and experience, the MDT were then able to develop pragmatic plan with him.

Therefore approaches to support the development of a community of practice should be explored, and may include **action learning groups**, an **online forum** and other **networking events or symposia**.

9.4 People providing care navigation came from a rich **diversity of backgrounds**; some examples included Macmillan nursing, mental health nursing, voluntary sector, ward clerk for a hospital trust, people with lived experience of chronic conditions, social sector, biomedical sciences, health care management. The skills mix within navigation teams was often seen to be an asset, whereby members of the team brought their unique knowledge of sectors and services, and could ask others for advice.

9.5 One common theme to emerge from many conversations was the learning processes, which reflected principles from adult learning theory; that people **brought prior experience and knowledge with them**. People regularly met with other team members to discuss and reflect on particularly difficult or complex cases. The learning process through interaction with other multidisciplinary team members at MDT meetings for example, was reported by some to be a good learning experience

and gave an opportunity to inform others of key information about services as well as difficulties.

9.6 Workplace learning and workplace based assessment were considered to be important components of any care navigation training programme, balanced with taught components. The use of apprenticeship training and mentoring were seen to be important also for people in navigation roles.

9.7 From the interviews and workshops, it is apparent the more in depth and enhanced/ expert level navigation roles are more likely to require support from taught components, and alignment with education institutes. The possibilities for people to 'bridge' into further academic pathways was also discussed during the workshops, for example in to clinical programmes such as nursing or higher management. The idea of being able to progress to higher qualifications was seen by some to be an appealing 'stepping stone'. Many acknowledged the importance to accredit modules/courses as an attractive added value for care navigation-posts.

9.8 In summary, these are the key areas of importance drawn from our findings which are important to consider in applying a competency framework for developing education/training programmes:

- **Reflection on practice** is a key ingredient for continuing professional development.
- Learning from and with **patients and carers** would offer a powerful learning method for helping to develop care navigation qualities.
- **Local induction** to key services and learning about the roles of other multidisciplinary team members is important.
- Training courses or modules might be used to deliver early training requirements to a cohort of navigation teams, followed on with local based modular training, to accommodate work and time commitments. The **Apprenticeship training route** could provide a more flexible means training in care navigation-roles.
- Peer support through **local and regional networks/local integrated action learning sets** could be a powerful educational component and will help develop a community of practice.
- A portfolio based learning and assessment approach would support flexible learning, continued professional development and progression.
- Workplace affordances could dictate learning i.e. may need a range of flexible blended approaches e-learning, workshops, portfolios, workplace assessments.
- **Supervision** and **mentoring** are important and developing the supervisor cohort is vital.
- Those at more enhanced and expert levels are more likely to need **further support in training and further qualifications i.e. for capabilities including mentorship, teaching, strategic management skills**.
- Providing a range of exposures to and immersion within multiple sectors including health, social, local councils, voluntary and patient/care groups are important ways people learn about services, acquire knowledge, skills and develop working relationships. Therefore exposure to working environments, with **work shadowing and placements** with others providing care navigation and key professionals are possibilities to be explored.

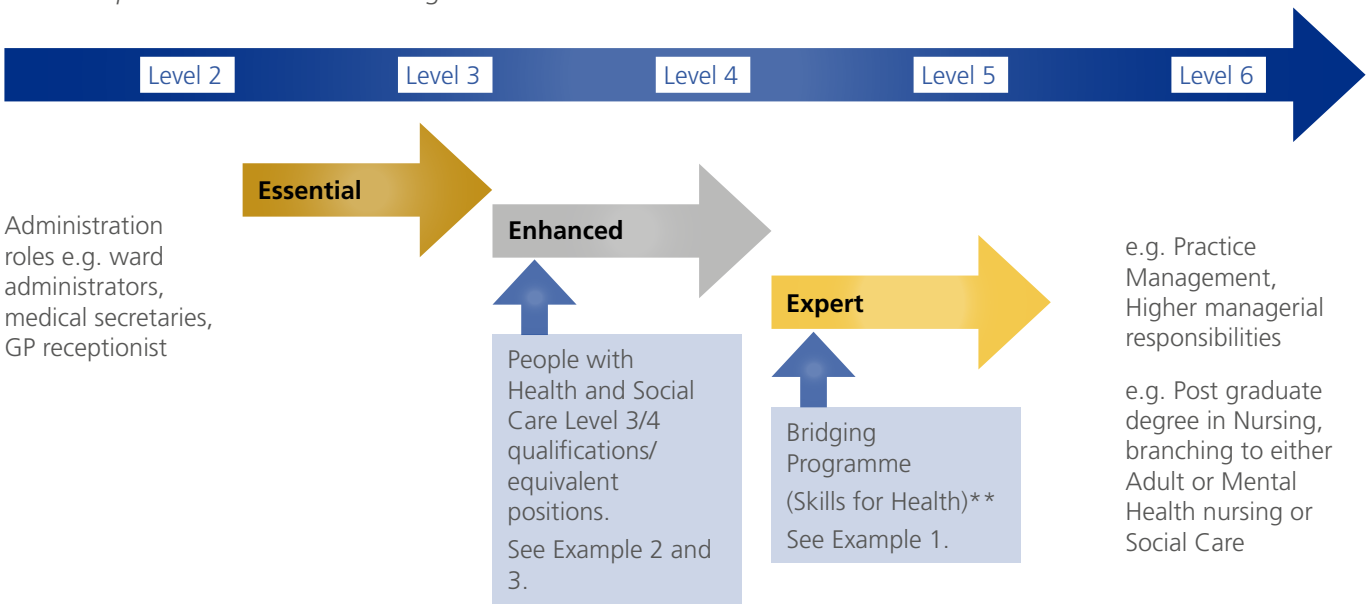
10. Building education and career pathways

