Scoping report: Patient navigator roles across Thames Valley

Executive Summary

This report presents the scoping of the care navigator roles across Thames Valley.

The intention is to present information on the care navigator roles implemented in the region which could support commissioners, providers and partners working towards a more integrated health and social care.

The findings refer to various pilots commissioned, some of which have been completed and others are being developed. The information provided in this report is not definitive as other initiatives might be developing in the near future. This report provides the basic information on the areas where care navigators can be located; further research would be needed for further development.

Reference is also made to previous national initiatives and available published researches.

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1. Introduction

The purpose of this scoping activity is to gather intelligence about the care navigator role across Thames Valley, in order to inform and support the HEETV workforce transformation programmes.

The outcomes of this report are as follows:

- Engage HEETV and its partners to stimulate further conversations on the development of care navigator roles
- Share current best practice across Thames Valley (TV)

The concept of patient navigation was founded and pioneered by Harold P. Freeman in 1990 for the purpose of eliminating barriers to timely cancer screening, diagnosis, treatment, and supportive care for patients in Harlem. Appendix 1 is the patient navigation model that he developed in order to eliminate these barriers.

Definition of the patient navigation

Hopkins' (2009) defines patient navigation as the support and guidance offered to patients and carers in "navigating" through the intricate health and social care systems to overcome barriers in accessing quality care and treatment.

The term "Patient navigator" is generic and the role is also known as Primary care navigation (PCN), care navigator, care coordinator, health navigator, life navigator…

What is the role of the care navigator?

The role of the care navigator is to support patients and carers in order to empower them to help themselves increasing their wellbeing, therefore reducing resources spent on health care. The main purpose of the care navigator is to navigate patients and / or carer to the source of help they need which could be medical, social, housing guidance…

The care navigator is not there to duplicate functions but to direct people to the right agencies, champions and other services. This is why this role is also called a care coordinator as it acts as a point of contact and guides patients to the appropriate services.

It is not evident in which setting these individuals are currently working, suggesting the need for an associated programme of workforce development.

2. Context

Need for integration - National Policy & Guidance

"The Care Act has created a single, modern law that makes it clear what kind of care people should expect." Care Minister Norman Lamb

The Care Act requires an integrated approach – one planning process across a person's whole needs, not separate ones for health and social care. This approach aligns with the Department of Health's vision: "Over time, the boundaries between NHS, public health and social care will become more blurred. Working in multidisciplinary teams, staff will need to be sufficiently skilled to enable them to work across sector boundaries, including with families who have multiple and complex problems, to break down barriers between primary and secondary care and other local public services" (DH, 2015).

Many patients and carers report significant barriers both physical and attitudinal, in understanding these changes and in benefiting from the opportunities provided. For example; language, jargon and terminology make it difficult to understand and therefore navigate the various structures; they require advocacy and support to build understanding and confidence to make informed choices (Brenton, 2015).

How care navigator could be one solution for this need

Studies have shown evidence of effectiveness of patient navigation in improving access to the right care (Leone et al., 2013), and a recent review demonstrated that patient navigation is a cost-effective approach (Donaldson et al., 2012).

Patient navigation is often conceptualised to promote patient engagement as a key component of improving disease management and health (Barry and Edgman-Levitan, 2012; Foundation, 2014). According to the National Association of Primary Care (NAPC), the role of the PCN helps to: reduce suffering, reduce the strain on the NHS and social care, benefit the GP practice and Pharmacy, and help primary care to increasing wellness, not just fix illness.

The use of Patient Navigators is becoming increasingly recognized as an evidence-based approach to address health disparities (Natale-Pereira et al., 2011). Levaux's case study (2012) demonstrates the benefits of the care navigator roles (see appendix 2).

HEE interest in care navigator

The Secretary of State for Health commissioned HEE to establish the independent Primary Care Workforce Commission. This commission presented the report "The future of primary care: creating teams for tomorrow" where the care navigator is considered as being part of the "teams for tomorrow".

The 'new ways of working' that HEE presents in its new work programme address this report. "We will be working collaboratively with NHS England and others to identify key workforce priorities that are known to support general practice – including care navigators. We will agree a shared programme of key pilots at scale in primary care, to invest in and trial new ways of working for these roles, demonstrating how they work across community, hospitals and within GP surgeries to support safe and effective clinical services for patients. This will support current GPs in managing their workload, as well as piloting new ways of working for the future". (HEE, 2015)

One of the successful initiatives that HEE supported was the Primary Care Navigator (PCN) training for all of their frontline Community Wellbeing Officer staff. Wellbeing Enterprises CIC, which partnered up with the NAPC, praised HEE, HEE South London and DH for the funding.

