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Sailing Stormy Seas: Care Navigation

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Everyone was fantastic from the ambulance crew, my GP right to the porter

I keep getting stone walled

Slipping through the gaps

When I'm running into problems I know who to call, they know me and I can get the right help

No one seems to be talking to each other

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This morning

1. Introduce the concept of care navigation. Why now?
2. Describe some UK care navigation services.
3. What is the evidence this works?
4. Education and training aspects of ‘care navigators’

What is ‘care navigation’?

Who are care navigators?

What do they do?

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Why now? Shifting tides

- Ageing population, complexity and multi-morbidity
- Ideas of health, well being and prevention
- Resource challenges
- Service and education and training implications

National Voices
People shaping health and social care

GENERAL PRACTICE
FORWARD VIEW

NHS Vanguards
Bringing health and social care together around the country

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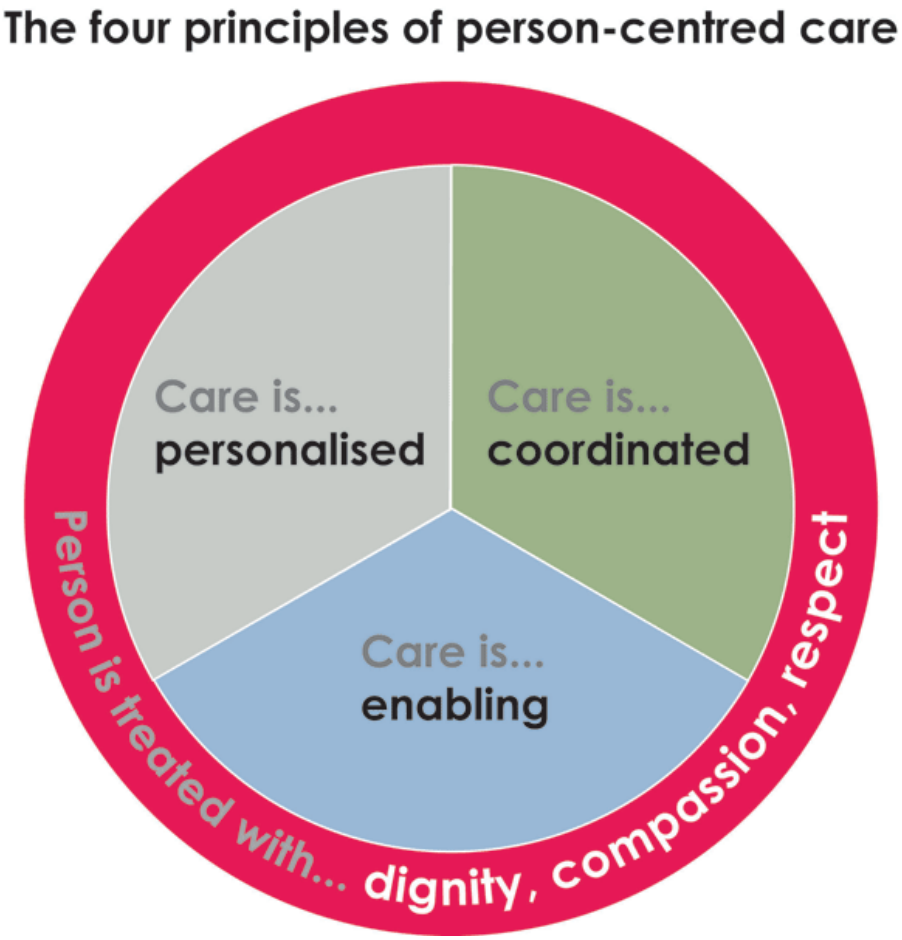
Person-centered care



