healthwatch Merton

Community Navigator Service (CNS) Evaluation

Report by
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Merton Voluntary Service Council
December 2017

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healthwatch Merton

EXECUTIVE SUMMARY

Key Successes

The Community Navigation Service connected 363 people (March 2016 - July 2017) across the Holistic Assessment Rapid Investigation Team and the GP Practice (both located at the Nelson Health Centre).

Out of the 181 referrals made to the Community Navigation Service there were 105 connections/referrals made to over 25 different organisations/services.

92% of patients, interviewed as part of the evaluation, said without the intervention from the Community Navigation Service they would not have come across the services/activities on their own.

85% of patients rated the Community Navigation Service as excellent or good

- *Patient said 'The Community navigator has been very helpful, if I hadn't come to see the Community navigator I don't think I would have done anything about going to the YMCA Wimbledon. GP's don't always know about all the community services.'*

Nelson Practice GP lead contact for the Community Navigation Service believed:-

- *Resource within the practice for clinicians and staff to learn about existing services*
- *Benefit to patients and positive feedback from patients on the service*
- *Reduction of GP time, (less appointments)*
- *Support in management complex patients*

As of July 2017, there were at least 180 sessions with the 76 patients that had been referred to the CNS from the GP practice. The average time spent during each consultation was an hour which equates to: -

- Approximately 720 GP appointments (based on 15 min appointments).
- Estimated saving (based on £50 a consultation = £36,000)

Through MVSC additional funding has been obtained to pay for patients to take part in activities.

Learning from the Community Navigator Service was fed into the Merton Social Prescribing Pilot, ensuing that this pilot was able to start quickly, supporting its success.

Key Challenges

Patient Data Management – inconsistency across GP and HARI (access to EMIS enabled a better service to patients and GPs, however this has been a challenge in HARI with no access to RIO)

Making contact with some services - small community groups are not always accessible – volunteer run, don't check emails, referral information is not always clear.

Getting correct and useful information on voluntary sector services can be a challenge. In order to support patients effectively there is a need to ensure that data for social prescribing services/activities is maintained, correct, useful and kept up to date.

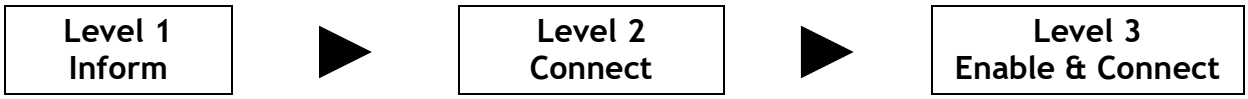
Lack of services to refer to – some do not exist (i.e., hearing support in Merton) or organisations providing services become overwhelmed (i.e., MCIL)

Managing demand within existing capacity

Key Recommendations

Further information on key recommendations can be found from page 13 onwards.

R1 The Community Navigation Service (CNS) support should be formally structured across 3 levels to formalise the types of support offered and to manage capacity within the service.



R2 A detailed review should be undertaken and recommendations produced for a plan to improve the way that Social Prescribing is able to access information about voluntary sector services.

R3 A communication and marketing plan should be developed to ensure the CNS maintains its identity and reputation within the Nelson GP Practice.

R4 A form should be developed for the GP aspect of CNS that list areas in which support can be offered by the CNS.

R5 When the CNS or Social Prescribing Service is implemented in other GP practices, it is important that the whole practice team are fully bought into the concept of CNS and social prescribing and have a clear understanding.

R6 A clear set of KPI's for the CNS should be developed in consultation with the CCG and aspects of the CNS should be aligned with the Social Prescribing Co-ordinator role KPI's.

R7 Access to EMIS, as part of the GP aspect of the CNS, has ensured better communication and understanding of patient needs. It is important that this is replicated within the HARI Team with access to RIO.

R8 The existing monitoring methods and measuring tools should be reviewed to ensure all positive interventions are recorded effectively.

R9 Investigate structuring follow ups with HARI and GP patients after they have exited the service (3-6 months).

R10 Continue the joint working with the Social Prescribing Co-ordinator and look at developing aspects together.

R11 Explore the development of a formalised network of providers who offer Social Prescribing activities or services across Merton.

R12 Integrate the CNS into the existing Social Prescribing steering group, to ensure that it is considered at a strategic level as part of development of Social Prescribing in the borough in the future.

R13 Explore joint opportunities with other organisations who could offer services specifically to CNS referred patients.

1. INTRODUCTION

1.1The Project Ambition
The Community Navigation Service is a 2-year pilot project delivered by Healthwatch Merton and funded by the Merton Clinical Commission Group (January 2016-December 2017).

In Merton there is a vision to build a more supportive, inclusive and resilient community. A key part of this vision is connecting people with activities, services and support in the community, bearing in mind their individual wishes, goals and preferences. The Community Navigation Service plays a vital role in helping to achieve this and is a valuable resource for Merton residents.

Often, people are not aware of the range of statutory and non-statutory services which could provide support and meet their needs and they may be reluctant to independently access such services without any endorsements from family, friends or professionals. Supporting people in Merton to navigate the complement of local services results in a wide range of benefits for people's health and wellbeing. The guidance people are given and the services that they are signposted or referred to is closely related to the individuals' needs.

1.2 The key aims and objectives of the Community Navigation Pilot Service, as defined in the service specification, are:-

- To provide personalised information, advice and support to people using the service.
- To signpost or refer people to appropriate activities, services and support which will help to meet their needs.
- To support service users and provide a range of accessible and flexible information in a manner that is responsive to their individual needs, preferences and wishes.
- To ensure service users are supported by staff who have the required knowledge, skills and competencies.
- To build, develop and maintain relationships with and knowledge of local statutory and non-statutory organisations, services and groups to support the effective operation of the service.
- To promote and increase awareness of the service in the borough.
- To deliver the service in a way that represents value for money.
- To utilise effective methods to gather service user feedback in order to evaluate the quality of the service.
- To provide robust and timely information on service quality and utilisation.
- To identify ways in which community navigation can evolve and be embedded to a greater extent across Merton.

1.3 This Community Navigator Internal Evaluation, being co-ordinated and complied by Bekir Yusuf (MVSC Associate), measures the success of the project against the key aims and objectives from the service specification (refer to 1.2).

2. The Community Navigation Service in Practice

2.1 The Community Navigation Service (CNS) is hosted by Healthwatch Merton who appointed a Community Navigator in January 2016

The overarching aim of the CNS for users, who engage with the service, is: -

To connect people with local activities and services which can make life more enjoyable and/or provide practical support

2.2 CNS Beneficiaries
The CNS can be accessed by service users who are resident in the London Borough of Merton and/or are registered at a general practice within Merton Clinical Commissioning Group.

The service is primarily for those aged 16 and above. Those aged below 16 can receive information and guidance; however, other services are likely to be better placed to provide support for this cohort and efforts should be made to obtain consent from the individuals in order to proactively refer them to appropriate services.

2.3 CNS Location
The CNS was initially located within the Holistic Assessment Rapid Investigation Team (HARI) based at the Nelson Health Centre from April 2016.

In September 2016 the Community Navigator also established a presence (1-1.5 days a week) at the Nelson GP Practice.

2.4 CNS Referrals
The key referral criteria for both the HARI service and GP practice is that the patient is a user of either of those services.