The next sessions will attempt to present the care navigator roles across Thames Valley.

3. Methods

Various methods were used to gather the information: Reviewing internal HEETV documents, online research, emails, face-to-face or telephone conversations. The scoping started in November 2015 and was completed in XXX 2015, although, as the care navigator role development is becoming more important on agendas, this report could be used as a stepping stone for further research.

The online research consisted on exploring the various initiatives that are already on going across Thames Valley. Information were collected from CCGs strategic plans reports, the NHS jobs website to survey trusts in Thames Valley currently recruiting for care navigators. The scoping also included exploring initiatives and programmes developed in other LETBs.

Workforce planners across the various trusts were contacted for information regarding the development of care navigators within their respective geographical areas. They were also asked to provide us with information on potential future plans to develop the role.

Additional information to this was obtained from the transformation leads at Oxfordshire Council, East and West Berkshire Council, and Buckinghamshire Council.

Information about third sector employing care navigators was collected via online research followed by emails and telephone conferences.

Initiatives supported by other HEE local offices were gathered by obtaining their reports through internet searches and conversations where possible.

The first section explains how the care navigator works as a coordinator of different services and could be hired by different services to perform their role such as by hospitals, local authority or other third sector groups commissioned by CCGs. Therefore the findings will be presented by county in order to present which county is more involved in developing the role and thus share their experience and best practice.

4. Key Findings: Overview of existing roles in Thames Valley

Thames Valley works closely with NHS England's Local Area Teams covering Berkshire, Buckinghamshire and Oxfordshire while the South Midlands and Hertfordshire Local Area Team covers Milton Keynes. Other key partners include the 11 Clinical Commissioning Groups (CCGs), responsible for commissioning healthcare services for the Thames Valley (HEE website).

Berkshire

Wokingham CCG:

It is on the CCG strategic plan to develop the care navigator roles in order to support practices to signpost people to the extensive range of voluntary sector services available to them. The CCG is also aiming to use the care navigator to reduce social isolation amongst older people and help people to access support at an early stage. The CCG recognise the role as contributing to integrated health and social care. The Community Navigator Coordinator will be employed by Involve, a local charity supporting the voluntary and community sector across Wokingham borough.

This new role has been created in response to feedback from the public, including from the CCG's 'Have your Say' consultation events that took place in March 2015, where people expressed strong support for the idea of improving awareness of the services available from the voluntary sector and better coordination of these services.

Involve community (IC):

IC is setting up the Community Navigator project which began in September 2015 with the recruitment of a Community Navigator Coordinator. The plan is to have a network of volunteer navigators based in GP surgeries and some community venues across the borough providing information and signposting for people as to what is going on in their community to support them socially or with their health. As it is relatively new, no volunteers are in place yet. Seven persons have shown interest, they will be trained in early January 2016 and will be based in three surgeries across Wokingham Borough from late January 2016. Recruitment and training will be on-going to end up with a network that is borough wide. This organisation has funding for three years to set up and deliver this project.

To the organisation, Community Navigator volunteers are not support workers so they won't use Outcome star or something similar, but will be capturing data on who they have seen, basic details, where they have been signposted to and then follow up calls to find out the outcomes. Evaluation will be possible after the volunteers will be in post for few months.

Bracknell and Ascot CCG: Better working with social care

People with complex needs often find it hard to navigate the many different services available. In response, the Bracknell Forest Council is working on setting up a fund to support older people called the Better Care Fund, which will include NHS money and social care money. The fund will be used to integrate services and make them easier to use for local people and for their GPs. The intention is to provide better coordinated care for people with long term conditions, meaning that they will be supported to stay healthy and independent at home and avoid hospital as much as possible.

Working with the council, the CCG commissioned **Age UK Berkshire** to hire one personal independent coordinator for a 12 month period. This member of staff sits with the integrated health and social care team to help GPs to support older people who are making avoidable contact with GPs. Their main focus is on patients with increased need but still do not require clinical attention. As the Chief Executive declared, this initiative has been working very well and measured.

North and West Reading CCG:

The CCG commissioned **Age UK Berkshire** for two full time care navigators. Age UK Berkshire noted a positive impact and change within twelve weeks of these two members of staff being in post. Their main purpose is to find information about social group and accompany isolated elderly to these groups. These two navigators are operating in North and West Reading with good results.