10.1 Throughout the UK, organisations have been developing various navigating, coordinating and signposting roles, in order to help people negotiate and access complex health and social systems. However the **education requirements of these roles are poorly defined and there is lack of clear career structure** for such non-clinical and administrative front-line roles within the NHS. Through collating core common competencies, which transcend a particular role or workplace, it is possible to develop and link this with **educational levels and a career 'escalator' and pathways**. This can form a line of sight for the workforce, onto progressively more advanced managerial, coordinator type roles or 'bridges' in to other career directions for example health or social care. This will help recognise and promote recruitment and retention of these important non-clinical workforce, which could move between traditional social, voluntary and health care provider boundaries.

10.2 There is ongoing work to help build competency and career frameworks for people entering and working in to non-clinical roles, in different organisations. For example collaboration with Our Healthier South London has also identified similar core common competencies and performance levels. Through conversations with people providing navigation, clinicians, education providers at the workshops, some common themes emerged in relation to building career pathways:

- Aligning the tiered competency levels with **recognised qualifications** was important for many and could attract people to these roles.
- Education providers would need to **contextualise the training and education**, as services and systems will vary.
- Accredited courses and qualifications would be important for some.
- Some people in navigation roles have sought a range of additional qualifications e.g. postgraduate certification in care management and health advocacy. Some navigation teams who identified with the 'enhanced' tier had health and/or social care qualifications e.g. NVQ level 3 care management.
- Care navigation jobs/roles could provide a **bridge** across from non-clinical into clinical paths e.g. nursing or social care.
- The tiered competency framework could provide a **step** on to a career ladder for Bands 1-4 non-clinical job roles.
- Apprenticeship schemes cold be used to develop training programmes for care navigation roles.
- Some possibilities of how this may work in practice were discussed at the workshops and interviews:

Figure 6: *Care navigation: Education pathways, progression with examples of education and training*



Example 1

Care navigators working in general practices across north west London for example can undertake a University year long 30 credit postgraduate Certificate (PGCert) module in 'care management' at Buckinghamshire New University.

If the individual has a life sciences degree (for example biology, psychology) with a year experience as a care navigator, there is opportunity to 'bridge' into a 2 year post graduate nursing course.

Example 2

A team including clinical, education general practice staff and patients, with Southern Health Foundation Trust have built a development framework for the care coordinator role . The role is within the community trust, and the pathway developed leads to a foundation degree. A bespoke care coordinator roles module was created (Integrated care team navigator) which can be part of the foundation degree or a stand alone module. Pre-requisites include level 3 advanced apprenticeship or diploma in business administrators.

Example 3

Skills for Care are developing health and social care diplomas, within a health and social care apprenticeship to meet the needs of integrated roles including for care navigation.[26]

* Levels are used in education and work to compare different qualifications in England, Wales and Northern Ireland. They attempt to provide a standard to capture the difficulty and content of qualifications and also show how one qualification can lead to another. Frameworks for qualifications include the Regulated Qualifications Framework (RQF) and Framework for Higher Education Qualification (FHEQ).

** The Bridging Programme (Skills for Health)[27] aims to develop the study skills in healthcare and social care support workers needed to, progress through health related vocational programmes in Higher Education, including vocational Foundation Degrees and vocational higher education Diplomas

11. Case studies

The following section outlines some of the examples of practice, where people in care navigation or coordination roles work in a variety of organisations. As shown, there are a variety of job titles, with variations in duties. Some of the main activities are outlined, which are drawn from both written job descriptions and conversations from the interviews and workshops. To illustrate, each example is accompanied by a reflection from people providing care navigation of a memorable patient, event or encounter.

Stroke navigator, Waltham Forest, London.

- Supports people in 'life after stroke' including signposting people to important services such as benefit claims, entitlements, appointments, social care, psychological services
- Attends a multidisciplinary meeting once a week, to raise issues to the team seeking advice and support to feedback to the person.
- Visits the person, with permission in hospital and/or at their own home
- Takes a positive, enabling approach to try encourage and person to do as much as they can for themselves
- Has a background in a caring profession and is passionate about stroke care
- Receives referrals from GP and hospital. A typical 'contact' period will be for about 3 months.

"I tend to work all over, and get referrals from the hospital stroke unit or GP practice. I will try visit the person, if they want me to, in hospital before they are discharged home, just to make an introduction. I tend to visit them at their home or can chat over the phone. I am really passionate about stroke care, especially as once someone leaves hospital they think 'right what on earth do I do now?'. I try to make sure I help them help themselves and stay independent - for example using the bus or walk to meet somewhere rather then driving them. I have sometimes gone with people to their GP appointments, as they are not sure or confident sometimes of what to ask the doctor."

“We were made aware of an older gentleman who had recently been discharged from hospital after going in for a fall. He had come home but refused to have any carers in. He lived by himself. His neighbour was worried about him not managing and contacted his GP. He wasn’t however for what ever reason registered with a GP. We picked him up and went to see him. He was in a bit of a state, very untidy house, his fridge was empty he was struggling. I contacted the care coordinator, GP and practice nurse – this man needed to be seen early by a district nurse as his leg ulcers were quite bad. He needed some help from social services – he agreed for some help but just had not been feeling well enough to sort things out. It can take a while to get things up and running but we got there in the end.”