The CNS works with users to offer solutions that can work for them (overview of the service taken from Community Navigation Service leaflet): -

- *It's all about what's right for you*
- *Together we'll look at lots of areas of your life that you want to improve, and help you identify what is most important to you.*
- *We'll do our best to find the right service to help you, based on what you want, and help make it easier for you to access the service.*
- *We will give you information on what services are available.*
- *We can make phone calls, send emails and help you fill in forms for other organisations.*
- *You can choose what type of appointment with a community navigator would suit you best.*
- *We can come with you to 'taster' sessions at other organisations.*

2.5 Nelson HARI Referral Pathway

All members of the HARI Team (Doctor, Nursing Staff, Occupational Therapists, Physiotherapists and support workers) can make a referral to the Community Navigation Service

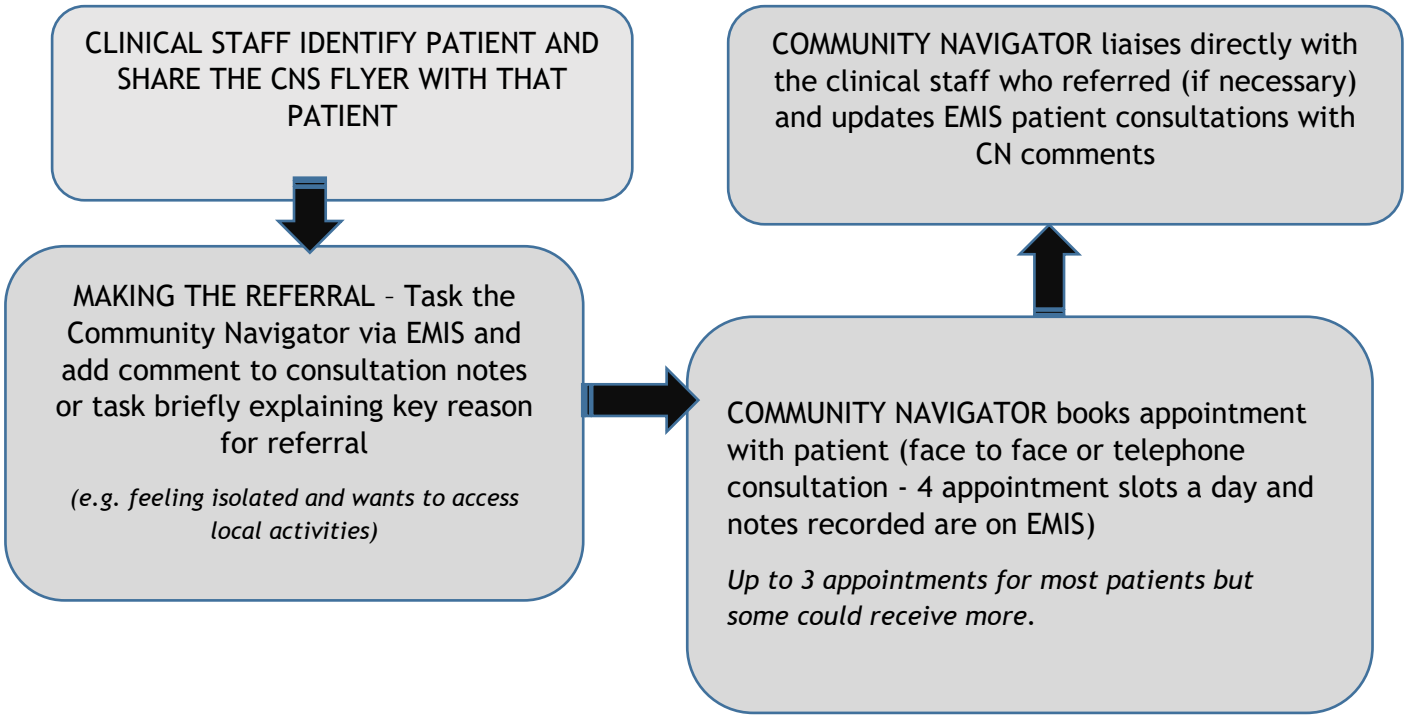
The Community Navigator also completed referrals after ad-hoc interventions (usually whilst chatting to patients in the waiting area) if the patient consented.

The CNS does not have access to the RIO patient data management system that is used in HARI, so, all referrals are paper based and records stored in compliance with the Data Protection Act in a locked cabinet.

Key outcomes and progress of each referral is noted on the referral form *(e.g. patient referred to the Wimbledon Guild Outreach Service – 24.5.16)*

2.6 Nelson GP Practice Referral Pathway

All clinical staff within the Nelson GP Practice can refer directly to the CNS.



3. Evaluation Methodology

3.1 The evaluation will pull together known statistics of the following: -

- The number patients who engaged with CNS across via HARI and the GP practice
- Age and ethnicity breakdown
- Health conditions themes of patients if known
- The key interests/area from patients requesting support from the CNS
- Referrals/connections made by to organisations/services

3.2 As part of the process a sample of patients were interviewed by phone by Bec Yusuf (Community Navigator Sept 16-Jun 17) and Clara Jones (Community Navigator):

- 9 Nelson Health Centre HARI Patients who connected with CNS
- 5 Nelson GP practice patients who connected with the service

In addition to the phone interviews a sample of comments from patients who engaged in the CNS have been included.

3.3 A case study of patient/s referred by HARI and the Nelson GP practice has been included to offer a more detailed insight into how valued the CNS is by its beneficiaries.

3.4 In addition to the patient data collected and surveys feedback has been collated from:

- A GP within the Nelson GP Practice (CNS main liaison)
- Members of staff within the HARI Team (Advance Nurse Practioner, Occupational Therapist and Staff Nurse)

Feedback has also been included from Clara Jones (CNS Community Navigator) who highlighted what worked well and challenges experienced.

4. HARI @ Nelson Health Centre

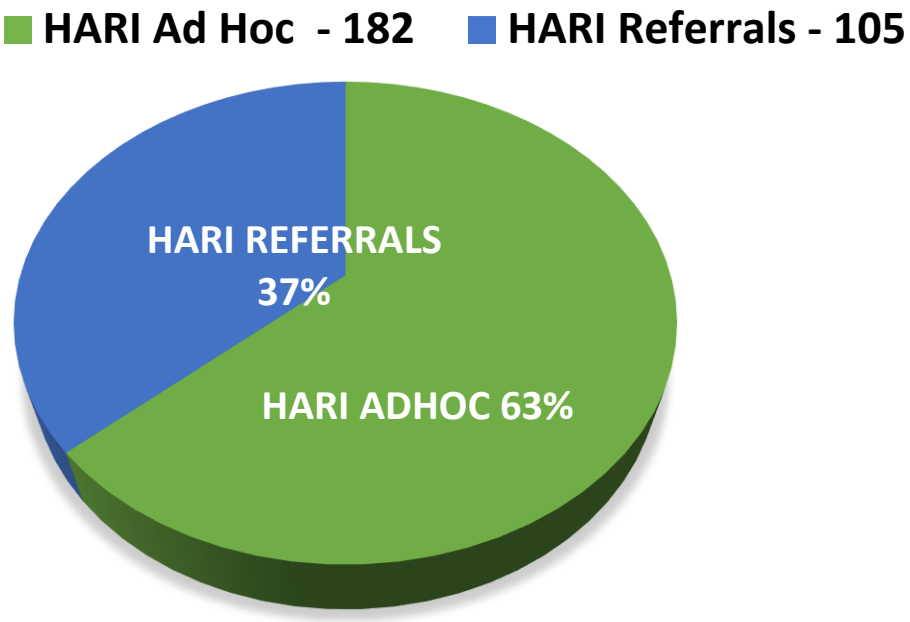
4.1 Between March 2016 and July 2017 287 patients had contact with the Community Navigator *(these took the form of adhoc navigation and referral based navigation)*.

4.1.1 Adhoc Navigation

- Assessing – chatting to people whilst they are waiting to be seen by one of the HARI team (usually 3-8 people in waiting area of the HARI section at the Nelson Health Centre)
- Informing and Signposting – raising awareness on what services and opportunities are available and giving the person information if they agree to it.

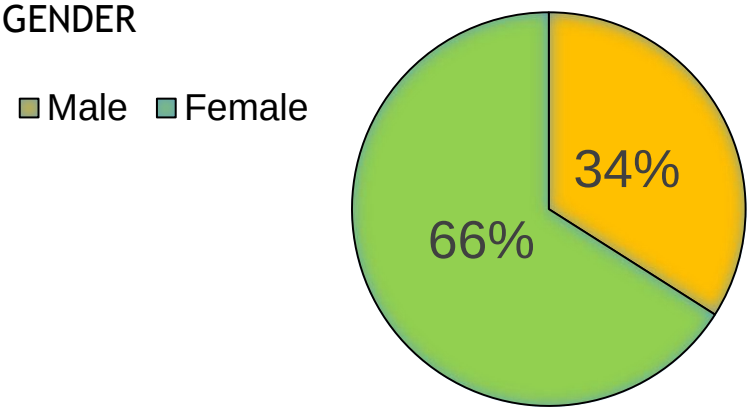
4.1.2 Referral Based Community Navigation

- Referral forms are completed by a member of the HARI team or the Community Navigator which states the beneficiaries
- The support will involve assessing what the person needs, informing and signposting
- Beneficiaries are connected with other organisations if the person agrees to their details being shared