Earlier this year, the CCG funded **Reading Voluntary Action** to deliver a Social Prescribing pilot project in Reading. The pilot is funded through the Partnership Development Fund and is currently available in two GP practices, Tilehurst Surgery and the Reading Walk-in Health Centre. The project aims to improve patient health and wellbeing, increase patient access to community resources and reduce GP appointments

Newbury CCG:

Age UK uses care navigators in a hospital discharge setting. The workers help discharged patients to navigate across the various options they have. They support these patients' needs to help prevent them going back to hospital. The Age UK workers work in this setting in partnership with the Red Cross and other volunteers/charities who hold in-depth knowledge of community level services and groups.

Slough CCG: Steps to the Future

The project in Slough was built on insights from patients about primary care and what they believed was needed to improve access and to help them keep well. It was co-designed by patients with their GPs and practices

Patient Navigators are being piloted through work with the local voluntary services to help people make the best use of local information that is already available to help them keep well (see appendix 4).

Slough Council for Voluntary Service (**Slough CVS**)

A pilot has been running in Slough for the past 9 months in three GP surgeries with "Community Navigators" and due to end on 31st March 2016.

The three surgeries are: Bharani Medical Centre, Farnham Road Surgery, and Langley Medical Centre.

Slough CVS has delivered its Pilot at Bharani Medical centre and used the model of a social prescription which is completed by a volunteer, nurse or doctor - which then gives the patient access to voluntary sector services. In Farnham the pilot was delivered by a local charity - **Destiny Support** and in Langley by **Slough CAB**.

In 2016 Slough CVS will be working in partnership with **Royal Voluntary Service** to expand this model across Slough. The plans for 2016 are in development.

Windsor, Ascot and Maidenhead CCG:

The transformation team is working on restructuring their care management system where the care navigator role will be explored. It is likely that care navigators will feature as part of this model re-design by summer 2016 at the earliest.
However in the same geographical area the care navigator role is already being implemented at **Chrome Tree Care** home which relies heavily on Care Coordinators. It is an extremely vital part of their home care provision because they believe that Care Coordinators reflect values of high standards of care set at Chrome Tree Care. The Care Coordinator provides and coordinates individualized care and resources to their clients in the community.

The Care Coordinators have been employed at **Churchill House Hospital** as part of the community matron service and the role is classed as administration duties/support with no clinical expertise.

A navigation service has been in place for the past 2 years at **Royal Berkshire Hospital** where staffs are helping supporting and advising patients.

Buckinghamshire

The Aylesbury vale CCG commissioned a pilot to manage all patients registered at the seven north locality practices through 'Ben' based at Milton Keynes hospital. Ben became known to patients as '**Buckingham Ben**' when he successfully worked as a discharge coordinator to reduce the length of hospital stay. In his first year of being in post, significant input by the discharge coordinator reduced the average length of stay by nearly two days, the average delayed days to discharge once medically fit dropped by 75%; and hospital admissions have reduced by less than half (see appendix 4).

Following the 2009 National Dementia Strategy's recommendations, the **Buckinghamshire Joint Dementia Commissioning Strategy** proposed in 2011 the creation of a 'dementia care adviser', otherwise called PCN, and would have a "mixture of navigator, brokerage and support worker responsibilities" where these posts would have been by voluntary sector agencies. HEE evaluated the benefits of the PCN at a national level which can be seen in appendix 4.

Milton Keynes:

Patient pathway co-ordinator and admin are being recruited at **Milton Keynes university hospital** to be the point of contact for all patients' issues relating to their pathway of care, both for inpatients and outpatients. The Patient Advice Liaison Service (PALS) is there to help patients, and their relatives and carers, find speedy and effective solutions to any issues and to receive feedback on hospital care, treatment and services.

The Home To Stay Team at **Milton Keynes Community Health services** supports patients and their carers for up to 30 days after discharge from hospital, helping them to understand how to access the services they need to keep them well at home. In this trust the role is called a discharge liaison specialist and supports patients to avoid unnecessary admission.

It is one of a range of intermediate care services which provide therapies and rehabilitation in community settings for adults in Milton Keynes.

Oxfordshire:

Oxford CCG:

The CCG piloted a "Care navigators" scheme based in GP practices in Oxford where care navigators work with staff in hospitals and social care to offer better, joined up care for the 2% patients registered with city practices with the most complex conditions. Care Navigators co-ordinate support for these patients and liaise with their GPs, families and carers in practices and in patient's homes to ensure care is proactive. In Abingdon, Care Navigators provide an information and signposting service to all patients registered with participating practices."