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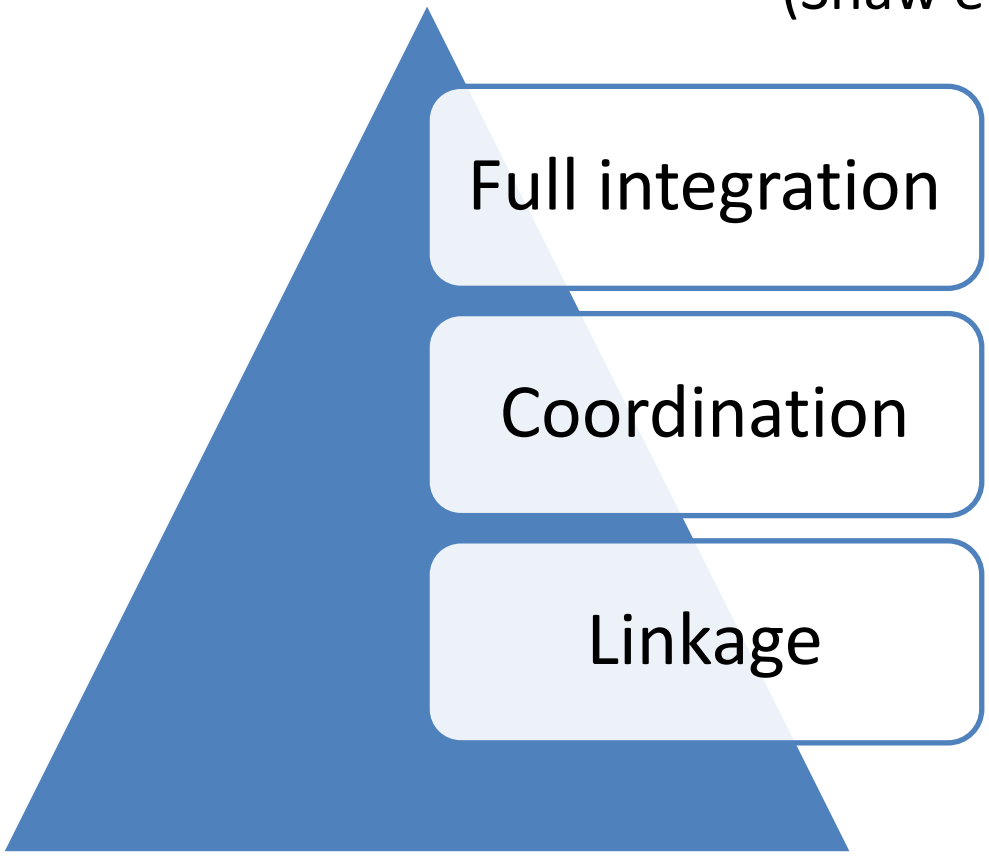
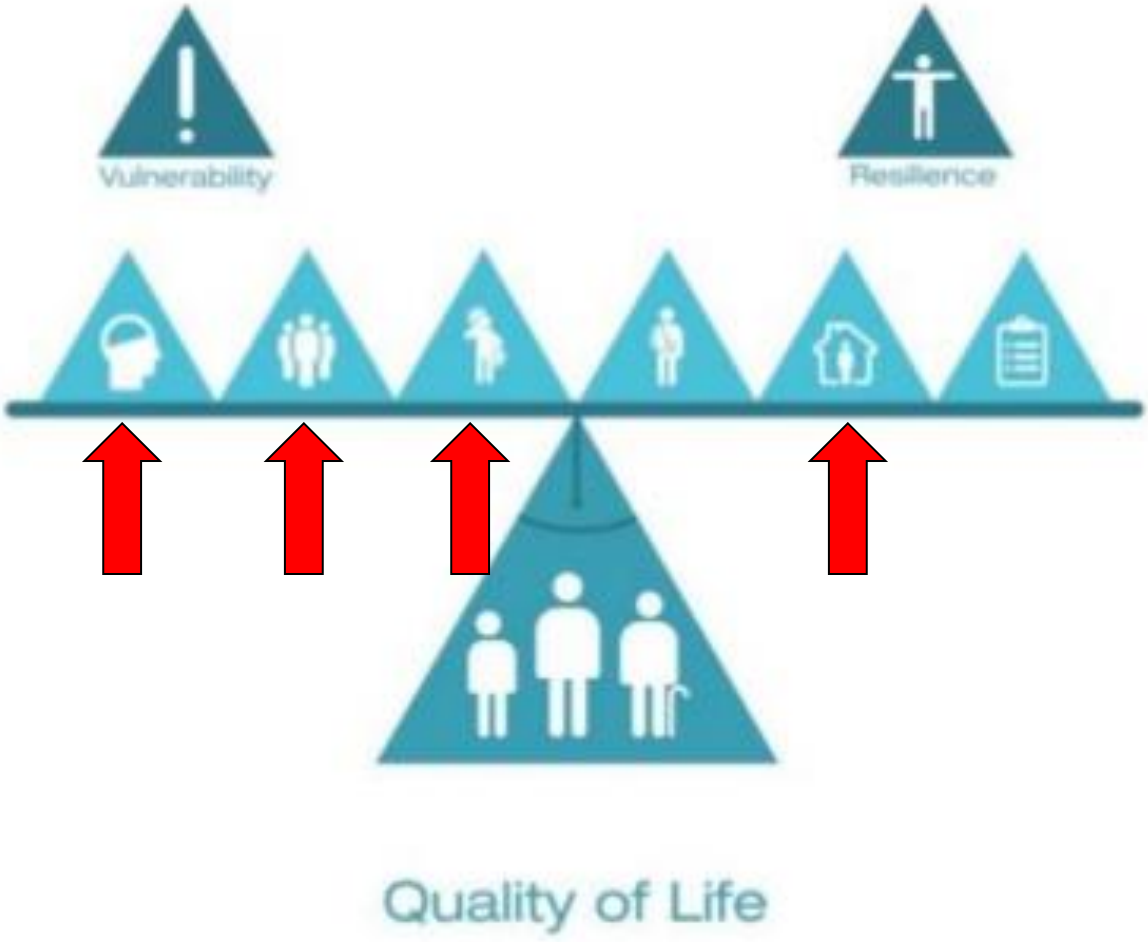
Integrated care

