Community Navigation in Brighton & Hove
Evaluation of a social prescribing pilot

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Acknowledgements

The evaluation of Community Navigation in Brighton & Hove was led by Impetus. Patient interviews were conducted and analysed by an independent consultant supported by volunteers.

We would like to thank interview participants who gave their time to the evaluation, volunteers who conducted patient interviews and the GPs and surgery staff who gave their time to the study.

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EXECUTIVE SUMMARY

Twelve months into delivering Community Navigation within GP surgeries, the pilot can report on numerous lessons, recommendations on good practice and positive patient outcomes regarding the provision of a social prescribing service. Results from consultation and follow-up interviews show that Navigation is effective for patients, GP surgeries and volunteers.
Patients feel listened to and understood by Navigators, have increased access to the right services at the right time and are able to take the next steps towards improving their health and wellbeing.
GPs continue to increase referrals, are satisfied with the quality of the service and are seeing positive benefits for their patients.
Navigators value their volunteering role and suggest the training and support provided by the staff team enables them to carry it out effectively.

Key Successes

- 393 patients were referred across 16 surgeries during the first 12 months of the pilot and 741 referrals were made to groups, services and activities patients would not have otherwise accessed.
- The service attracted a highly experienced and skilled volunteer team to carry out the Community Navigator role. Most Navigators have a previous or current career in healthcare, social services, teaching or counselling.
- There were overall improvements to patients' health and wellbeing as a result of Community Navigation with 93% saying they had all the information they needed to address their issue and 62% being able to take the next step within 3-6 months.
- Patients reported 98% satisfaction with the service saying they felt listened to and understood. 85% said they would recommend their Navigator to family and friends.
- GPs and Practice staff reported 89% satisfaction with the quality of the Community Navigator service with 95% saying the service is effective at providing a referral route to non-medical services and 87% reporting it as effective at improving the wellbeing of patients.
- Volunteer retention throughout the pilot was high, with over half the Navigators remaining on the team after one year, despite only signing up to an initial six month commitment.
- Volunteers gave an average of 7 hours per week of their time during the first 12 months of the pilot, which calculates at 5824 volunteer hours given to Community Navigation.
- The service developed positive and effective relationships between Health and VCS partners, fostering a shared understanding and learning.
- A positive and effective partnership between two VCS charities was developed; B&H Impetus and AUKBH.
- Effective working practices and procedures were developed, to meet the needs of patients, Navigators and GP practices.
- The pilot saw an upward trend in referrals throughout the first year of reporting.

A year in numbers

During the reporting period (October 2014 – September 2015):
393 referrals were made from GPs
322* patients seen by a Navigator
1188 total number of navigation sessions
741 total number of referrals to groups, services and activities
3 per patient, average number of sessions
16 days/ 2.3 weeks, the average patient wait time from visiting the GP to the first session with a Navigator
5824 volunteer hours were given
4% (16) patients referred had complex needs that required specialist support or care co-ordination
23% of patients that worked with a Navigator had mobility needs, including wheelchair use

62% of patients referred to Navigation were aged over 55
*(The 71 patients who were referred but did not see a Navigator either did not attend any appointments made or did not want the referral.)

The most frequent referrals reasons were; social isolation, low mood, stress, housing and finance issues. Most clients presented with multiple referral reasons.

The main categories of referral made to groups, services and activities include social groups, older people's services (e.g. Age UK Help at Home, nail cutting, LifeLines), exercise, adult learning courses and support with benefits and finance.

The top five services Navigators referred to

1. The Hop 50+ (formerly St John's Day Centre, social and practical support for older people)
2. Impetus Neighbourhood Care Scheme (Befriending Service)
3. Access Point (Social Services)
4. Age UK Information and Advice Service
5. Money Advice Plus (debt and benefits advice)

Patient Outcomes

Results showed that 3-6 months after completing the process, Community Navigation proves effective. Patients feel listened to and understood by the Navigator, are more able to access the right service at the right time are able to take the next steps towards improving their health and wellbeing.

85% of patients said they would recommend their Community Navigator to family or friends
98% felt listened to and understood by the Navigator
84% experienced improvements in their sense of wellbeing
93% said they had gained access to the right information to help address their issue
49% were able to access services, groups or activities following the Navigation process. Barriers to access include; lack of disability access, not feeling welcomed at the group or activity and lack of response from the service they were referred to.
62% of patients interviewed were able to take the next step identified with their Navigator after 3-6 months.

GP Practice Outcomes

GPs and other practice staff were asked what impact they thought Community Navigation makes for their patients and their practice.
The results showed a vast majority of GPs and practice staff were satisfied with the quality of the Community Navigation service. Most respondents thought it had improved wellbeing of their patients and increased the surgery's links with the local community. The majority of GPs suggested the service has decreased the amount of times patients came in to the surgery for non-medical issues.