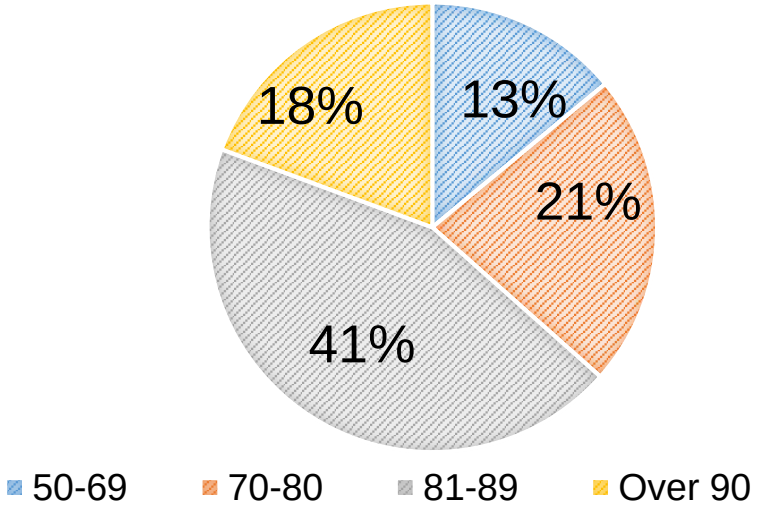


4.2 HARI Referral Based CNS Breakdown of Beneficiaries

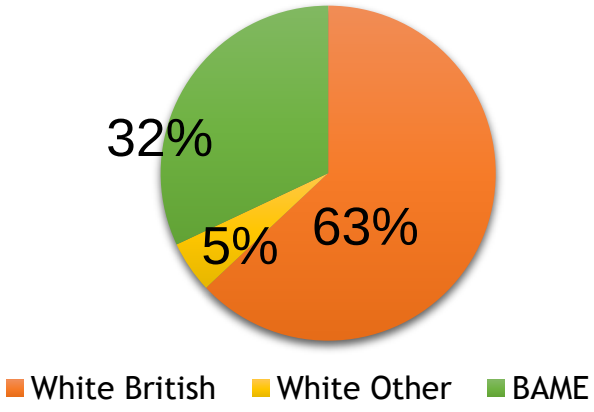
GENDER



AGE



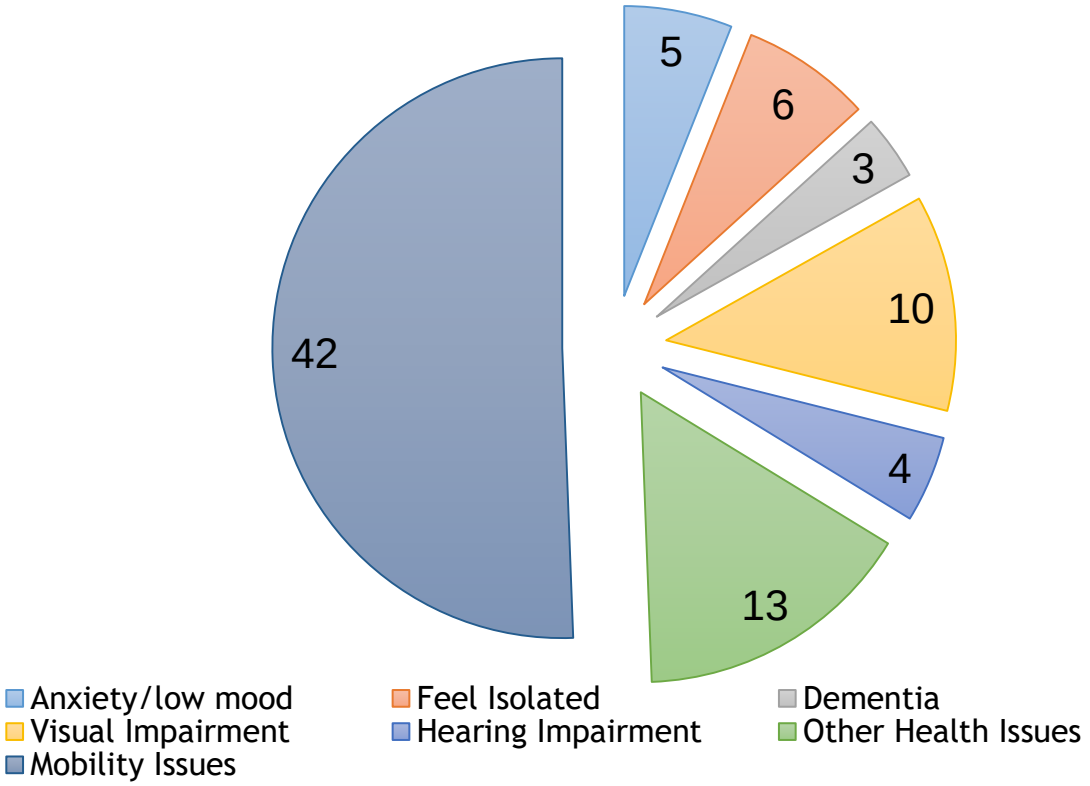
ETHNICITY



The breakdown of ethnicity closely replicates breakdown of HARI admissions: - White British - 68%, White Other 9% and BAME 23%

4.3 Key Health Conditions of Beneficiaries (Referral Based)

Out of the 105 referrals made to the Community Navigator service between April 2016 and July 2017 the key health related condition or issues were: -

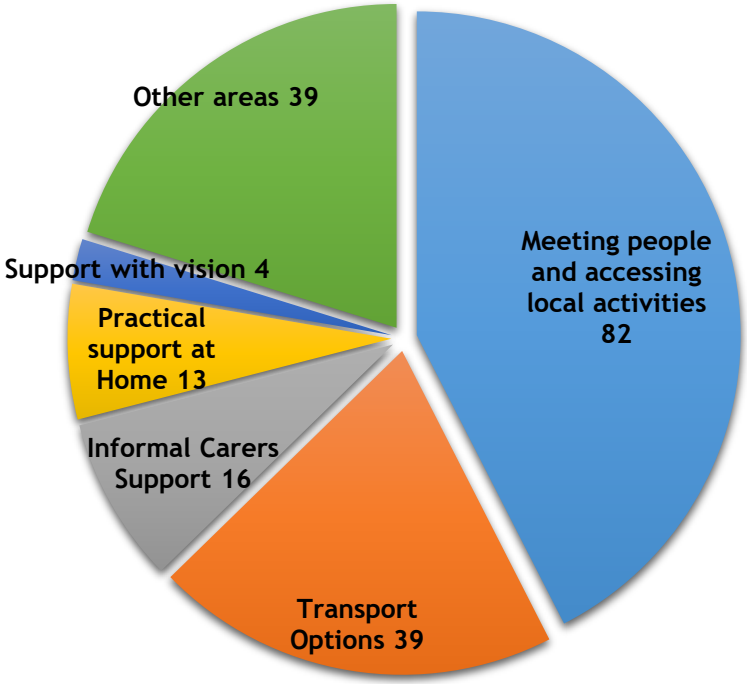


Many of the beneficiaries who visit the HARI team are likely to have multiple health conditions and issues