- Different perspectives shaping integrated care

(Shaw et al, 2011)



Frailty fulcrum and CGA



Integrated assessment

Domain	Areas to consider
Social Environment	• Families • Friends • Communities
Physical Environment	• Clothing and footwear • Home • Immediate locality • Wider area
Systems of Care	• Formal care packages • Primary & Community health care • Funding
Psychological Status	• Specific conditions or symptoms • Spiritual, Emotional & Cultural aspects
Long Term Conditions	• Physical health • Mental health • Functional impairment
Acute Health Events	• Current acute events • Past acute events • Risks of future events

Care Navigation

- Originates from different places
  - Freeman's concept 'patient navigator' USA, to improve access, reduce inequalities in cancer care
  - London workforce transformation (health & social navigator)
  - UK Patient Liaison Officer in general practice
  - Voluntary care sector

- Challenges
  - Definitions, language and job titles vary
  - Is there any added value in a crowded service sector?

Definitions

- Macredie et al (2014)

  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

- Age UK
  - **Personalisation support** (assessment for social care with follow up to enable smooth running, advice and signpost personal finances)
  - **Coordination** (re-refer to services if needed, alert health professionals needing input, help, step up care)
  - I**ntegration** across health, social care &voluntary sectors.

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What's in a name?

Community connector

Carer

Care navigator

Key worker

Link worker

Health champion

Care coordinator

Health and social navigator

International examples

- Manderson et al (2012) Canada
  - Systematic review navigation services older people
  - Heterogeneous models and evaluation methods
  - Care plans, linked to community, elicit personal needs

- Ferrante et al (2010) USA
  - Patient navigator; pilot in primary care
  - Based in surgeries, social work background
  - Valued by patients, carers and doctors

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Care Navigation in UK

Do you know of any examples?

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Care Navigation in UK

- A complex seascape!
  - Who provides care navigation?
  - To whom?
  - Where do they work?
  - What do they do?
  - Is it effective?

