Appendix D- Brokerage, Navigation and Support Coordination Requirements

Purpose

The Provider must deliver a countywide Brokerage, Navigation and Support Coordination function that ensures carers can access the right support, at the right time, through the most appropriate pathway.

The purpose of this function is to remove barriers to accessing support, reduce complexity for carers, coordinate interventions across organisations and ensure that support identified through assessment is translated into meaningful outcomes.

The Provider must act as the primary navigation and coordination service for carers requiring ongoing support and must ensure carers do not experience fragmented or disconnected services.

The Provider must operate on the principle that carers should not be expected to navigate complex statutory, health and community systems independently where additional support is required.

Navigation and Support Planning

The Provider must support carers to understand and access services available to them.

This must include:

1. Personalised information and guidance.
2. Navigation of statutory services.
3. Navigation of community and voluntary sector services.
4. Support to understand available options and pathways.
5. Identification of barriers preventing access to support.
6. Development of personalised support pathways.
7. Assistance to access relevant services and interventions.
8. Follow-up activity where required to ensure support has been accessed successfully.

The Provider must ensure that support plans developed through assessment are translated into practical actions and outcomes.

Brokerage and Managed Referrals

The Provider must undertake active brokerage on behalf of carers where appropriate.

This must include:

1. Managed referrals to community organisations and support services.
2. Warm handovers between organisations.
3. Coordination of support across multiple agencies.
4. Liaison with statutory services where required.
5. Facilitation of access to specialist services.
6. Monitoring referral outcomes.
7. Escalation where services are unavailable or inaccessible.

The Provider must maintain oversight of all active referrals and ensure that carers are not lost within the system.

Multi-Agency Coordination

The Provider must coordinate support across health, social care and community services where carers require support from multiple organisations.

This must include:

1. Collaborative working with Adult Social Care.

2. Collaborative working with health services.
3. Liaison with Primary Care Networks.
4. Partnership working with community organisations.
5. Engagement with VCFSE providers.
6. Joint working around complex cases.
7. Coordination of interventions where multiple organisations are involved.

The Provider must ensure carers experience a seamless pathway regardless of the number of organisations involved in delivery.

Respite Access and Support

The Provider must play an active role in supporting carers to understand and access respite opportunities.

This must include:

1. Information regarding available respite options.
2. Support to understand eligibility criteria.
3. Support to navigate access pathways.
4. Assistance with referral processes where appropriate.
5. Liaison with relevant Lancashire County Council services.
6. Identification of barriers preventing access to respite.
7. Promotion of respite planning and uptake.

The Provider must work collaboratively with Lancashire County Council to improve awareness, access and utilisation of respite support across Lancashire.

Crisis Prevention and Caring Breakdown

The Provider must identify carers who may be at risk of crisis or caring breakdown and intervene proactively wherever possible.

This must include:

1. Monitoring identified risks.
2. Early intervention activity.
3. Practical problem-solving support.
4. Regular review of high-risk situations.
5. Escalation to statutory services where required.
6. Coordination of urgent support.
7. Support to develop contingency arrangements.

The Provider must work to prevent avoidable crisis and maintain sustainable caring relationships wherever possible.

Emergency Planning

The Provider must support carers to develop emergency and contingency plans.

This must include:

1. Identification of emergency contacts.
2. Consideration of alternative arrangements.
3. Development of contingency plans.
4. Review of emergency arrangements as circumstances change.
5. Support during periods of sudden change or instability.

Emergency planning should be promoted as a routine element of support rather than solely in response to crisis.