OxFed, the GPs Federation in Oxford City are working closely with **Age UK** and six Care Navigators have now been recruited and inducted (Sept15). Advance Primary Care Nurse Posts have been advertised for the Early Visiting teams. OxFed is working closely with Oxford Health NHS Foundation Trust who provides the local Community Nursing Service on a joint strategic approach to the roles and the opportunity to share learning. (Health Overview and Scrutiny Meeting: Better care Fund Update, 17 September 2015)

Oxford Health is working with **Oxford Mind** to support 18 – 65 years old people with mental health to become independent and re introduced into the community. The support is provided by Transitional housing support recovery worker who are recruited by Oxford Mind.

There are no care navigators employed by Oxford Health but the care navigators they are managing are mainly employed by **Age UK**. There is only one care navigator with an honorary contract with Oxford Health based in Abingdon Community Hospital (0.4 FTE). The other care navigators are based in the **John Radcliffe Hospital** and **Horton** and have honorary contracts with OUH (2.1 FTE). Age UK is recruiting 2 additional care navigators for the JR and Horton (OUH) for temporary winter pressures scaling up. The Age UK project (Circles of Support) is funded to end of April 2016 currently. The community networkers have honorary contracts with OH as they are based in OH ILTs. There are six staffs, but four are part time so it is the equivalent to 5 FTE across the County.

5. Conclusions and Provisional Recommendations

From this scoping exercise it appears that the care navigator role is being developed across Thames Valley with some clusters more advanced than others. Berkshire seems to be at the forefront with most of CCGs having commissioned various initiatives; positive outcomes have been identified. In Oxfordshire, the CCG recently started working in collaboration with Oxford Health and OxFed to move this forward.

Care navigator is a wide concept which seems to be interpreted at different level. Each organisation thinks about it differently so the role is defined by different need.
The various CCGs have been commissioning different organisations to fulfil the need for the care navigators. It appears that most of these pilots are using the charity sector to supply the workforce. Some of these workers work in hospitals, others in primary care and communities. Although the label is different and the settings might vary, these workers are helping members of the community to navigate their way through health and social care in order to reduce avoidable access to services. These workers are usually hired at level 3/4 qualifications or Band 4 -5; however this varies and no standardised job description has been implemented yet. In some settings care coordinators are expected to have clinical qualification whereas majority are seen as admin/support staff.
It will be interesting to see how HEETV can support the development of this role bearing in mind that due to the integrated nature of the role, it will overlaps the social care workforce which HEE doesn't have a responsibility for. However by exploring this further HEETV might fulfil the DH's recommendation to prepare a workforce that can work across sector boundaries.

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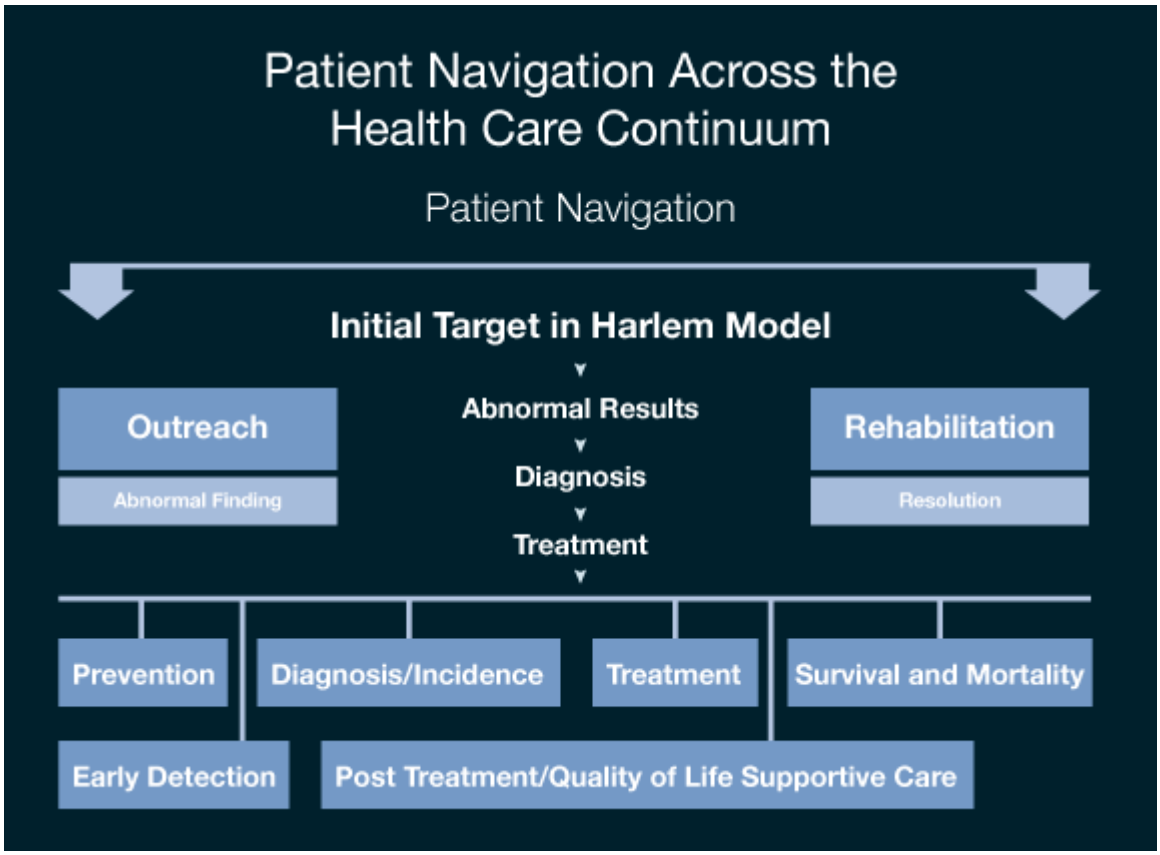
7. Appendices