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Care Navigation

- Who?
  - ➢ Clinicians
    - Nurses Barnsley navigation services
  - ➢ Administrative staff
    - GP receptionists West Wakefield – trained to signpost to local services, determining patient need, saved 930 GP hours over 10 months
  - ➢ Peer / lay navigators

Care Navigation

- To whom?
  - Frail older adults (i.e. Tower Hamlets Together)
  - Disease specific (i.e. stroke, HIV)
  - Vulnerable hard to reach groups (homeless)
  - Lived experience

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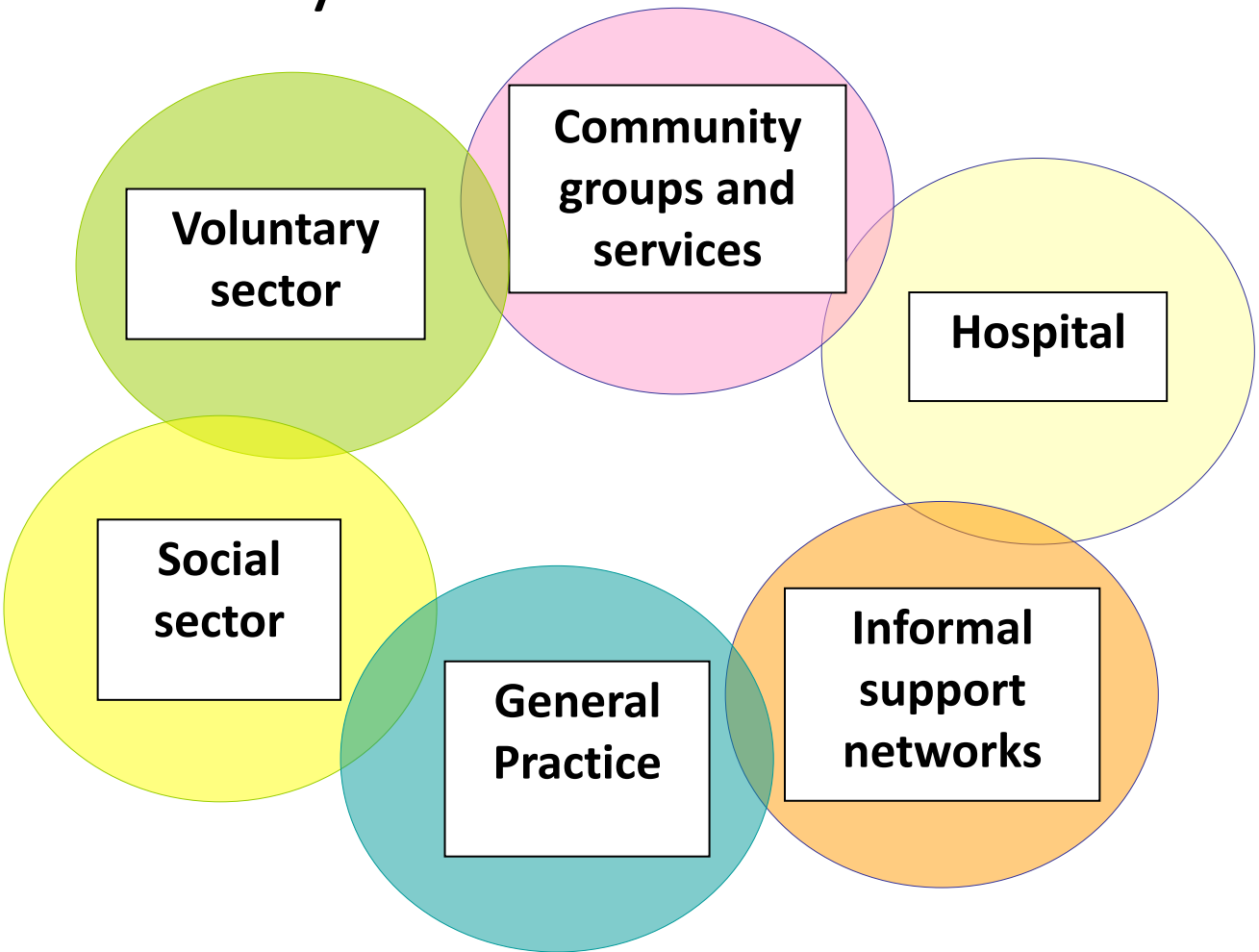
Care Navigation

- Where do they work?