Care co-navigator/health and social care navigators Waltham Forest and East London (WELC)

- Navigators are part of an integrated care pioneer programme and embedded within a care coordination for high risk patients model (long term health conditions, older people for example)
- Navigators work within an integrated team, including other key workers such as GP, lead nurse, social workers, acute trust geriatrician
- Some of the key tasks of the navigator include:
  - supporting assessment and development of a personal care plan based on needs, together with relatives, patient, health and social workers
  - being a point of contact for patients to help coordinate care across primary secondary and community care
  - attending case conferences and multidisciplinary meetings
  - reaching out to providers for appointments and to clients to check the care plan is followed
  - supporting people to access services from a range of statutory and non-statutory sectors including arts, faith, voluntary, education.
  - being flexible, able to multi-task, prioritise jobs, cope with stress, deal with challenging clients.

“We will see anyone who is over 16 years old, with one or more long term complex problems. Whilst we tend to think of older people with a complex mix of long term conditions, younger people can have problems too. I remember seeing a young man in his 30s with a learning disability who could not read or write. When he needed help to fill out a benefits form, he was able to speak to me over the phone, and so didn’t need to book and wait to see his GP. We try to be helpful, and find the right service for people when they don’t know where to go, and they don’t need to be seen by a Doctor or Nurse.”

Locality health navigators Age UK Islington, London

- They are key part of Islington integrated care strategy and will see people over 16 years old with any long term conditions.
- Their purpose is to help support people in own health improvement and personal goals, connecting them to appropriate services.
- Navigators are trained in communication techniques to influence and promote healthier behaviours including health coaching and motivation interviewing.
- Work in collaboration with GPs, community matrons, social care, carers services users/patients and non-traditional provider organisations to help integrate care.
- Often work with multidisciplinary teams
- Key components of job role include: integrated care coordination; information and data coordination; patient support; general.

Non-clinical navigators (e.g. Homerton University Hospital Foundation Trust and the Whittington Hospital, London).

- Work within a busy A&E and the Medical Assessment Unit (MAU) within a hospital setting
- Liaises with the triage nurse team once people are medically cleared, to screen and offer signposting to appropriate services outside of hospital if required
- Liaises with the A&E rapid response team to identify patients readmitted multiple times, and offer information to try help reduce further readmission
- Require administrative skills and be able to use IT, including finding out information from the internet on where and how to access services.
- Works within a team of people including doctors, nurses, physiotherapists.
- Some important skills include good communication with people, able to listen, presenting information at board rounds

"A patient attended A&E and was advised by the clinician who saw her that she needs to have an ultrasound done soon as possible. The problem was the patient is registered up north where her permanent address is, and she is currently in London for 10 weeks for work. I advised the patient that she could register with a GP here as a temporary patient in order to get the referral for the ultrasound. I found out which GPs the patient is in the catchment areas for, and out of those which ones accept temporary patients and gave her the information. The patient was very happy to have the issue sorted out so quickly."

"I used to work as a ward clerk and a job came up as a non-clinical navigator at the hospital MAU I work in. The role came about from a programme to help support timely discharge of people out of hospital. I used to be a volunteer for a charity so love working with people. I will introduce myself and speak to each patient on the MAU, check if they have any questions generally about what's happening, and check what they may need before going home. Some like one older lady I saw was going to need lots of help, who had no carers and was struggling. I flagged this up with the medical team at the morning board round who then make a clear plan. I feel very part of the whole ward team; even when a patient tells me they are not well will go let the doctor or nurse know. I know lots about how to make referrals and the admin, so help the nurse out such as a district nurse referral so save them time and worry."

Community supporter navigator/coordinator in Hackney, London

- The One Hackney programme was developed by City and Hackney CCGs. One Hackney has 4 quadrant teams, to help develop care plans for older frail adults with complex needs. Each team member can refer to the voluntary sector such as Age UK
- Community navigators play a role to ensure services are accessed as smoothly as possible for clients
- The programme support coordinator oversees these activities in each quadrant
- Navigators and Coordinator in One Hackney play a role in 'spot purchasing' with a budget available to purchase packages of care and services.
- The coordinator also helps oversee and troubleshoot issues with community navigators, and help to manage budget and finance and collate evidence and reports about the service
- The coordinator also plays a role to develop a local network of services from different sectors, as well as remove services that do not meet quality standards or requirements
- Key skills for the coordinator include excellent written and IT skills, understand older peoples needs, knowledge of the voluntary sector, ability to manage workloads and prioritise, motivated, organised, excellent interpersonal and confident communication skills

Care navigators and the Harrow Integrated Care Programme

Key role of care navigators

- Integration across service boundaries
- Navigation of the organisational boundaries between services for patients
- Working in partnership with other professionals.
- Case Management – organising what a patient needs better, giving them access to different services
- Social Aspects – organising the softer aspects of a person's care including future living arrangements, personal budgets.
- Avoiding duplication of care needs and information
- Signposting patients to services they may benefit from.
- Increasing knowledge base of community services

"An 87 year old gentleman had recently been discharged from hospital. He had a high risk score for being readmitted to hospital. He lived alone, no next of kin and wife had passed away 1 year ago. He had a history of depression with multiple conditions including high blood pressure, diabetes and recurrent falls. We identified him from the risk register. We discussed at multidisciplinary meeting including the district Nurse, Practice Manager, GP and Practice Nurses and though that patient could benefit from a Care Plan. I rang the patient, explained the benefit of coming in for a Care Plan, and saw him for 30 minutes. We developed a Care plan focusing on his needs, wishes and own goals, which included him feeling isolated at home, overwhelmed with his tablets and fear of falling, which made him frightened to leave the house. This led to some key tasks, which I agreed with the patient to follow up on, which were prioritised. These included; following up his falls clinic appointment at the hospital, look for a Befriending Service and Social Clubs, book in him in for a Medication Review, and provide advice and information on Telehealth for Pendant Alarm."

