

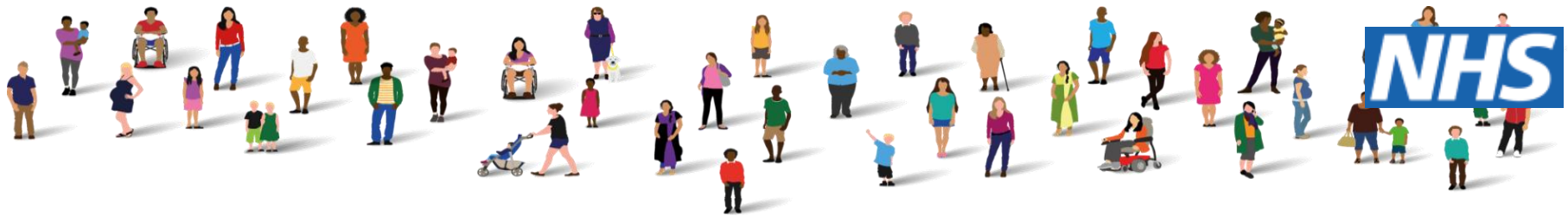
# How can a care navigator add value to patient experience in accessing health and care services at the right time, right place with the right support and input?

A rapid review of existing evidence

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# Overview

Care Navigation refers to assistance offered to patients and carers in identifying and accessing the systems and support that are available to them within health and social care and beyond. They support people to make positive choices to promote good health and emotional wellbeing and can often provide a non-medical referral option that can support existing medical treatments for patients. Examples of assistance offered include referrals to social groups such as walking groups, arts groups and lunch clubs or offer assistance to obtain advice for issues such as housing, benefits or debt management.

This paper provides some key examples of initiatives that have brought care navigation into Primary Care, Community Health Services, the voluntary sector and online. The following slide lists the studies and where possible provides their key quantified impact. It is important to note that as this is a rapid review, it is not systematic nor does it cover all existing initiatives and data on the subject. Rather it pulls out some key examples to share learning and provide good practice guides.

## Methodology

The rapid review used mixed methodology combining qualitative and quantitative approaches to capture a broad range of examples. The first stage used desktop research via academic resources such as the King's Fund, Nuffield Trust, British Medical Journal and Google Scholar. The research team also examined a range of sources such as project reports, stakeholder websites and press releases and then contacted project leads and practices directly to identify the quantifiable impact of the studies and fill in any missing information.

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# Key studies and their impacts

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5	Case Study 1: Facilitating access to voluntary and community services for patients with psychosocial problems: a before-after evaluation	Graduate mental health workers within Primary Care setting	<i>Significant reduction in psychological distress and mental health problems, GP consultations and prescribed medication</i>
6	Case Study 2: West Wakefield: Using online care navigators to support skill mix change	Digital: care navigation app	<i>A saving of 66 GP hours/month, 219 hours of surgery appointments and 79 hours of telephone consultations</i>
7	Case Study 3: Newcastle Social Prescribing Project	Linkwork service within existing voluntary organisations	<i>64% increase in patient confidence in managing their LTC</i>
8	Case Study 4: A service evaluation of the feasibility of a community-based consultant and stroke navigator review of health and social care needs in stroke survivors 6 weeks after hospital discharge	Specialist health and social review based in patient's home	<i>Readmissions for stroke decreased to 0%</i>
9	Case Study 5: Brighton and Hove Community Navigation Pilot within Primary Care	Age UK managed care navigator volunteers based in GP Practices	<i>Estimated £1365 cost saving per patient</i>
10	Case Study 6: NHS Cumbria CCG Care Navigators Pilot	Age UK and GP managed band 4 care navigators based in GP Practices	<i>67% patients reported an improved patient experience</i>
11	Case Study 7: Dundee Equally Well Sources of Support a Social Prescribing Pilot in Maryfield	Social Prescribing link worker	<i>Patients showed significant (<math>p&lt;0.5</math>) improvement in mental wellbeing and functional ability</i>
12	Case Study 8: Social Prescribing in Rotherham Pilot	Voluntary sector employed advisors to receive GP referrals Additional investment into voluntary sector.	<i>Inpatient, A&amp;E and Outpatient attendances reduced by 20-21%</i>
13	Case Study 9: Tower Hamlets Integrated Provider Partnership	Care Navigators supporting Community Health Services	<i>Hospital admissions decrease by 72% (n=49).</i>