89% GPs and practice staff are satisfied with the Community Navigator service.
95% of GPs and practice staff think the service is effective at providing a referral route to non-medical services.
87% GPs and practice staff think the Community Navigation service is effective at improving the wellbeing of patients.
84% think the Community Navigation service is effective at improving the surgeries' links to other resources and services in the community.
68% of GP practice respondents think the Community Navigation service is effective at reducing the amount of time patients attend the surgery with non-medical matters, whilst 19% did not know.

GPs commented:
"I would really value having our Community Navigator stay on for our practice. I know patients have gained a lot from her too."

"I really think the service is a good one to offer help to patients and point them in the right direction with non-medical problems therefore 'freeing' GP appointments to be used for the unwell and those that need them."

Volunteer Outcomes

Good practice in recruiting, training and supporting volunteers is essential in providing an effective Navigation service. Volunteers should be recognised for their contribution by all partners at every available opportunity. Operating the service with volunteers also requires a higher level of flexibility than is usually expected of paid staff.
Volunteer Community Navigators are highly skilled individuals with a wealth of experience and skills to offer. Most have worked or are currently working in a related profession, e.g. healthcare, teaching, social services or counselling. Volunteers feel well trained and supported to carry out their role effectively and value the experience and opportunity it brings them.
Navigators want to feel part of GP surgery teams and need to have direct follow up contact with GPs regarding cases.
Community Navigation is an effective volunteer opportunity to support people into employment or change to a health related career. Navigators value further opportunities for training on key issues affecting patients (for example mental health, housing).

Social Value

Evidence gathered during the pilot suggests Community Navigation;
• Supports patients' wellbeing by utilising a 'whole-person' approach
• Increases access and contributes to health equality
• Supports partnership working between Health and Voluntary and Community Sectors
• Improves community cohesion and integration of services
• Provides an opportunity for the city to utilise a highly skilled volunteer team
• Provides an opportunity for local people to gain additional skills and compete in the job market

Net Savings in Primary Care

The Community Navigation model was based on an Age UK service in Penwith and Cornwall. Evidence from a matched cohort study there showed a 12.7% increase in Primary Care capacity, translating as a £1500 cost saving per patient per year. If we extrapolate and assume a comparable affect in Brighton & Hove, this would result in Community Navigation providing a net cost saving of approximately £1365 per patient. Considering that at least 1000 patients could have access to Navigation each year if the service is provided citywide, this means that;

£1.36 million per year of GP time could be put to more effective use by providing the Community Navigation service as part of the Primary Care offer in Brighton & Hove.

Lessons Learnt

Numerous lessons can be drawn from developing and implementing the Community Navigation service, including; the development of shared perspectives between Health and Voluntary and Community Sectors, utilising volunteers in providing a social prescribing service, understanding how to build relationships with GP surgeries, the need for flexibility and a definition of what it means for a GP practice to be 'Navigator ready'.

Conclusion

Community Navigation in Brighton & Hove has proved to be successful in providing a social prescribing service that is closely linked with Primary Care. The person-centred methods used resulted in significant improvements to patients' health and wellbeing. Patients have been provided with the right information to help them access social, emotional and practical support. Patients have also been able to make positive choices concerning their broader health and wellbeing needs and most have already taken steps to improve their situation.

Partnership working between the Health and Voluntary & Community Sector has promoted a shared understanding of the differing approaches and methods used to achieve positive outcomes for patients and a growing number of GPs demonstrate trust in the Voluntary & Community Sector by referring their patients to the service.

Numerous lessons have been learnt about working flexibly, building relationships between sectors, operating the service with volunteers and what it means for a GP surgery to be 'Navigator ready'. The pilot has also collected evidence about the need for and use of groups, services and activities in Brighton and Hove.

Analysis of key findings and learning throughout the pilot produced a detailed understanding of how to provide a suitable, high quality and cost effective service in partnership with Primary Care. The pilot can also share its awareness of challenges, risks and opportunities in developing and providing a social prescribing service using a volunteer model. Learning from the pilot led to key recommendations for longer term development and a series of model options and associated budgets for providing the Community Navigation service citywide.

Key Recommendations

1. Integration with Primary Care is vital to the success of the service. The main referral route should continue to be GPs, and Navigators should continue to be based within GP surgeries.
2. Community Navigation is more effective in supporting people to make positive choices and take the next step when 3-6 sessions are offered.
3. Volunteers need to be well trained and supported, as well as recognised for their contribution by all partners at every available opportunity. Operating the service with volunteers also requires a higher level of flexibility than is usually expected of paid staff.
4. When working across sectors, a well-developed service level agreement is needed from the outset to foster a shared understanding of aims and expectations as well as to ensure the service can be delivered as cost effectively as possible. This should include details of governance structure and arrangements.
5. When implementing a new service based in GP surgeries, it is important that CN staff meet the whole practice team. This requires an appropriate lead in time when implementing the service in multiple surgeries.
6. Some GPs and Practice Managers are able to support the service and refer more patients than others. They can be utilised as champions of the service to encourage others to refer.
7. All surgeries hosting the service need to be 'Navigator ready' to ensure an effective and equitable service is delivered for patients (see definition on page 42).
8. Referrals mechanisms should be simple for GPs, practice staff and volunteers to use, and tailored flexibly to suit individual surgery systems as needed.
9. Providing regular feedback about outcomes for patients encourages a higher number of referrals from GPs as well as ensuring greater appropriateness of referrals. The CN service should provide regular reports for each surgery showing reasons for referral and services referred to.
10. Streamline the governance structure by utilising the more commonly used 'steering group' approach.
11. Patient outcomes have been measured using a variety of methods throughout the pilot, including patient follow-up interviews. As the landscape of health and VCS services shifts, new models of outcomes measuring need to be identified and implemented, e.g. monitoring of distance travelled, bench-marked with patients before and after navigation.