Out of the health-related conditions 23 of the beneficiaries had more than on

- Parkinson's
- Diabetes
- Kidney Disease
- Cancer

4.4 Ad hoc Intervention Key Themes

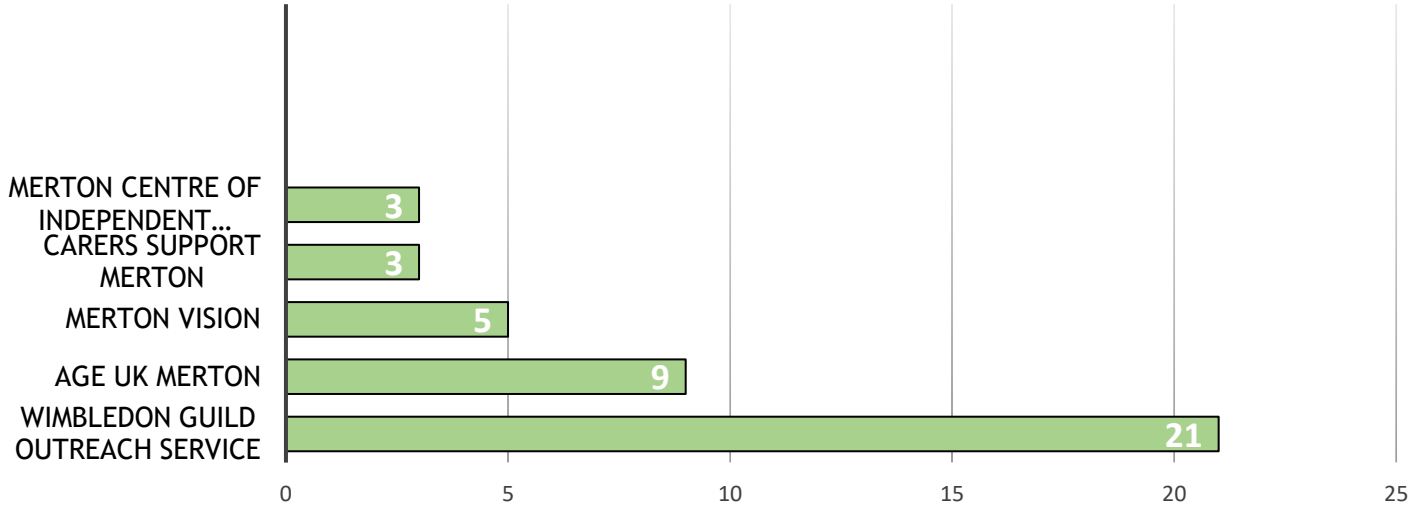


4.5 Referral Based Intervention Key Themes

Themes	Areas
Meeting people & accessing local activities	Exercise classes, befriending, day centres with transport, art classes, bridge, chess, knitting, singing, walks, community specific groups (i.e. Asian Elderly), long term condition groups (i.e. Arthritis Care Support Group), activities for people living with Dementia, trips out, community gardening, etc.
Transport Options	Taxi-Card, Dial-A-Ride, Blue Badge and informing people of organisations who can supporting with completing the forms
Informal Carers Support	Increasing awareness amongst users of organisations offering local support (i.e. Carers Support Merton and Help for Carers - Beyond Barriers programme)
Practical Support at Homes	There have been requests for mobile hairdressers, handyperson services, gardeners, cleaners, meals delivered to homes and domiciliary dentist service
Vision	Support with resources that could be provided at home to help those visually impaired or registered blind. People are connected with or given information on Merton Vision
Other areas	The range of information shared included Merton IAPT service, mobility scooter hire, bereavement service, podiatry, volunteering, ICT befriending, footwear, asthma support, difficulty leaving home, help with entitlements, help with shopping, (i.e. Attendance Allowance), housing issues, finance, personal alarms (MASCOT), etc.

4.6 Referrals to Organisations and the Key Themes

Out of the 105 who connected with the CNS referrals were made to organisations who could work with the person in respect of the interest or request flagged up.



4.7 Feedback from HARI Beneficiaries

4.7.1 Nine HARI patients contacted by phone who were referred to the CNS. (The earliest referral was April 2016 and the most recent was March 2017)

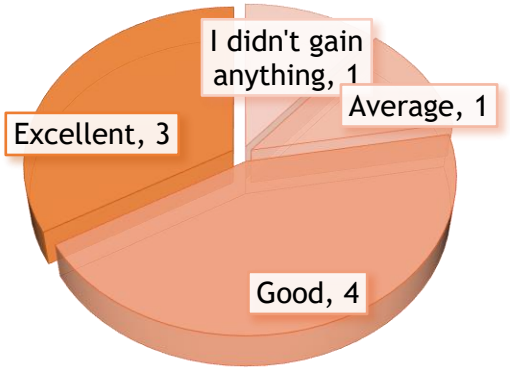
4.7.2 The survey focused on statement based related questions and open ended qualitative themed questions

	Statements	Strongly Agree	Agree	Disagree	N/A
1	I am more aware of activities/services*	2	6	1	
2	It has helped me identify my priorities and goals	2	5	1	1
3	I have relied less on other health services		2	3	4
4	My physical health has improved		3	3	3
5	I feel more positive		6		3
6	I feel less isolated	2	4	2	1
7	I manage my symptoms better	1	2	1	5

Out of the 9 patients interviewed by phone 8 of them felt that without the intervention from the CNS they would not have come across the services/activities on their own.

Patient Comment 'No, I doubt it. It was an opportunity that I was there, and CN was there. By chance that you were there and great be there'

Patients were asked how they rated the CNS overall



4.7.3 Key Comments from Phone Interviews

Interviewee Profile	Comments
Female Age 70 First contact June 2016	*I have spoken to the community navigator on two occasions when I went to the HARI the first time and then again when I went to see them again in 2017. It was wonderful to speak to the community navigator both times. It was lovely that she referred me back to Age UK as I had lost touch with them.* *Age UK offered me a befriender, and i am glad they have experts in benefits*
Female Age 88 First contact January 2017	*Companionship was a big area for me and I feel like I mix better and I am happier. Transport helps me make it happen.* *I am now attending Wimbledon Guild and Morden Baptist Church regularly with my new friend that I met at HARI*
Female Age 89 First contact March 2017	*Overall, it has been a very good thing for me to join. If it wasn't for you (CNS) telling me I wouldn't think about it.* *Meeting someone at HARI was great as well and we have become good friends who go to the activities at Wimbledon Guild and Morden Baptist Church together.*
Male Age 76 First contact October 2016	*Getting help with Dial-A-Ride has given me the opportunity to reconnect with activities I used to attend before I came unwell. I now go out twice a week and get chance to socialise and do exercise.* *I know where to go when I need help with service and activities as can pop to Age UK Merton. You are doing a good job*
Male Age (unknown) First contact May 2016	*Thanks for telling us about the Parkinson's organisations, but we know all about them already. My husband is not well enough to go to these activities now, but we hope to go back some time. I know you must go through all the things just in case. We are saving the Library home visits until he is better, we might need this in the future, so thank you for that information. Please do call us again.*

Female Age (unknown) First contact May 2016	*It was useful to find out about home visits from my dentist. I also have a lady from Wimbledon Guild who comes to visit me*
Female Age (unknown) First contact April 2016	*Wimbledon Guild are a wonderful organisation. I attend Wimbledon Guild Chiropodist, I go once a week on a Tuesday. I also attend talks and go to the cafe for lunch (Its lovely home cooked food) Dial a ride is very useful, it's a little bus I get to the Guild every week. Wimbledon Guild helped me with the Dial a ride application.*
Female Aged 88 First contact May 2016	*I don't really have time to do anything now. I go to see my son three times a week. He used to look after me, and then he had this terrible stroke. I know that exercise is good for me, it makes me feel better in my head somehow as well, but I don't have time to go along to any exercise classes right now. I do the exercises I was given at the HARI from time to time at home. It is nice to know that someone cares, and I will keep the Age UK and Wimbledon Guild leaflets in my drawer to get out if I need them, or if I have the time.*
Male Age(unknown) First Contact April 2016	*I had not heard of these organisations before, so it's good to know they are there. I've not got in touch with them yet for one reason or another, I was a bit confused by the food catalogues, I've not been well, so I didn't get in touch with the day centres, and I've not applied for any transport help yet.*

4.7.4 Feedback/progress notes on other HARI beneficiaries who accessed the service throughout the period

Comments
"Thanks so much for your help, which was really useful. I was sure there must be a dentist that would come and visit. I still have my own teeth and I would like to keep them."
Found all the information given useful and did go along to Age UK and apply for a post. She has now reconnected with volunteering and does it as and when she feels up to it at a nursing home in Purley where she used to volunteer before. She found the community navigator (Clara) was very encouraging, motivating and helped her to reconnect with volunteering
D has serious health problems and poor mental health over a long period. He was glad to contact Merton Vision and Wimbledon Guild know him from when he used to attend when he was better. *Wimbledon Guild organising a befriender. D was pleased to see them again, and to know that he is touch with all the services out there. He said he "puts a brave face on things" and "I haven't had a good day since I had the stroke". Discussed having more bright spots in the day even if things were hard. Didn't feel would alter wellbeing significantly, but we have put him in touch with all services available.*
Managed to get Mascot Alarm at a lower price, had home visit, organised next day, was very happy with service "one of the best things that I've ever done, I would thoroughly recommend to anyone for peace of mind. The Community Navigator information was invaluable".

Nelson Health Centre HARI Case Study

Two older ladies were accessing the HARI service together and both connected the CNS within weeks of each other (both ladies were interviewed as part of the Community Navigation evaluation process)

Patient A had restricted mobility and prone to falls. They had 2 strokes in recent years. The main reason

Patient A agreed to engage with CNS was so that they could meet people and make friends.

Patient B had reduced mobility and wanted help with meeting people and transport options. B said 'my neighbour gets picked up weekly by Dial-a-ride and goes to the Wimbledon Guild (WG)…. I think I would like to do this as well'

Both patients were referred within weeks of each other to the Wimbledon Guild Outreach service by the Community Navigator

WG visited patient A and supported her with making an application for attendance allowance (beneficiaries can receive either £55.65 or £83.10 a week if they qualify). Patient A is now in receipt of attendance allowance and visits the WG every Thursday

WG supported patient B with her application to Dial-a-ride and helped her access pension credits which she did not know she was entitled to. In addition, she also now regularly attends the WG every Thursday

As patient A and patient B continued to attend the HARI clinic they formed a friendship which continues today.