Greenwich care navigators

- Greenwich Coordinated Care is made up of partners including CCG, acute trusts, mental health trust and local Healthwatch
- Care navigators were introduced to help co-ordinate multidisciplinary care planning, scanning and integrating different sectors including health, social and community sectors.
- Navigators work to develop 'I' statements, personalised care plans which build upon a person's goals, desires and needs.
- Key elements of the job include: speaking with people over the phone to determine their individual needs, working closely with other agencies which may reach far and wide including housing, voluntary organisations, using a motivational interviewing style, acting as a main point of contact for the carer or client, take part in team meetings and being able to communicate confidently and assertively when necessary, to help champion the needs of a person. Education and training is in-house.

“An 86 year old lady was referred by her GP, she lived alone but was struggling with poor vision. The main issue identified on referral was that the client needed help finding prepared food which could be delivered. The Care Navigator (CN) noted the client’s vision was poor and there appeared to be areas in the client’s accommodation that appeared unsafe and possible hazards. The Client said that she needed better lighting, particularly a reading light beside the chair for reading. The CN also noted that on entering the property that the client looked unsteady and could possibility benefit from a hand rail to grab hold of. There was also brief discussion about the clients’ finances and informed them they may be eligible for attendance allowance.

The CN found an affordable, reputable company which delivered fresh ready-made food to the doorstep and arranged for the company to send the client brochures and information. A referral was also sent to the aids and adaptations department to address the potential hazard with the clients lights. The CN contacted the local Age UK advice and information team to arrange a home visit to assist with attendance allowance form. A referral was made to Adult Social Care OT, to look at possibility of a hand rail. When she was followed up several weeks later, the housing association had repaired the damaged lights and client reported feeling safer and more confident in his home. Adult Social Care occupational therapist had assessed and a hand rail was fitted outside the property. She was awarded attendance allowance and pleased with food delivery company. She didn’t need a carer from social services.”

Camden care navigators, Age UK

- Navigators work as a team of six with a team manager, who oversees and supports the training and work of the navigators
- Navigators focus on supporting people to access mainly community and voluntary sector services in Camden

Navigators have a wide range of background in health social care e.g. Macmillan nursing, substance misuse services.

- They work across a network of services
- A local directory is created and team members share information and knowledge – it is important to meet with one another to learn together and reflect on challenging cases
- Key tasks include signposting people to services, provide advice, contribute to MDT meetings, help coordinate care people e.g. to attend appointments at the hospital
- Receive referrals from GP, and may involve speaking to clients over the phone or arranging home access visits
- They help set goals and develop individual personalised care plans
- Important elements of the job include: understanding some basic medical terminology, knowledge of impact of long term conditions on health, mental health and capacity issues, confidence, excellent communication, presenting information at a meeting, persistence
- Education and training is usually in house, where the team leader seeks available on-line and other courses.

Barnsley care navigation Service

- The service is led by a dedicated team of NHS nurses and the team supports clients with a long-term condition.
- There is no definitive list of long term conditions – diabetes, asthma, stroke, coronary heart disease, high blood pressure and heart failure are all examples.
- The service helps clients navigate care and provide support, so they feel more in control of their health condition. The service has a range of ways to do this; providing free, confidential information, advice to people living with a range of long term conditions.
- There are a variety of things the service can help with, depending on individual circumstances. The service tailors care to best suit the client and this includes: Personalised information and advice about clients condition, support to help the client identify things that could help them improve how they feel, help to access local services that would help and suit the client, helping the client spot early changes in their condition that require medical attention, to prevent things from getting worse , motivate a client to work towards and achieve any goals including use of motivation interviewing and health coaching. Education and training is in-house.

Kirklees care navigation service

- The team works with adults aged over 18 and offers an advice and signposting service for clients and their carer's, whether or not they are eligible for support from the council through Fair Access to Care.
- If they are eligible for support from the council, they work with an assessor to; complete an assessment, identify a personal budget and create a support plan highlighting the outcomes they wish to achieve. This support plan is shared with the Care Navigation team.
- The care navigation team then help the client and carer to find the support identified in the support plan to help maintain and maximise independence, choice and control regarding support.
- Have local knowledge of groups, organisations, suppliers and services to give a more personal service
- Have knowledge and experience of direct payments, community support and voluntary organisations
- Support client's to develop a personalised package of support to enhance quality of life
- Build support packages which are new and innovative that allow client's to fulfil potential whilst still receiving the support they need
- Work with people who need support to access health and social care. This includes signposting and information for carers help people who are eligible for support from the council to decide how they would like their support to be delivered. This could be through a brokered service or a direct payment to fund their tailored package or a combination of both.