Appendix 1: Patient Navigation model by the pioneer H. Freeman



Freeman (2006) Patient navigation model

Appendix 2: Case study of an older vulnerable patient – care navigators'outcomes

Care navigators' outcomes:
A man in his late 80s, previously fit and coping, but increasingly experiencing multiple complex conditions, is using more GP and secondary care time. He had been referred and placed on the practice list of older vulnerable patients.

Referral:	Signposts and referrals:	Outcomes:
● By GP as they noticed a general deterioration in patient's physical and social wellbeing ● In the three months before navigator intervention the patient had attended accident and emergency twice and contacted the out of hours service three times	● Following an introductory telephone call, a home visit was carried out due to the patient having poor mobility ● Key issues such as isolation/loneliness, poor medication compliance and patient being in need of support to help organise homecare were identified ● Liaised with GP and chemist to organise a dossett box ● Assisted patient to complete a taxi card application form ● Social worker contacted for information ● Assisted patient to contact various homecare agencies ● Regular contact to follow up on action plan (telephone and home visits) ● Age Concern befriending service (referral) ● Age Concern garden guardians (referral) ● Age Concern support broker (referral) to advise on homecare options ● Taxi card scheme	● Patient has a befriending volunteer who visits him weekly ● Medication compliance has improved ● No A&E admissions or out of hours contacts since intervention ● Patient has booked a trip away and his socialising has improved

Cost benefit:

Costed	Average cost	Events during 3 month period	Cost over 3 months	Estimated cost over 12 months
A&E attendance (cat 1 investigation with level 1-2 treatment)	£108	2	£216	£864
Out of hours	£45	3	£135	£540
Total			**£351**	**£1,404**
Uncosted (with example of possible costs)				
Admission for investigation (organic brain disease)	£350	2	£700	£2,800
Admission for investigation (organic brain disease)	£677	2	£1,354	£5,416
Did not attend for podiatry	£22	2	£44	£176
Did not attend for hearing aid test	£48	2	£96	£384
Total			**£2,194**	**£8,776**

Navigator (cost per year)	
Band 6 mid-point or equivalent	£40,000
Leading Workforce Transformation mentor x 2 hours/week at £40/hour	£4,160
Local management	£4,160
Office space and computer	£5,000
Total	**£53,320**

Caseload and cost per patient on scheme	
Number of cases/navigator/month	15
Number of cases over 8 week care package	30
Six cohorts of 8 weeks/year	180
Divided by cost of navigator (£53,320)	£296.22
Cost per patient of navigator scheme	**£296.22**

Leveaux et al.(2012) Care Navigators' outcomes case study

Appendix 3: examples of Job descriptions

Berkshire

Care Coordinator - slough - chrome tree

Buckinghamshire

Care coordinator High Wycombe 2015.

Oxfordshire

Oxford Mnd 2015.pdf

Care coordinator Ox Health 2015.doc

oxfed practice care navigator job descrip

Milton Keynes

JD Patient_Pathway_Co

PS Patient_Pathway_Co

Appendix 4: Some initiatives and evaluations

Appendix 4a. Initiatives:

National

patient-navigation-pil ot-july2011 breast ca

NAPC Overview of PCN Programme PS S

Thames Valley

OXFED.pdf

pmcf-poster-slough-f eb15.pdf

pmcf-poster-slough. pdf

Social prescribing Project - Reading.pdf

Social-Prescribing-bri efing-paper-update-2

Appendix 4b. Evaluations:

HEE Derbyshire Care Co-ords Developmen

Benefits Report on PCN dementia -Deloit

12. Nurse Navigator Poster SMH.pdf

Buckingham Ben.docx