Every week one of them books the Dial-a-Ride for the Morden Baptist church physio programme (Tuesdays) and the Wimbledon Guild (Thursdays)

They have both become good friends and talk regularly outside of their twice weekly meet ups.

Patient A 'We are great friends (with patient B) now and always talk on the phone. It would be nice if we could go on a trip together as most of the trips offered are more for those that are more mobile than us both'

Patient B 'We have got to know lots of people and even have a good natter with the WG driver. I didn't actually think you make good friends like patient A. We share our problems which is nice'

Both patient A and B are a great example of how HARI at the Nelson Health Centre, with the addition of the CNS, also addresses the social needs of patients as well as tackling the physical and mental health needs.

They are both now better off financially (patient A – attendance allowance and patient B – pension credits) and their wishes for companionship and making friends has happened.

Patient B also stated they had become less reliant on health services

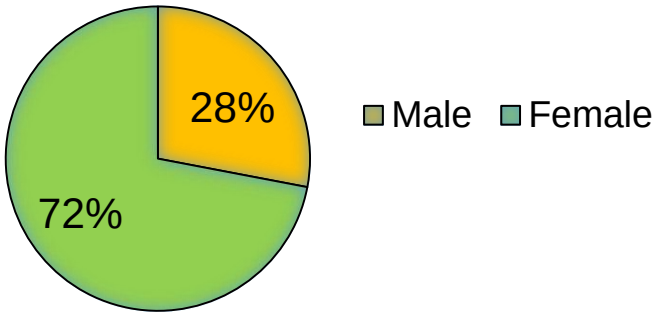
5. Nelson GP Practice

5.1 Since the beginning of the GP Practice element of the CNS pilot, in September 2016 until October 2017, over 80 patients have had contact with the Community Navigator *(average of 1-1.5 days a week at the practice)*

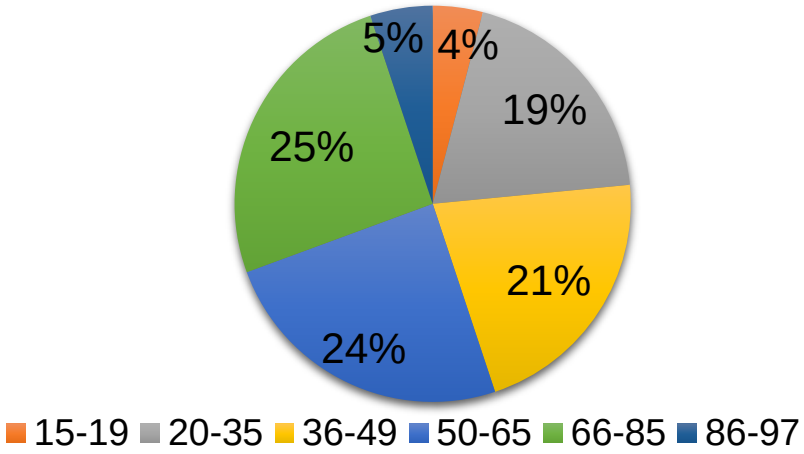
5.2 The breakdown of the 76 beneficiaries below are those who have face to face appointments with the Community Navigator and does not presently account for all those who have received advice via phone or email (period covered September 2016-July 2017)