Barnet health and social navigators

- Care navigators pro-actively support general practice to review and assess their frail and elderly population.
- Intervention, to implement a preventative plan and ensure that individuals are appropriately sign posted to services and facilitated to access support where required
- Navigators come from a variety of backgrounds, including health advocacy roles.
- Some work across multiple General Practices
- Work includes moving between different organisations including visiting people in their own homes, discussions over the phone, visiting in hospital

"I saw an 80 year old lady, who said she felt dizzy coming down stairs and had had several falls at home. I alerted the rapid response team that she was wobbly on feet and struggling at home; she had been reluctant to ask for help. I wasn't able to get her an appointment with hospital falls clinic for over six months. So I asked around and made phone calls and referrals to get her seen, including the physiotherapist and occupational therapist, and the local Age UK for a new pendant alarm. I brought her up at the GP practice MDT meeting, then followed her up a few weeks later. She felt much happier and steady on her feet. I feel I want to do everything I can to make someone's life easier. I try manage over phone, but sometimes we need to go visit them face to face."

Appendices

Appendix 1: Key principles which underpin person-centered care and support

From the Health Foundation[28]:

- Being enabling (supporting people to build on their own capabilities).
- Offering personalised care, support or treatment (focusing on what matters to the individual and their family).
- Offering coordinated care, support or treatment (across multiple episodes and over time).
- All whilst affording people respect, dignity and compassion.

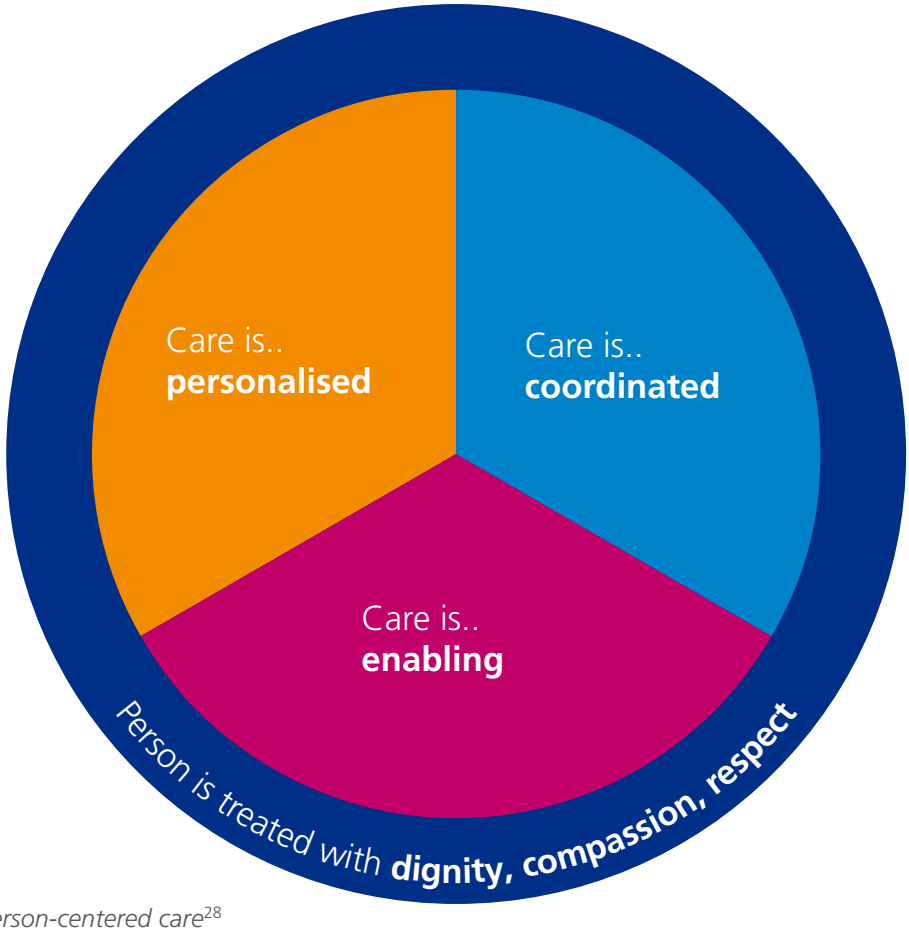


Figure 7: *Principles of person-centered care*[28]

Appendix 2: Principles of patient navigation.

This is adapted from Freeman and Rodriguez (2011) for Patient Navigators in North America[29].

1. **Navigation is a patient-centric healthcare service delivery model.**

   Patient navigation has the potential of creating a seamless flow for patients as they journey through the care continuum.

2. **The core function of navigation is the elimination of barriers to timely care across all segments of the healthcare continuum.**

   This function is most effectively carried out through a one-on-one relationship between the navigator and the patient

3. **Patient Navigation should be defined with a clear scope of practice that distinguishes the role and responsibilities of the navigator from that of all other providers.**

   Navigators should be integrated into the healthcare team in such a way that there is maximum benefit for the individual patient.

4. **Delivery of navigation services should be cost-effective and commensurate with the training and skills necessary to navigate an individual through a particular phase of the care continuum.**

5. **The determination of who should navigate should be primarily decided by the level of skills required at a given phase of navigation.**

   There is a spectrum of navigation extending from services that may be provided by trained lay navigators to services that require navigators who are professionals, such as nurses and social workers.