# Case Studies

# Case Study 1: Facilitating access to voluntary and community services for patients with psychosocial problems: a before-after evaluation

## Background and Case for Change:

Many patients present with psychosocial problems in primary care who can potentially benefit from a variety of community, educational, recreational and voluntary sector resources rather than referral to mental health services. Often, it is difficult for primary care teams to help people access these resources appropriately.

Schemes where GPs refer patients to a link worker with knowledge of community organisations can improve access of patients to community and voluntary sector. Link workers historically have extensive pre-existing knowledge of the local voluntary and community sectors and often also significant training and experience making them scarce or expensive. This study evaluates the feasibility of using graduate primary care mental health workers (GPCMHW) with limited previous experience to allow for widespread adoption.

## The Solution:

The finding that graduates with limited training in mental health and no prior knowledge of local community resources can help patients with psychosocial problems access voluntary and community services, gives the possibility of widespread adoption

In the UK, this would be through GPCMHWs adding this to their roles within practices. This would also be consistent with a stepped care approach in primary care mental health, whereby briefer and less costly interventions are tried first, before more intensive mental health interventions.

***Quantified Impact: Significant reduction in psychological distress and mental health problems, GP consultations and prescribed medication***

## Impact:

- 108 patients consented to take part in the study and at three-month follow-up, 63 (58%) had made contact with a community service identified as suitable for their needs.
- Most were satisfied with the help provided by the GPCMHW in identifying and supporting access to a suitable service.
- There were significant reductions in psychological distress and improvements in work and social adjustment as measured by validated and reliable questionnaires.  
(There was a significant reduction in the number of patients with a probable mental health problem on the GHQ-12 from 83% to 52% (difference 31% (95% CI, 17% – 44%))
- There were also significant reductions in the recorded number of consultations with the GP and other primary care team members and in the proportion of patients' prescribed psychotropic medication.

# Case Study 2: West Wakefield: Using online care navigators to support skill mix change

## Background and Case for Change:

By 2031, the proportion of the population that is over 65 in Wakefield is expected to grow by 50%. In addition, Wakefield's population has particular problems with life-limiting long-term conditions. In response to these issues and financial pressures, West Wakefield Health and Wellbeing set out to improve access to primary care; improve coordination and integration with other services; and increase technology use and support for self-management.

*Quantified Impact: A saving of 66 GP hours/month, 219 hours of surgery appointments and 79 hours of telephone consultations*

## The Solution:

Improving access to primary care has been approached in a number of ways. Patients have the option of seeing an alternative to a GP through the 'Physio First' and 'Pharmacy First' schemes, supported by care navigators operating in each surgery and digital navigation resources available online.

A care navigation app provides a logical decision tree, helping patients find the most appropriate care. It signposts patients to information and resources as well as alternative services such as physiotherapy, pharmacy and mental health, before eventually offering a GP appointment if appropriate. The service also offers extended opening hours (delivered through a central hub) and is developing video consultations using Skype for Business and an e-messaging service through SystemOne.

## Impact:

Directing patients to alternative services through the 'Physio First' and 'Pharmacy First' schemes has yielded positive results.