CNS Beneficiaries Breakdown of Users

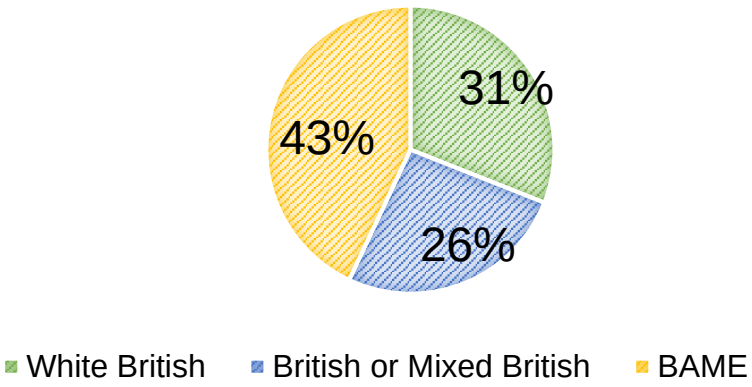
GENDER



AGE OF BENEFICIARIES

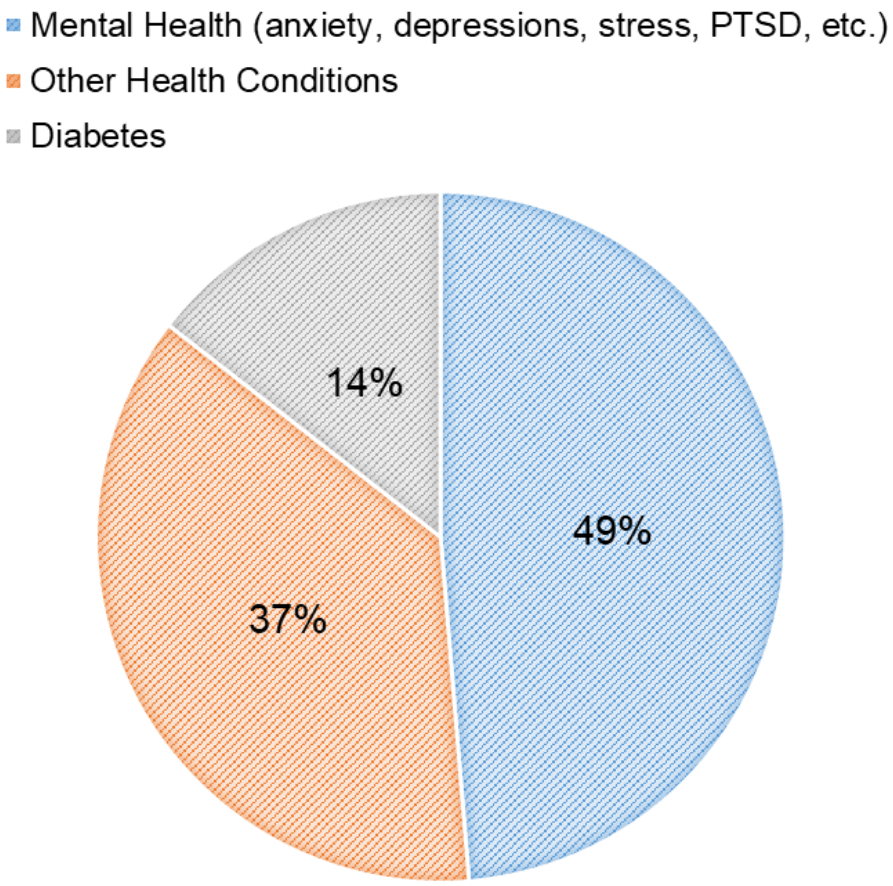


ETHNICITY OF BENECIFIARIES



5.3 Key Primary Health/Other Themes

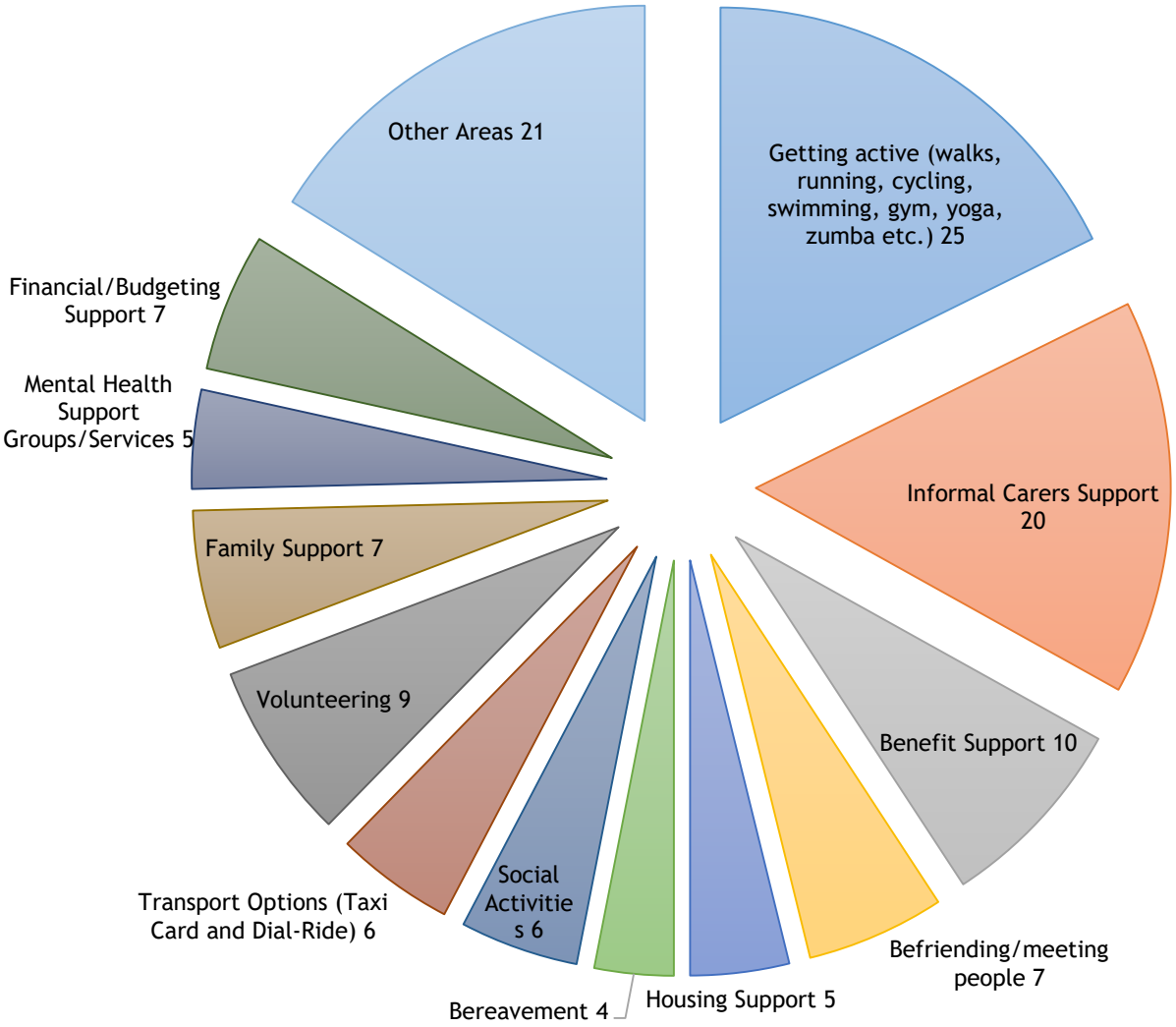
Out of the 76 referrals made to the Community Navigator service between September 2016 and July 2017 the key health related condition or issues were: -



Other Health Conditions	Arthritis, osteoporosis, spina bifida, HIV, visual impairment, hard of hearing, COPD, vestibular disorder, dementia and sickle cell

5.4 Key Themes for Community Navigator Intervention

Out of the 76 referrals the key themes/areas were (many the patients would have expressed in interest in more than one area): -

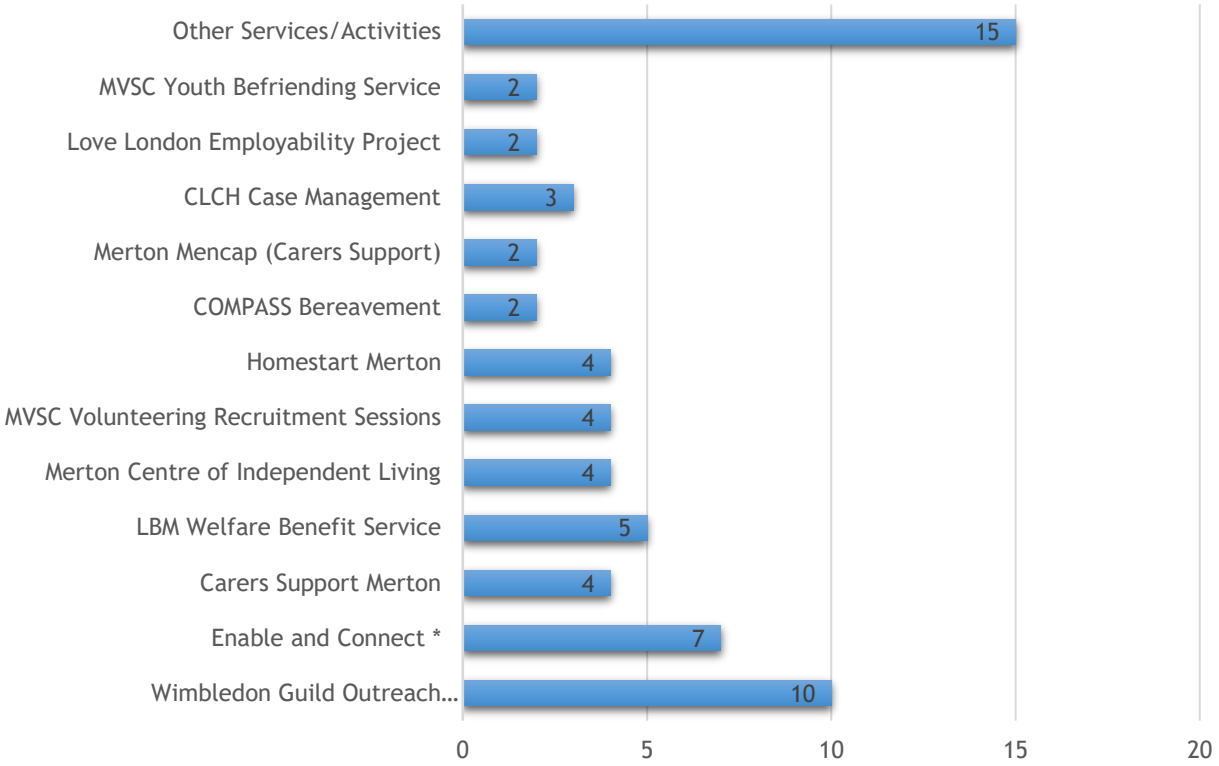


The range of interest expressed against the theme above 'Other Areas' included: -

Other Areas	Legal advice, employment and training, health support groups, practical support at home, support with vision, hard of hearing, counselling, help with study, dementia services, healthy living, home library service, community gardening and crisis grants

5.5 Referrals/Connections to Organisations and the Key Themes

Out of the 76 who connected with the CNS referrals/connections were made to organisations who could work with the person in respect of the interest or request flagged up.



**Enable and Connect is a CNS project that connects and supports patients interested in exercise predominantly with YMCA South West London (Inclusive Lives Programme) and Better Leisure (patients living with mental health issues or isolated)*

The following organisations received 1 referral/connection from the CNS

Other Services/activities	LBM Transforming Families, Freedom from Torture, MVSC Fayre and Square volunteering programme, Wimbledon Guild Counselling, Livewell 12-week weight management programme (ceased at end of March 2017), Merton Vision, Age UK Merton, Domiciliary Dentist, Association of Pastoral Care in Mental Health Befriending Service, Christian Against Poverty Finance Course, Commonside Development Trust (CDT) Step Forward Programme, CDT Money Matters and LBM Adult Social Care

5.6 Feedback from Nelson GP Practice Beneficiaries

5.6.1 Five GP patients contacted by phone who were referred to the CNS. (The earliest referral was November 2016 and the most recent was October 2017)

5.6.2 The survey focused on statement based related questions and open ended qualitative themed questions

Statements	Strongly Agree	Agree	Disagree	N/A
I am more aware of activities/services	5	1		
It has helped me identify my priorities and goals	3			
I have relied less on other health services		2		
Since my first Community Navigation appointment I have visited my GP less in the last 3-6 months	1		1	3
My physical health has improved	1	3	1	
I feel more positive	1	3	1	
I feel less isolated	1	3		1
I manage my symptoms better	1	2	1	1

Out of the 5 patients interviewed by phone 5 all of them felt that without the intervention from the CNS they would not have come across the services/activities on their own