6. **There is a need in a given system of care to define the point at which navigation begins and the point at which navigation ends. We must keep in mind that for the cancer patient involved, the need is not over until the cancer is resolved.**

7. **There is a need to navigate patients across disconnected systems of care, such as primary care sites and tertiary care sites Patient navigation can serve as the process that connects disconnected healthcare systems.**

   Navigation systems require coordination. In larger systems of patient care this coordination is best carried out by assigning a navigation coordinator or champion who is responsible for overseeing all phases of navigation activity within a given healthcare site.

Appendix 3: Example job descriptions for each framework level

Example job descriptions were developed for each competency tier; essential, enhanced and expert. These were developed by Dr Jackie Tavabie, a GP education and workforce lead working in South London. Existing job descriptions of non-clinical staff across London were collated, and then shaped by the inputs from workshop and interview discussions. They are designed to be illustrative, of how the care navigation competency framework may be used to craft job descriptions – there will be necessary variations depending on the organisation and local context.

Example Job Description: Care Navigator/ Patient Liaison Officer/Case Manager/Ward Clerk/ Health Champion/Emergency Medical Dispatcher

Essential level: Grade Band 3/4

Reports to: Organisation Manager/Service delivery lead

Job purpose:

The post holder, as a member and representative of the organisation, will have direct contact with service users and will be instrumental in ensuring that plans for individual service users, and information that the organisation wishes to share with its clients/patients, are enabled and enacted. The post holder will have excellent communication skills, to ensure that every contact counts, through a range of media (telephone; face-to-face; IT) and will demonstrate excellent customer care though commitment to follow-through of established plans to improve health/customer outcomes. He/she will have sound knowledge of local services and providers; maintain an up to date database of this information, and understand how to access these services. He/she will have knowledge of health promotion issues and current locality initiatives and be able to offer this information to clients/ patients. He /she will be able to deal with complex information, using knowledge of local services and pathways to signpost clients to appropriate agencies. Acting as the client's advocate, they will be able to make brief assessments of client needs, and be able to recognise emergencies and urgent need, both for physical and mental health problems.

The post holder will be responsible for ensuring care plans are implemented, keeping accurate and relevant records and communicate progress or any problems with managerial or clinical staff, as appropriate. They will be competent in the use of computer databases; audit, and in the production of reports and updating of care plans. They will be able to organise and run meetings (one-to-one or groups), from administrative aspects to delivery and to evaluate outcomes, feeding back to senior members within the organisation

Key responsibilities

1. To develop a thorough knowledge of the employing organisation and to work in accordance with written protocols.

2. To implement agreements and policies concerning data sharing and client/patient consent

3. To provide excellent customer care, demonstrating empathy; patience and an holistic approach to client/patient care, with commitment to follow-through of care plans and building effective working relationships.

4. To be able to triage calls, directing clients/ patients appropriately to relevant personnel/ services

5. To have excellent communication skills, with the ability to communicate in writing (letters and electronically) and verbally with a wide range of providers and users of services, including patients; carers; voluntary; social; primary and secondary care providers

6. To have a sound and up to date knowledge of local health and social care policy, together with service availability and how to access those services

7. To maintain an accurate database of services available to clients/patients

8. To understand, and be able to disseminate, health promotion information, using this to identify clients who might benefit from these services and to signpost accordingly.

9. To keep accurate records of all client/patient contacts, using the organisation databases and templates as directed, updating as necessary

10. To be able to carry out audit of organisation and own activities; coordinate satisfaction surveys; produce reports and give presentations within the organisation and locality

11. To be able to organise and facilitate meetings for the organisation and for clients/patients (on a one-to-one or group basis) such as carers groups and to be able to take minutes of such meetings.

12. To understand the common needs and safeguarding issues of vulnerable patient groups, including the elderly; housebound and those with long-term conditions, including physical and mental disabilities.

13. To understand the legal; ethical and regulatory principles of the NHS, and know personal boundaries and when to seek help

14. To be aware of own impact in the process of care; the need for reflection on practice and resilience when faced with challenging situations

15. To understand the importance of confidentiality

16. To respond appropriately in emergency situations

17. To report any incidents that might compromise health and safety for self, other staff or customers/patients

18. To take part in annual appraisal, developing a personal development plan, from which training needs will be identified and training undertaken,

19. To assist in the training of other colleagues where appropriate

20. To work in accordance with Equal Opportunities Policy; Data Protection; Health and Safety, an organisational dress code

21. Other liaison/health promotion activities as agreed with the organisation

Example Person Specification

1. Qualifications

- Minimum GCSE English and Maths or equivalent
- Secretarial qualification or demonstrable experience at NVQ Admin level 3, RSA3 or equivalent

2. Experience

- Previous experience in reception or administrative role with customer contact and evidence of ability to use initiative and work independently
- Confident in communication through a wide ran of channels and competence in use of relevant IT databases
- Current Adult and Child Safeguarding training level 3
- Basic life support training

Attributes and personal abilities

- Positive attitude towards staff and customers/ patients
- Able to take initiative and prioritise workload
- Demonstrate effective organisational skills
- Able to work under pressure and meet deadlines
- Good interpersonal skills
- Commitment to effective communication and attention to detail
- Respect for confidentiality
- Able to deal with conflict and distress
- Able to work in a challenging and changing environment, responding quickly and flexibly to new developments
- Able to problem solve
- Willing to learn and develop within the organisation

3. Communication skills

- Confident in communication methods and able to communicate effectively with a range of customer and provider groups
- Confident in the use of computer databases and able to record information accurately and in a timely manner
- Able to convey clear messages to seniors in the organisation; customers/patients/carers, and other provider agencies, including the production of reports and giving presentations