- Patient referrals have increased, and between December 2014 and May 2015, 1,124 appointments with the physiotherapist were attended (a monthly average of around 190 appointments compared with the baseline of 132 appointments that were attended).
- Care navigators are estimated to have helped save approximately 66 GP hours per month, and the digital care navigator is also likely to have contributed to this increase.
- Navigation to third-sector providers has increased and use of the app library and service directory has been growing.
- Increased out-of-hours care – saving approximately 219 hours of surgery face-to-face time and approximately 79 hours of telephone consultations.
- Uptake of video and e-mail consultations has been limited. Clinicians have had difficulty integrating video consultations into their daily work and the group is still trying to identify the most appropriate place for this technology.
- The pilot has not led to a reduction in A&E attendances or improvements in patient satisfaction

# Case Study 3: Newcastle Social Prescribing Project

## Background and Case for Change:

In August 2011, NHS Newcastle West CCG conducted a pilot to embed a single, integrated process of 'social prescribing' into healthcare pathways for people with long-term conditions (LTCs).

*Quantified Impact: 64% increase in patient confidence in managing their LTC*

## The Solution:

The project aimed to:

- Develop a linkwork service within existing voluntary organisations to enable health professionals to refer people with LTC to non-clinical community services
- Raise awareness and equip health professionals to be able to use the service through roll out of care planning training and support to all local practices<sup>1</sup>; and
- Develop and maintain a comprehensive web-based information resource to support the project.

Cost: £100,000

## Outcomes:

- 70% of all referrals did engage with a linkworker of which 91% set goals. Of those that set goals it is evident that 41% achieved their goals and 59% did not.
- Monitoring data shows 69% of patients, based on completed records, experienced an increase in SWEMWB score and that 64% have achieved an increase in confidence in managing their long term condition.

## Recommendations:

- It is important that strategic stakeholders with the ability to influence policy and resources remain engaged. Central coordination of referrals and management is important
- It is important to resource and facilitate linkworker training, briefings and networking to share best practice, improve coordination and deliver consistent outcomes for patients.
- Prior to the commencement of any future social prescribing service consultation should be undertaken with the GP practices active in this project to discuss and agree the referral systems, forms and feedback mechanisms to ensure they are fit for purpose.
- In designing any future social prescribing service consideration should be given to ensuring the implementation of outcomes tools to capture patient progress in a consistent manner.
- In designing any future social prescribing service consideration should be given to the patient cohort i.e. LTC or less acute conditions, physical or mental health support, etc. and the expectations of what the linkwork service can achieve with this cohort
- Prior to the commencement of any future social prescribing project it is important to consider how the Health Signpost Directory could be used to support delivery and embed referring behaviour.

# Case Study 4: A service evaluation of the feasibility of a community-based consultant and stroke navigator review of health and social care needs in stroke survivors 6 weeks after hospital discharge

## Background and Case for Change:

More than 900,000 people living in England who have had a stroke and around half of stroke survivors are left dependent on others for everyday activities.

Within the context of the steadily ageing population, with increasing co-morbidities and frailty, costs to health- and social care are likely to increase exponentially. The Department of Health Stroke Strategy (2007) recommends that post stroke patients are reviewed within 6 weeks of discharge. Historically, a 6-week outpatient appointment was offered. This was primarily a medical review and not a full assessment of health, social care status and secondary prevention needs.

## The Solution:

The Camden Stroke Navigation Service started in March 2011 with the aim of offering specialist health and social reviews to all Camden residents diagnosed with a new stroke. This model of a 'one stop shop' multidisciplinary team (MDT) review in the patient's home environment provides a holistic review of stroke aftercare and the needs of stroke survivors.

Stroke navigation assists patients and their families to understand and cross the stroke pathway, ensuring that they access the services that best meet their needs including community resources. It concentrates on education and secondary prevention of stroke, and includes sign-posting to services focused on life after stroke and community integration.

To note: The stroke navigator is a band 7 AHP with experience in stroke, from an occupational therapy, physiotherapy or nursing

*Quantified Impact: Readmissions for stroke reduced to 0%*

## Key findings and Recommendations:

- There were no readmissions at 6 weeks and 6 months post stroke compared to a 7.5% baseline
- The results indicate a positive reaction from service users reflecting a diverse assessment approach and onward referral based on individual needs
- This form of integrated partnership working seems to promote seamless life after-stroke care, while enhancing patients' understanding and includes the provision of secondary prevention and self-management strategies.
- Feedback shows that the joint clinic service is viewed as a central point of contact in the stroke community, ensuring that no one is isolated on discharge
- This 'one-stop shop' approach would warrant formal evaluation



# Case Study 5: Brighton and Hove Community Navigation Pilot within Primary Care

## Background and Case for Change:

Community navigators (CN) were created by Brighton & Hove Integrated Care Service (BICS) invited Age UK Brighton & Hove (AUKBH) and Brighton & Hove Impetus as part of the Extended Integrated Primary Care Programme.