Patients were asked how they rated the CNS overall

5.6.3 Key Comments from Phone Interviews

Interviewee Profile	Comments
Female Age 37 July 2017	*Home-start Merton has really helped. They are in contact, they have visited, and I have a volunteer who comes regularly.* *Honestly, I have gained a lot coming to this CNS. Clara has been really good and is amazing and has got me connected into running groups (Get Active Wandle Project) * which has really helped me.* *Where I was before to today is so much better. Before I would isolate myself but now I am more open to getting out. My husband is happy that things have improved.* *The main issue is still ongoing, but all the support is helping me deal with that differently than I did before.* **The running leader has given me the confidence to go out running on my own (Get Active Wandle Project) - Anna"*
Female Age 50 October 2017	*The Community navigator has been very helpful, if I hadn't come to see the Community navigator I don't think I would have done anything about going to the YMCA Wimbledon. GP's don't always know about all the community services, they are busy with the medical side of things, and you must wait along longer for the information. I would recommend this service to others.*
Female Age 42 June 2017	*"MCIL really helped with my ESA and housing benefit. Also, Colin at Merton and Lambeth CAB. Helped me write a letter to the bank and they stopped taking money in charges. My financial pressures have been reversed and I am in a much better place now. I even took my son to the Acacia Adventure Playground you told me about which he loved. I am really satisfied with how Bec and Clara treated me'*

Female Age 63 November 16	*It was good service, and it did help me to get out and meet people and get out for extra exercise.*
Female Age 63 April 2017	*"Process of getting Universal Credit was a nightmare. It has taken me 6 months to start receiving benefits (they did backdate it to May). I found it very difficult to get through on the phone to the department of working pensions Things were online (journal) and it would take took 8-10 days to get back to you* *The jobcentre lady was really helpful and useful and she guided me through the whole process which I have to said I found traumatic. I am at last getting some income where for over a year I wasn't getting anything.* *I have been befriending for a few months now and am really enjoying it. It is good feeling and the lady who I befriend said 'I was so happy when I woke up this morning because I knew you were coming to see me'"*

5.6.4 Feedback/progress notes on other GP beneficiaries who accessed the service throughout the period

Comments
'The Community Navigator was always understanding and non-judgemental. Helped get things started and help with housing issue'
'Wasn't sure what to expect when I was referred and had no idea what I was signing up for. I am far more relaxed now and can move on with my life with no regrets'
I had more time to talk about things. Being told what is available within my vicinity and I speak to people about services they could access now. *It has made me get out and meet other people and opened new doors for me'*

Nelson GP Practice case study

The following has been written by a young person aged 19 at the time (written July 2016)

I suffered with mental health issues. Then at a time in my life when I felt a bit lost, my GP recommended I meet with the local Community Navigator who would be able to help me find what's out in the community. I met with Bec at my GP surgery, in the beginning I was scared and unsure, but those thoughts quickly went away. He talked to me and showed me loads of information about different organisations available in my area. Including MVSC which stands for Merton Voluntary Service Council, an organisation, which I am actually volunteering with at the moment.

The aim of this MVSC youth befriending service is help build confidence of a young person. Essentially, I am a befriender/ mentor and I have a befriendee who I meet with on a regular basis. The aim of this is to help this young person go to places without feeling scared or unsure and help build their confidence.

Bec gave me information which I took home, looked into and choose what organisations to follow up with. Then in about a month we booked a follow up appointment where we discussed what I have been doing, what organisations I found helpful and any other queries I had.

I think community navigators are a stepping stone we need in our community to help show people what's out there and help them at a time in their life when they feel a little lost. I am so grateful to have had the opportunity to meet Bec and am so pleased with the outcome of what our meeting have led me onto do.

Now I volunteer with 2 organisations Imagine being the other one who promote positivity about mental health. Here I help run drop in sessions, courses and even attend the YMCA where we have an exercise class called Move for Mood which helps people who suffer with mental health issues have fun while doing exercise. I also volunteer with the MVSC Befriender project. With both these organisations I work with people of different ages and different walks of life and I get such a reward from being able to help others.

6. Feedback from members of the HARI Team and Nelson GP Practice

6.1 Three members of the HARI team and one of the GP Partner's within the Nelson GP Practice responded to 5 key questions that were emailed directly to them asking for their feedback.

6.2 The breakdown of questions and responses are below: -

What have been the strengths of the Community Navigation Service?
• Resource within the practice for clinicians and staff to learn about existing services • Benefit to patients and positive feedback from patients on the service • Reduction of GP time, (less appointments) • Support in management complex patients
Availability of someone with wider knowledge of the scope of voluntary services in the community and the links across many services providing information tailored to people's needs.
Patients respond really well to the service. Often our patients are overwhelmed and it's nice that there is a dedicated person we can refer to help them find their way and direct them in how to get help with things that they need.

What areas or aspects of the Community Navigation Service do you feel need to be developed or improved?
• Ensure evaluation of service to continue its work • Enable community navigator to attend practice coffee time/events/meetings to integrate within the practice
We (HARI Team) did benefit from more availability at the beginning of the development of the service. With a daily presence there was more scope for face to face contact when patients were present in the department.
I am not sure. The service is very good so far and the referral is easy to use.
It would be good if they had access to our notes so that it could be documented what the outcome was. Clara (Community Navigator) and I have recently been talking about ways to get feedback and document interaction with patients.

Do you have any comments you would like to share in regards to a referral or referrals made by yourself to the Community Navigation service and how you feel it benefitted them?
The service has been of overwhelming benefit to our patients and staff – particularly our more vulnerable patients with mental health needs.
We have benefited from referrals made for people who do not fit the mould and therefore need investigation of services that would suit their particular needs.
Personally, I really embrace the service as it is so rare to have all information gathered as you do and have someone to talk about it when needed. I referred many of my patients because I believe that they need the extra care by having to talk to someone instead of having a phone number and they have to deal with it without any insight of what the service is. My patient requires the extra help and someone to explain what there is in the community. This decreases their vulnerability, encourage them to do something, to initiate new activities and reduce risk of being more depressed or isolated. The idea of having a follow up phone call from community navigator is very valuable because it might encourage the patient to initiate to visit the places discussed.
Patients love the service. Often they are isolated or struggling with day to day life and don't know where to start in terms of where or who can help them. They find it really reassuring that there is team who can direct them. Also, its small things that really matter to people... I had one patient who was in ill health and had multiple medical needs but all she was really worried about was getting help with her gardening! It's nice that we can help people in making their lives a little bit easier and more enjoyable.

Are there any other examples of how the Community Navigation Service has supported you with any other situation or issue? (i.e., information shared on local services you were unware of)
Awareness of local buddying schemes
Yes, I have been given information regarding help getting patients without transport out for their weekly shopping.
The community navigator when on site is always approachable and knowledgeable of the information needed. If they don't know they always look it up and inform us - the professionals.
I'm new to community healthcare so it's nice to have team that I can ask for advice on the area.

Any comments or other suggestions?
We would like to see the service continue in our practice as it has provided invaluable help to our clinicians and patients
HARI would benefit from more input from the community navigator than just one day a week.
I personally found your service excellent and essential to HARI service.

6.3 Feedback from Clara Jones - Community Navigator

The Initial Challenges	How things have moved on
The Nelson Health Centre HARI Team The HARI Team were not sure initially about what the Community Navigation Service was and how it fitted with HARI. I was not allowed to speak to patients in a private space and did not have access to RIO (patient data information system)	The HARI team feel the Community Navigation Service is part of the overall service and can see the benefits. Space is made available as and when needed to talk to patients and sometimes the Community Navigator is asked to come and speak to the patient during one of the medical or therapy consultations The Community Navigator service still does not have access to RIO, but, summaries are shared with the HARI Team member who referred the patient which can be uploaded by themselves as notes to RIO
The Nelson GP Practice It took 8 months before the roll out of the service within the GP Practice. I was asked to attend a practice clinical meeting within the practice at which I was quizzed about my qualifications and what evidence there was to show it would be useful. GP's – even with Andrew Murray being a partner and Shweta Singh being a main contact. I was eventually told about a meeting I should attend, it took a further 3 months to be invited, and at the meeting I was asked what my qualifications were and if there was any evidence that what I was doing could be useful	On day one of starting within the GP Practice I was given access to EMIS and allocated a consulting room The admin contact within the GP practice enabled and supported me in rolling out the community navigation service. GP's and other staff within the practice see the value and are happy with how things have progressed.