4. Team-working

- Able to relate to, and work with, all professional and non-clinical staff within the organisation
- Able to motivate other team members to support care plan and health promotion initiatives
- Able to demonstrate an understanding of own impact on the process of care, and resilience when faced with challenging situations

5. I.T.

- Confident in the use of electronic records; databases and spreadsheets, and other equipment as specific to the organisation

Example Job Description: Care Navigator/ Case Manager/Senior Ward Clark/Senior Health Champion/Personal Assistant/Medical Assistant

Enhanced level: Grade Band 4/5

Reports to: Organisation Manager/Service delivery lead

Job purpose:

The post holder, as a member and representative of the organisation, will take primary responsibility for assessment; development and co-ordination of plans for individual, and groups of, service users; monitoring those services and their impact on client care, giving feedback on outcomes and client satisfaction to the organisation. They will work with colleagues from across a number of services in developing a multi-disciplinary approach to patient care, ensuring an holistic approach is taken. Fundamental to this approach will be ensuring that services work together to provide a seamless service which adds both financial and patient value, reduces unnecessary duplication and builds relationships between services. The post holder will have excellent literacy and IT skills, being confident in the use of risk stratification tools to identify at risk client groups; conducting audits and producing reports at a strategic level that will guide developments within the organisation.

The post holder will have excellent communication skills in a multi-professional environment, being an advocate for clients, and able to negotiate with both clients and providers, to achieve best outcomes. They will have a good understanding of risk in physical and mental illness to prioritise need, making and receiving referrals as required. They will provide both emotional support for vulnerable clients, and motivational skills to support change management and create a supportive working environment for both the organisation and service users. They will understand their impact their own actions on those they seek to

help and colleagues, and have resilience to cope in challenging situations.

They will have a sound knowledge of health and social care policy, together with local services and health promotion initiatives, that will enable the safe transfer of clients between different provider services, and the integration of services from different providers where indicated.

Key responsibilities

1. To have a thorough knowledge of the organisation and its strategic aspirations, to work in accordance with written protocols and to contribute to the development of new policies.

2. To provide excellent customer care, acting as the client advocate; taking and receiving referrals; prioritising need and ensuring a smooth delivery of appropriate services

3. To understand the principle of assessment for vulnerable patients, particularly those with mental health needs and long term conditions, and to maintain awareness of safeguarding issues

4. To use risk stratification, or other, tools, as necessary, to identify at risk groups and individuals to target for health promotion or welfare interventions.

5. To take both clinical and social histories from clients in sufficient detail to enable effective and timely intervention, and to use this information to develop care/action plans, in negotiation with them and provider agencies

6. To have a sound and up-to-date knowledge of health and social care policy, at national and local level, and of available local services, in order to be able to advise within the organisation and signpost clients to access services or manage their own care (e.g. personal budgets)

7. To be able to work confidently in a multi-professional environment, being fluent in medical; social care and lay terminology, and able to produce reports and presentations that are meaningful to all.

8. To provide emotional support for vulnerable clients in crisis (patients or carers) and timely onward referral.

9. To be able to contribute to multi-professional meetings and case reviews, producing summaries for senior management and clinicians.

10. To have a sound knowledge of current health promotion initiatives, delivering both health promotion advice and monitoring progress, through motivational interviewing both opportunistically and through targeted intervention.

11. To understand the legal; ethical and regulatory principles of the NHS, and know personal boundaries and when to seek help.

12. To respond appropriately in emergency situations.

13. To be self-aware and demonstrate resilience in the face of challenging situations.

14. To report any incidents that might compromise health and safety for self; other staff or clients/ patients

15. To monitor performance of the organisation within the scope of own work and ensure those standards are met.

16. To be able to undertake developmental training of other staff as required.

17. To take part in annual appraisal, developing a personal development plan from which training needs will be identified and training undertaken.

Example Person Specification

1. Qualifications

- Minimum A level education with English and Maths at C grade or above at GCSE

- Has the ability to move between sites in a timely manner
- Secretarial and/or I.T. qualification at NVQ Admin level 3, RSA3 or equivalent experience
- Adult and Child Safeguarding Level 3 training
- Basic life support training

2. Experience

- More than 3 years experience of working in health, social care or information and advice, in direct contact with people, families and carers in a paid or voluntary capacity
- Experience of working in a multi-professional environment in the health; social or voluntary care sectors
- Experience delivering services to vulnerable clients with long term conditions and/or mental health conditions
- Experience in collating data; audit and producing and presenting reports

3. Attributes and personal abilities

- Positive attitude towards staff and clients/ patients
- Ability to work under pressure and meet deadlines
- Excellent interpersonal skills and diplomatic when dealing with sensitive matters
- Commitment to effective communication and attention to detail
- Respect for confidentiality
- Able to deal with conflict and distress
- Able to work in a challenging and a changing environment, responding quickly and flexibly to new developments
- Able to work independently, making judgements and working pro-actively, within the organisation premises or client residence
- Strong organisational skills, with ability to plan; prioritise; monitor progress; produce reports; identify gaps in services and opportunities for development
- A willingness to learn and develop within the organisation

3. Communication skills

- Confident in communication methods and able to communicative effectively with a range of customer and provider groups, verbally and in writing
- Proficient in the use of negotiation and motivational skills to promote health and ensure services are used efficiently and effectively
- Diplomatic when dealing with sensitive information or managing potential conflict