Its aim is to reduce the number of GP consultations with patients presenting with non-medical issues that affect their health and wellbeing. They increase capacity of practices to meet the needs of these patients with for example, low to moderate depression, bereavement, social isolation and financial difficulties.

## The Solution:

The model has rolled out into 16 GP practices and is supported and managed by Age UK.

Community Navigators are volunteers who work from the GP practices and are supported and supervised by a Volunteer Coordinator. They receive Motivational Interviewing and Action Learning training.

Navigators offer a social prescribing service and act as a bridge between community services, groups, activities and GP surgeries, creating better two way communication and relationships based on increased awareness and understanding.

Cost: £172,276 over first 16 months

*Quantified Impact: Estimated £1,365 cost saving per patient*

## Key Findings:

- 68% of GP practice respondents think the Community Navigation service is effective at reducing the amount of time patients attend the surgery with non-medical matters.
- 93% patients gained access to the right information to help their issue, 49% were able to access services, 84% experienced improvements to their wellbeing.

## Recommendations:

- Integration with Primary care is crucial to success
- Community Navigation is more effective when people have been offered 3-6 sessions
- Volunteers need to be well trained and require a degree of flexibility
- Referral mechanisms should be simple and tailored to individual need
- Patient outcomes should be communicated regularly to GP practices to encourage high level of appropriate referrals

# Case Study 6: NHS Cumbria CCG Care Navigators Pilot

## Background and Case for Change:

The Care Navigator service was created to support the Better Care Together Out of Hospital initiative for Morecombe Bay.

The emphasis is to address local needs using a joined-up approach where services are more responsive to their users and community-based services become the first port of call for most people.

This is expected to reduce unnecessary inefficiencies and duplications within the system and improve self-management and preventative health.

## The Solution:

The Care Navigator role provides a proactive link between different parts of the system; being both a first point of contact for patients, carers and health care professionals, as well as guiding and co-ordinating the patient's journey through the care system.

Age UK or GPs provide the Care Navigator service for each locality within NHS Cumbria CCG. Band 4 (AfC) Care Navigators each have a caseload of 60-100 patients referred to them by GPs. Patients are 75 years and over who are frail and at risk of unscheduled admissions to acute care.

The Care Navigators work closely with case managers who work with patients with complex needs. The case managers co-ordinate and deliver nursing care, education, advice and support for their patients through proactive communication and coordination with external partners. They also provide a key point of contact throughout the delivery of their care plan.

*Quantified Impact: 67% patients reported an improved patient experience*

## Impact:

- 59% improvement in the number of referrals to third sector agencies (mostly to Age UK)
- Demonstrated success in patient contact rates and demand for service

## Similar Models:

This model is also in working in Kensington and Chelsea, Oxford and Isle of Wight

# Case Study 7: Dundee Equally Well Sources of Support a Social Prescribing Pilot in Maryfield

## Background and Case for Change:

The Scottish Government's Equally Well scheme aims to test new ways of working, predominantly in public services, to tackle health inequalities and improve community mental wellbeing.

The Dundee test site was chosen to address the following priority: *'the high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing'*.

Dundee proposed to address factors affecting mental wellbeing through its community and services by a process of engagement, awareness raising and capacity building, services and the community can change to better address factors affecting mental wellbeing.

*Quantified Impact: Patients showed significant ( $p < 0.5$ ) improvement in mental wellbeing and functional ability*

## The Solution:

To pilot and evaluate a social prescribing scheme to:

- Build evidence of effectiveness of social prescribing
- Identify operational issues and solutions to running a practice-based scheme
- Gain local support to sustain and roll out the service.