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What do they do?

- Integration, long term conditions, frailty agendas. Enabling person-centered care

Logistical	Relational
Signpost to services	Advocate needs patient/carer
Connect to services	Promote self management
F/U care plan actions	Emotional support
Information giving	Build relationships and trust

https://www.youtube.com/watch?v=Snr3g5bsUTE&list=PLGe38gpSF2BmuO-GcQxkg88WEa4QpiaH0&index=1

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Example of care navigation

- Signposting roles
  - Non-clinical Homerton hospital, A&E and MAU
  - GP receptionist staff
  - Primary care navigators (dementia, diabetes)

- ‘Health and well being’ facilitation
  - Harrow, NW London health and social navigators
  - Islington Age UK locality navigators
  - Camden care Age UK navigators

Is care navigation effective?

- Variable outcomes measured, lack of control
- Patient experience favourable
  - Macredie et al (2014)
- Unplanned hospital admissions?
  - Levereuax (2012); Tavabie (2015)
- Sharing / easing clinician workload?
- Cost effective?
  - Windle et al (2010)

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Case 1 – Camden care navigator, Age UK

- 86 yr lady recently discharged from hospital, admitted with a fall
- Discharge summary scanty - ?UTI, off-legs
- Falls clinic requested ?when
- Lives alone, heart failure, macular degeneration
- 3rd time 2 months admitted to hospital, d/c within 24hr

- **What do you do next?**

Care navigator input

- CN arranged to meet her at home; struggled make sandwich, poor lighting, unsteady gait
- Felt lonely, unconfident leave house, fear falling
- Referrals: OT, housing association, local council, physio, Age UK advice services (attendance allowance).
- Fedback to community MDT
- Taxi card, met 2 times in local café, attendance allowance, local falls prevention class, hand rail installed – no carers needed.

Age UK Camden navigators

- Patients >60 yrs
- Team of 6 with leader; range health/social backgrounds
- One-to-one, surgery, at home
- Signposting and complex case management
- Support access to community & voluntary services, goal setting, accompany people to appointments, create local directory, meet with team regularly to discuss; ***'pragmatic', 'problem solving'***
- Outcomes: 'improve my confidence', 'meet people and do things I enjoy', 'manage my money', 'look after myself'

Care navigation: 24 month pilot

Camden Clinical Commissioning Group

AGE UK CAMDEN: works across three localities, six care navigators

Patients suitable for the care navigation service will be 60+ and either frail, or pre-frail.
Patients may have one or more long term conditions,
and may have had a non elective hospital admission in the last 12 months.

Service in practices: 20 April 2015

Live referrals: 27 April 2015

REFERRALS from GPs only via EMIS

Points of liaison between patients, the locality multidisciplinary teams (MDTs) and local community and voluntary sector providers.

Care coordination support and escorting
for frail elderly and patients with long term conditions at risk of 'did not attend' (DNA) and/or use of inappropriate services

Referral service for patients to voluntary/community providers above the level of signposting volunteers in practices

Using online service directory resource

The coordination of referrals to volunteer networks, community groups and other voluntary/community services.

Dedicated support for practice and borough level multidisciplinary work, providing advice, information and coordination across clinicians and voluntary sector / community services.

Further information

- Contribute to care plans where appropriate.
- Care Navigation will be available to GPs and patients in each locality as a minimum between 09.00 and 17.00, Monday to Friday including phone, face-to-face and home visits.
- Phone service available on weekends.
- Work alongside integrated primary care team, and an existing base of volunteer navigators in GP practices, social workers in primary care and mental health team around the practice.
- Care navigators will have access to the Camden Integrated Digital Records (CIDR) when it is live and will link together health and social care information for patients in Camden.