4. Team-working

- Able to relate to and work with all professional and non-clinical staff within the organisation .
- Able to motivate other team members to support organisational developments and health promotion initiatives
- Confident in organising and chairing multi-professional meetings and case conferences
- Highly organised and reliable and willing to take responsibility for own actions

5. I.T.

- Confident in the use of electronic records; databases and spreadsheets, and other equipment as specific to the organisation

Example Job Description: Care navigator supervisor/Care connector/Organisation manager/Service delivery lead

Expert level: Grade Band 5/6

Reports to: Organisation lead/Senior management/ Board

Job purpose:

The post holder, will be responsible for the development and delivery of systems of working that improve the client's experience and outcomes within the health and welfare sectors. They will oversee the performance of the non-clinical workforce within the organisation; being responsible for the recruitment and induction of non-clinical staff (including the voluntary sector); for monitoring standards, and

developing staff through a robust appraisal process and regular supervision. They will contribute to service planning, (through research; identification of new ideas; development of business plans, and presentation) at a senior level and be responsible for managing projects and associated budgets, and evaluating outcomes. The post holder will be able to manage the coordination of complex care needs, engaging appropriately with health and social care teams, and the voluntary sector, to reduce avoidable crises. They will have excellent communication and negotiation skills, being able to contribute to service development across different organisations and within a multi professional environment.

Key responsibilities

1. To have a sound and up-to-date knowledge of health and social care policy (including public health priorities) at all levels and how this affects the organisation, and both know of, and be able to negotiate with, local service providers, regarding local service provision

2. To contribute to the development of strategic aspirations for the organisation, and protocol development for non-clinical staff members within the organisation

3. To identify opportunities for service improvement, particularly within the non-clinical framework, and to develop business plans to implement improvements.

4. To manage projects and associated budgets, producing interim and final reports; making best use of resources and meeting deadlines

5. To be a central care co-ordinator for care planning, being able to assess and manage complex care needs within vulnerable client groups, negotiating with clients; carers and multiple provider agencies, and ensuring smooth handover between agencies.

6. To promote enthusiasm and commitment of staff within the organisation to providing best care for clients

7. To provide supervision and mentorship for non-clinical staff, including voluntary staff, engaged in client signposting/liaison and care navigation roles

8. To deliver an effective appraisal process for non-clinical staff, ensuring that recommendations for training and development are acted upon.

9. To be able to organise and chair strategic meetings; producing and presenting reports; audits and evaluation of projects as required.

10. To be able to work confidently in a multi-professional environment and fluent in medical; social care and lay terminology

11. To understand legal; ethical and regulatory principles of the NHS, and demonstrate understanding of confidentiality; equality and diversity

12. To know personal boundaries and when to seek help

13. To understand the impact of 'self' in all interactions, with colleagues and patients/clients, and demonstrate resilience when faced with challenging situations

14. To respond appropriately in emergency situations

15. To address issues raised in respect of health and safety for self; other staff or clients

16. To take part in annual appraisal, developing a personal development plan, from which training needs will be identified and training undertaken

17. Other activities as agreed with the organisation

Example Person Specification

1. Qualifications

- Relevant degree or equivalent of training and experience
- Evidence of consistent pattern of learning from education; training and experience
- Evidence of leadership training and/or leadership activities in previous work
- Evidence of excellent administrative and I.T. skills with ability set up systems and processes and monitor performance
- Has the ability to move between sites in a timely manner
- Adult and child safeguarding Level 3 training
- Basic life support training

2. Experience

- At least 5 years experience in health or social care, in direct contact with clients, in a paid or voluntary capacity
- Co-ordination of services from a range of different organisations in a multi-professional environment
- Ability to work effectively and build relationships with a wide variety of people.
- Experience of working with vulnerable clients with complex needs, including mental health and long term conditions
- Project management; managing budgets; evaluating outcomes; analysing data and producing and presenting reports
- Demonstrated successful outcomes and meeting deadlines

3. Attributes and personal abilities

- Able to motivate and support staff and clients
- Excellent interpersonal skills and diplomatic when dealing with sensitive matters
- Able to deal with conflict, complaints and distress
- Ability to recognise and manage risk
- An understanding of confidentiality and its importance
- Highly organised; adaptable and flexible; able to plan; monitor progress
- Able to prioritise
- A positive approach to change and change management
- Self motivated and able to work independently and under pressure.
- Able to make judgements; use initiative, and take responsibility for own actions and seek advice when appropriate
- Able to share information and good practice appropriately
- Able to promote equality and diversity principles
- Willingness to learn and develop within the organisation
- Able to see opportunities for improvement

4. Communication skills

- Confident in communication methods and able to communicate effectively with a range of clients and provider groups verbally and in writing
- Able to undertake staff appraisals in a supportive and constructive way and facilitate change where appropriate in staff members
- Able to mentor staff and monitor progress, being proficient in giving feedback, both at appraisal and in supervision
- Proficient in use of negotiation and motivational skills with both clients and staff
- Diplomatic when dealing with sensitive information or managing potential conflict
- Understands the importance and limits of confidentiality

5. Team-working

- Able to relate to and work with all professional and non-clinical staff within and outside the organisation
- Able to lead in specified projects
- Able to motivate others
- Able to use initiative and develop new ideas to improve client services
- Confident in organising and chairing meetings

6. I.T

- Confident in the use of electronic records and systems; databases and spreadsheets; Powerpoint and other equipment as required for meeting the job requirements.

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