As the Community Navigation service becomes more embedded across teams some of the present challenges that are evolving include:-

- **Services to refer to** – some do not exist (i.e., hearing support in Merton) or organisations providing services become overwhelmed (i.e., MCIL)
- **If open door activities** in borough finish, will be harder to refer people (free exercise, health walks, Get Active Wandle)
- **Demand is greater than capacity** –Should I spend longer with fewer people and narrow the eligibility criteria?
- **Circular referrals** - Positive to have a network, but if everyone starts signposting, nowhere to signpost to. Some community organisations who previously offered support or services now offer signposting instead. Really important to call them and find out what they will do before connecting people with the services.
- **Sticking plaster risk** – I've got two patients discharged from CDAS, "we've done all we can for them please try another approach" – and GP has decided this should be me! and a person who has finished support from Transforming families. Now with me as GP's next option – big responsibility for me, and is that actually helpful for that person?
- **Information on what is out there -** small community groups are not always accessible – volunteer run, don't check emails Information is not always in a clear place and
- **Getting correct and useful information** on what is out there can be a challenge. In order to support patients effectively there is a need to ensure, as best possible, data for social prescribing services/activities is maintained, correct and useful

What is working well!	
HARI Staff understand what Community Navigation is about and are able to act on patient's requests Being on hand to respond to the HARI team add value to the patient's experience as they leave with information or the knowledge that services outside of the NHS can help	GP Being integrated with the EMIS system adds strength (i.e, instant screen message from GP with query and able to respond swiftly to links to their query – mental support activities for young people) Presence at the GP practice also aids CNS e.g. 1 - Diabetic Nurse able to support query for patient I was seeing in regards to where they can get machines for free **which sorted the situation within 24 hours** e.g. 2 – needed exercise referral to be signed for patient and relationship with GP's help this happen which ultimately enables the person to engage in the health-related activity sooner.

7. Has it worked - Key Findings and Next Steps/Recommendations

The Key Ambitions of the CNS (taken from service specification)	Findings/Outcomes	Next Steps/Recommendations
7.1 - Supporting Patients To provide personalised information, advice and support to people using the services To signpost or refer people to appropriate activities, services and support which will help to meet their needs. To support service users and provide a range of accessible and flexible information in a manner that is responsive to their individual needs, preferences and wishes. To ensure service users are supported by staff who have the required knowledge, skills and competencies.	CNS has engaged with 363 patients across the HARI and GP Service Support offered has varied from ad-hoc interventions (HARI patients), telephone consultations (HARI and GP) and up to 8 face to face consultations (GP Patients only) with those with greater and more complex needs 92% of users interviewed, as part of the evaluation process, felt that without the CNS they would not have known about the services/opportunities out there CNS have signposted and given information to all the 370 beneficiaries of over 40 different organisations/services Out of the 181 people who were referred to the CNS a total 105 connections/referral were made to over 25 different organisations/services The CNS secured funding from the Wimbledon Foundation to 'Enable and Connect' a minimum of 30 people into exercise related activities (funds contributes towards costs). The enable aspect does involve meeting patients at the venue hosting the exercise (predominantly YMCA Wimbledon or Better Leisure Wimbledon Leisure Centre)	R1 CNS support should be formally structured across 3 levels: - *Level 1 – Inform* *Patient given information needed on organisations/services CNS should still check if any concerns about whether service still running, is operating a waiting list, etc. These checks help manages patient's expectations* *Level 2 – Connect* *Patient given information needed on service and is also referred or connected with a service that can support their specific situation.* *Level 3 - Enable and Connect* *Once priorities and goals have been set then patient supported in accessing the service which may involve accompanying them to the first session or organisation they want to connect with. The enabling aspect may be taken on by volunteer (PPG member or other volunteer programme locally that fits)* *There would need to be an agreed limit of how many level 3 patients the CNS can support at one time to ensure best outcomes are achieved and capacity of the CNS is not overstretched.*

7.2 Partnership To build, develop and maintain relationships with and knowledge of local statutory and non-statutory organisations, services and groups to support the effective operation of the service. To promote and increase awareness of the service in the borough.	The CNS pilot project has been key to informing the initial direction of the MVSC Social Prescribing Co-ordinator role. The challenges that the CNS faced initially (i.e., importance to have access to EMIS) were addressed before the inception of the Social Prescribing Co-ordinator role. One of the challenges for the CNS that still occurs within the Nelson GP practice is some of the staff are not clear on what the CNS offers, however, the reputation has grown, and it is viewed as a valued part of the overall GP Practice service. *The lead GP for CNS within the practice views the service as* • *Resource within the practice for clinicians and staff to learn about existing services* • *Benefit to patients and positive feedback from patients on the service* Information on what organisations are offering is out there but can be a challenge to get hold of and there are several online resources hosting similar information (Merton-I, Health Help Now, Family Service Directory and MVSC). The CNS was part of a networking event in July 2017 at which around 30 people from organisations involved with social prescribing or carrying out social prescribing activities.	R2. A detailed review should be undertaken and recommendations produced for a plan to improve the way that Social Prescribing is able to access information about the voluntary sector. R3 A communication and marketing plan should be developed to ensure the CNS maintains its identity and reputation within the Nelson GP Practice. The plan could include (reviewing publicity regularly, attending practice team meetings, outreach in the waiting area on a quarterly basis or have permanent information area, CNS leaflets in all the consulting rooms and staff areas) R4 A form should be developed for the GP aspect of CNS that list areas in which support can be offered by the CNS (this would supplement the leaflet given to patients). This would ensure ongoing clarity on how CNS can support patients for staff within the GP practice who make referrals. R5 When the CNS or Social Prescribing Service is implemented in other GP practices, it is important that the whole practice team are fully bought into the concept of CNS and social prescribing and have a clear understanding.

7.3 The Impact To deliver the service in a way that represents value for money. To utilise effective methods to gather service user feedback in order to evaluate the quality of the service. To provide robust and timely information on service quality and utilisation.	The CNS service has saved valuable GP time with patients. The GP Lead felt that as a result of the CNS that there has been *'Reduction of GP time (less appointments)'* As of July 2017, there was at least 180 sessions with the 76 patients that had been referred to the CNS from the GP practice. The average time spent during each consultation was an hour which equates to: - • *Approximately 720 GP appointments (based on 15 min appointments).* • *Estimated saving (based on £50 a consultation = £36,000)* In addition to time saved, by the HARI team and GP team, patients have also seen their income increase as services they have been referred to have helped them access entitlements and benefits they were not aware of before they engaged with CNS (some included): - • *Attendance allowance* • *Taxi Card* • *Universal Credit* • *Personal Independent payment* • *Pension Credits* Presently feedback is recorded on referral forms for HARI and the EMIS system for GP practice. Progress is regularly requested from organisations that patients have been referred/connected to. EMIS can also run reports on patient characteristics that CNS has supported	R6 A clear set of KPI's for the CNS should be developed in consultation with the CCG and aspects of the CNS should be aligned with the Social Prescribing Co-ordinator role KPI's R7 Access to EMIS, as part of the GP aspect of the CNS, has ensured better communication and understanding of patient needs. It is important that this is replicated within the HARI Team as access to RIO will:-: - • *Saves HARI team time who are presently uploading notes shared with them from the CNS* • *Progress can be typed directly onto the RIO system that also save the CNS time* • *Safeguards against risk of not knowing that patient may have deceased as CNS does not have access to patient data* R8 The existing monitoring methods and measuring tools should be reviewed to ensure all positive interventions are recorded effectively. This would include: - • *What else can EMIS record and moving forward once integrated RIO* • *Look at how effective the Wellbeing Outcome Star has been and whether CNS should adopt (CNS has used aspects of the Wellbeing Outcome Star themes for the evaluation process)* • *Adapt the online survey form to be used for monitoring referral themes, connections/referrals, experience of patients within organisations and CNS satisfaction*

		R9 Investigate structuring follow ups with HARI and GP patients after they have exited the service (3-6 months). The follow ups can identify another goal/priority for the patient as circumstances/situations do change
7.4 The Future of Community Navigation To identify ways in which community navigation can evolve and be embedded to a greater extent across Merton.	The CNS is presently awaiting an outcome from the Merton CCG on whether it will continue in the future. CNS has helped inform a bid, that MVSC has been a partner in, to the Department of Health which will see an increase in Social Prescribing roles across Merton and Wandsworth if successful. Many lessons have been taken from the CNS that has helped inform a strategy for developing social prescribing service on a larger scale across Merton. Social prescribing is becoming a principle that is being adopted by services/organisations across sectors.	R10 Continue the joint working with the Social Prescribing Co-ordinator and look at developing aspects together (i.e., volunteering opportunities to help enable and connect people to services/organisations) R11 Explore the development of a formalised network of providers who offer Social Prescribing activities or services across Merton. This network will closer working between providers and can identify gaps in provision (i.e., housing advice, support for people living with diabetes, hearing impairment) R12 Integrate the CNS into the existing Social Prescribing steering group, to ensure that it is considered at a strategic level as part of development of Social Prescribing in the borough in the future. R13 Explore joint opportunities with other organisations who could offer services specifically to CNS referred patients (i.e., benefits advice worker running clinics on a fortnightly basis that CNS can book people directly into)