Examples of referrals:

- Community organisations / associations offices or meeting halls
- Meal and social clubs
- Places of worship
- Befriending and 'connector' services
- Other local health and social care services (including GP practices)
- Residents associations
- Day centres and drop in centres
- Community events / activity days
- Private local services

Case 2 - Health and social navigators, NW London

- 87 yr old man, recently discharged from hospital; frequently attends.
- Deemed ‘high risk’ with various risk stratifications score by GP
- No NOK, lives alone, widower
- Plans to determine how to ‘avoid admission’

- **What do you do next?**

Care navigator input

- MDT -> care plan -> navigator calls patient
- Concerns about isolation, overwhelmed with tablets, worried about memory, feeling 'useless'; used to be a carpenter
- Would call LAS once fortnight – unspecified admissions
- Confided in navigator, anxious, lonely

- Plan – medication review GP booked,
- Suggested and helped refer to local area activities – carpentry classes, gardening, befriending service Age UK
- Point of contact – who to call, when (when not too) – uses coaching approach
- GP assess memory and consider memory clinic referral

Health and social navigators

- Harrow, North London

- Integrated care programme
- Proactive seek out ‘high risk’ GP registers
- GP referrals
- Arrange visit – write care plan
- Administrates MDTs – actions and chase up
- Database, directory building of ‘local wisdom’
- Links to social care
- Feedback to clinicians and commissioners services

Brighton and Hove pilot (2015)

- 12 months, community navigation in 16 GP surgeries
- Volunteers (health, social backgrounds)
- Mainly older people, socially isolated, low mood, housing and finance issues

- Outcomes
  - 393 patients; 98% satisfied, 93% had enough info
  - 89% GP, practice staff satisfied; 68% save time
  - Cost: potentially £1.36 million / yr GP time
  - Practice needs to be ‘navigator ready’

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Education and training: project

- Aim: to explore and develop training and education opportunities for people providing care navigation

- Understand skills, tasks, contexts
- Develop core competencies and a framework for care navigation (purpose)
- Lay foundations of education / career routes for non-clinical staff progression

- What are the important skills and knowledge people providing care navigation should have?

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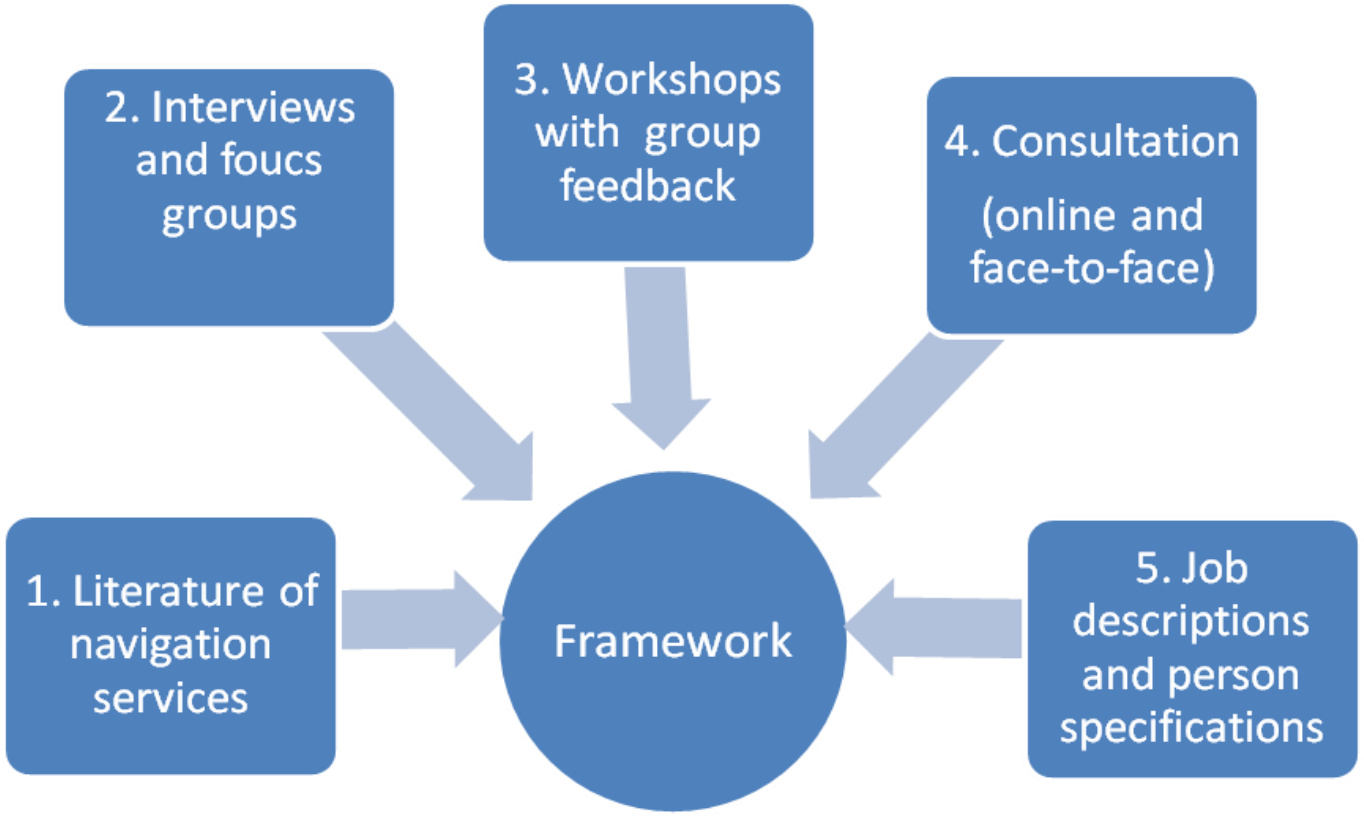
Core competency framework