This would be achieved by

- Community and service provider engagement
- Increased understanding of mental wellbeing in its broadest sense
- Building community and service capacity to support mental wellbeing
- Identifying and supporting changes that will make a difference

Patients are referred by the GP to a link worker. They receive up to 4 consultations to assess their need and identify appropriate support required (e.g. information, support or activities).

## Impact:

- Most patients found the scheme to be appropriate to their needs, helpful, flexible, accessible and offering a good variety of activities and support.
- Pilot provided stronger more effective links between health services and a very large variety of community based services/support

## Recommendations:

- Strong communication systems are needed to convey strengths of social prescribing process
- GPs are more likely to refer when their primary care culture supports a holistic and psycho-social approach to patient care.
- Success of meeting patient needs depends on wide range of good quality, flexible community based services.

# Case Study 8: Social Prescribing in Rotherham Pilot

## Background and Case for Change:

Social prescribing in Rotherham aims to increase capacity of GPs to meet the non-clinical needs of patients with complex long-term conditions, the most intensive users of primary care resources.

A two year pilot was set up to run a GP led integrated case management scheme that would increase the capacity of GP Practices to meet non-clinical needs of patients with long term conditions. Social Prescribing was a key component of this scheme.

*Quantified Impact:  
Inpatient, A&E and Outpatient  
attendances reduced by 20-21%*

## The Solution:

Social Prescribing delivered by Voluntary Action Rotherham (VAR), commissioned by NHS Rotherham CCG.

This component was designed to address the non-clinical needs of patients with complex long-term conditions (LTCs) who are the most intensive users of primary care resources

Additional investment in the community provided 24 voluntary and community organisations grants to deliver 31 varied social prescribing services covering information and advice, community activity, physical activities, befriending and enabling.

A core team of project manager and 5 voluntary and community sector advisors (VCSA) were employed to run the project, liaise between VCS and NHS providers and manage the grant programme.

GPs referred eligible patients to VCSAs who offered an assessment (typically within patient's home) and discussion on social prescribing options.

Cost: £1.1million for 2 year pilot.

## Key findings and Recommendations:

- 83% of patients experienced positive change in at least one health and wellbeing outcome area
- Referrals made to 25 voluntary and community organisations.
- Return of investment is approximately £3.38 for every £1 spent.

# Case Study 9: Tower Hamlets Integrated Provider Partnership (THIPP) Care Navigators

## Background and Case for Change:

One of the aims of THIPP is to improve patient experience and to reduce inappropriate service use and hospital admissions by ensuring a person's care is delivered at the right time in the right place by the right people.

Community Health Service (CHS) Teams (extended Primary Care teams) within THIPP have been set up to support adults with complex health and social needs in the community, to try and prevent unnecessary A&E attendances and subsequent admissions.

These teams include a range of expertise such as physiotherapists, district nurses, GPs and dieticians. They support patients who are classified as having complex needs or high risk of hospital admissions in the management of their care and social needs and to support them to work towards self-care.

## The Solution:

15 Band 4 (AfC) Care Navigators are placed within the Community Health Services locality bases to support the patient's care within the CHS team. The care and support they offer to patients is designed to be rehabilitative and shaped around what is important to the patient and built on the patient's personal skills, resources and the assets of the individuals and the community around them.

This includes:

- coordinating care and services, to be delivered within community to support independence.
- to be a point contact for patients in coordinating their care across primary, secondary, and community health care as well as social and mental health care.

*Quantified Impact: Hospital admissions decrease by 72% (n=49).*

## Impact:

Evaluation (2003-2004 data) is based on the Community Health Services that the Community Navigators support.

- Bed day usage decreased from 1142 to 294 bed days
- Average hospital Length of Stay reduced from 60 to 19 days
- 89% (n=9) of patients surveys stated that all or most of the different people treating and caring for them worked well together to give them the best possible support.