Primary Care, Voluntary Sector, Secondary care

Health Watch/patient representatives, Education providers

Findings (1)

- Plethora of roles/job titles
- Unclear job remit
- Training ‘ad hoc’ and variable
- Unclear line of sight for further training or career progression
- Common themes
  - E.g. Communication, networking, administration, support people with often complex holistic needs

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Findings (2)

Findings (3)

Get **access to services**, take responsibility for **databases** and **follow up care plans**

They should help people **connect and link up into what they need**

We need more navigators – with **excellent communication, skills,** our navigator is so helpful when I have very limited face to face time with patients

A ‘go to’ person who glues it all together, makes things happen

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

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

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Core Competency domains

- Effective communication
- Enable access to services
- Personalisation care and support
- Coordination and integration
- Building and sustaining professional relationships
- Knowledge for practice
- Personal development and learning
- Handling data and information
- Professionalism

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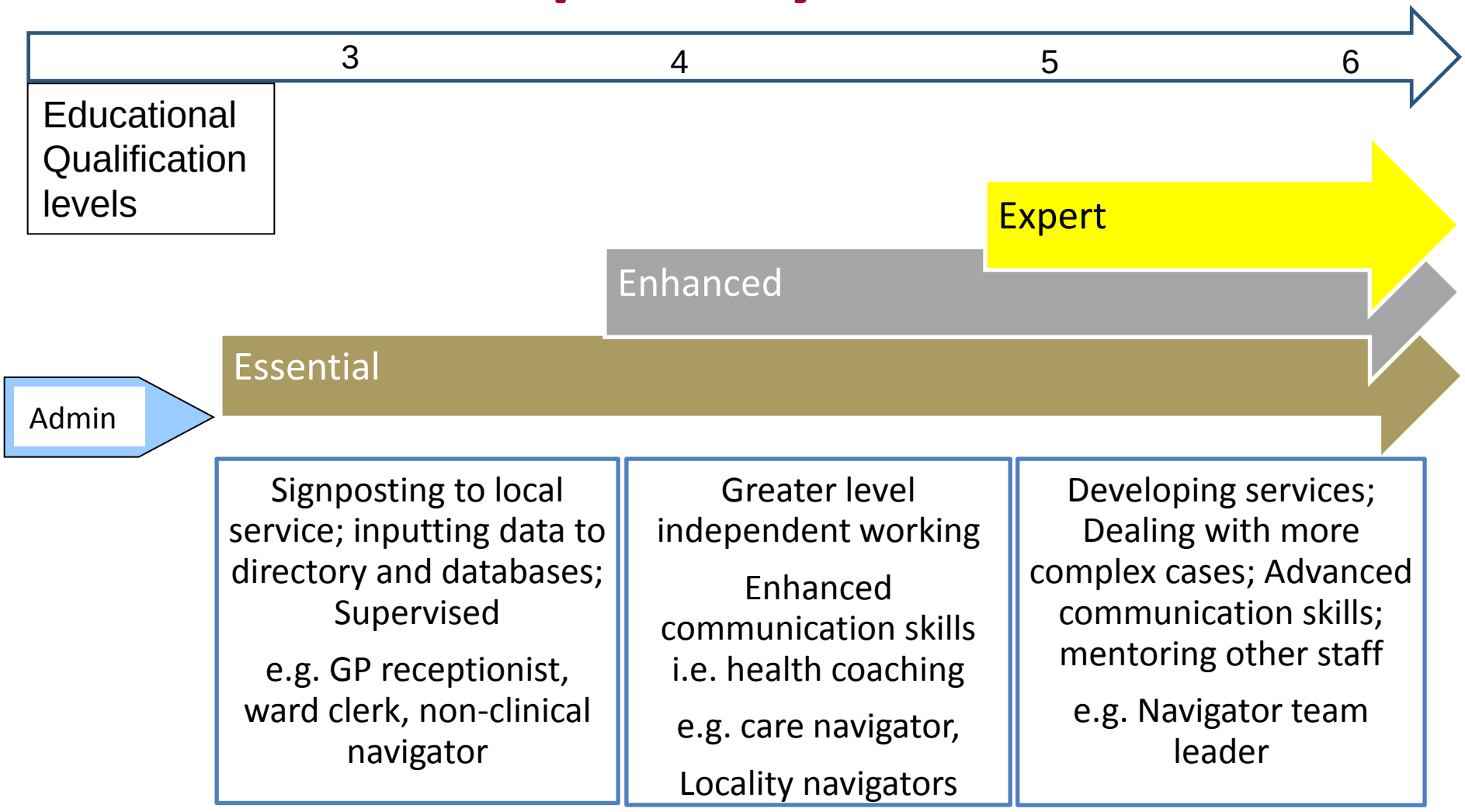
Competency Levels



Education and training approaches

- Reflection on practice, regular action learning sets
- Apprenticeship model
- Importance of mentors / supervisors
- Portfolio based
- Accredited courses, qualifications (higher levels)
- Importance of MDT and workplace mentorship

Next steps

- ‘Common ground’ to develop coherent recognised training and education programmes

- Working with education providers and CEPNs to develop and pilot training programmes using competency framework

Thank you

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References

- Freeman H.(2006). Patient navigation: a community centered approach to reducing cancer mortality. *Journal of Cancer Education*. 21(1):11-14.
- Leveaux C et al. (2012). Safer passage : how care navigators help improve mental health services. *Health Service Journal*.
- Tavabie JA and Tavabie M (2013). The patient liaison officer: a new role in UK general practice. *Quality Primary Care.* 21(5):303-313.
- Primary Care Navigator Training programme for dementia (2015). National Association for Primary Care. Manderson H et al (2012). Navigation roles support chronically ill older adults through healthcare transitions: a systematic review of the literature. *Health and Social care in the community*.20(2):113-127. *Health and Social Care in the Community*
- A narrative for person centred coordinated care. (2013). *National Voices*.
- Windle K et al (2010). The National Evaluation of Partnerships for Older People Projects.
- Macredie S et al. (2014). Care Navigation. A report on research into patient and carer perspectives on the nature, effectiveness and impact of care navigation systems in Bradford, Airedale, Wharfedale and Craven. Making time in general practice (2015). Primary Care Foundation. Available: http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/PCF_Press_Releases/Making-Time-in_General_Practice_FULL_REPORT_28_10_15.pdf

Dohan D and Schrag D (2005) Using navigators to improve care of underserved adults. *Cancer.* 104(4):848-855.
Windle K (2015). What role can local and national supportive services play in supporting independent and healthy living in individuals 65 and over? *Government Office for Science*

Windle K et al (2010). The impact of the POPP programme on changes in individual service use. Available: http://www.pssru.ac.uk/pdf/uc/uc2010/uc2010_impactofPOPP.pdf