1 INTRODUCTION

This is an evaluation of the Community Navigation service, a one-year social prescribing pilot. The model for the pilot was based on Age UK national templates, drawing from their vast knowledge and experience of delivering other similar services across the UK.
Brighton & Hove Integrated Care Service (BICS) invited Age UK Brighton & Hove (AUKBH) and Brighton & Hove Impetus to work on designing the model as part of its Extended Primary Integrated Care (EPIC) Programme, which aimed to improve access to primary healthcare services in Brighton and Hove[1], based within 16 GP practices across the city. Brighton & Hove Impetus became the main delivery partner, working collaboratively with AUKBH and BICS throughout the pilot.

The EPIC Programme was funded by the Prime Minister's Challenge Fund from August 2014 until May 2015, then granted an extension until November 2015. It was created to 'improve access to Primary Care and for patients to see the right person, at the right time, in the right place'.
The social prescribing workstream reflects the desire of some GPs to reduce consultations being carried out with patients that frequently attend the surgery presenting non-medical issues affecting their health and wellbeing. In these cases, the GPs response is necessarily limited but accessing social support and non-medical services can help reduce attendances and improve broader health outcomes for the patient.
More information on the other four workstreams within EPIC can be found at:
http://epic-pmchallengefund.uk/

The Community Navigation service was designed to increase the capacity of GP practices to meet the non-clinical needs of patients with long-term conditions and other vulnerabilities, e.g. low to moderate depression, bereavement, social isolation, financial difficulties.
The service aims to;

- Link patients with groups, services and activities that can help improve their health and wellbeing, including sources of social, practical and emotional support.
- Promote self-management through the use of patient-centred methods and an empowering approach; involving patients in exploring options and making decisions about the support they access.
- Provide a bridge between Primary Care and the voluntary and community sector, linking GP surgeries with a broader range of non-medical services that can support patients' wellbeing.
- Collect evidence about the use of and need for groups, services and activities in Brighton & Hove that support patients' health and wellbeing.

The Community Navigation pilot received £172,276 over sixteen months between August 2014 and November 2015. Navigators began seeing the first clients in GP practices from October 2014. The Community Navigation service was delivered by a team of three part time staff and 16 Community Navigators. During the first 12 months of providing the service, 322 patients were seen.

This report analyses twelve months of patient evidence from the start of October 2014 until the end of September 2015 along with reflections on learning, challenges and successes throughout the whole pilot.

1.1 About the Community Navigation (CN) model

Community navigators work in GP surgeries to assess patients non-medical support needs and help them access groups, services and activities that can broadly improve their health and wellbeing.

Navigators are volunteers with a background in helping people meet their social or support needs. They are recruited, trained and supported by a volunteer co-ordinator at Brighton & Hove Impetus. Potential volunteers are invited to a one-to-one interview with CN staff and assessed for suitability against a set of criteria. Those selected attend 2 days training covering every aspect of the Community Navigation journey including all CN policies and procedures. They also practice each stage of the CN process and are given a bespoke handbook covering all CN guidelines and training notes. Once Navigators have completed this initial training, they begin an intensive induction process which involves shadowing experienced Navigators, one-to-one meetings and telephone support from the Volunteer Coordinator and meeting staff at their surgery before they begin seeing their first clients. CN staff also conduct periodic observation visits. On-going individual support is continually provided for CNs to discuss strategies and receive guidance in supporting their clients. Group support and training is given via a monthly 'Action Learning' meeting where Navigators share learning, issues and solutions as well as receive service news and themed training sessions from CN staff and guest speakers. All CNs have further access to specific training that can support them in their role via Brighton & Hove City Council (BHCC) and Voluntary & Community Sector (VCS) opportunities available.

1.2 The Community Navigation journey

1. The Navigator offers up to 6 appointments of around 45 minutes each, which mostly take place in the GP surgery, or in the person's home if they are housebound. Shorter appointments also take place over the telephone where needed. The Navigator's relationship with patients is facilitative, empowering and short-term. They encourage and enable people to take up groups, services or activities and do not create dependence on the Navigation service itself. Navigators do not offer any medical advice nor do they have access to patients' medical records.
2. Navigators work one-to-one with patients, adopting a motivational interview technique 'guided conversation' to assess non-medical support needs. They work in a person-centred way to find solutions which fit priorities identified by the patient.
3. Navigators find information about services, groups and activities by using a referrals directory developed and regularly updated by the Community Navigation service, along with local knowledge and other research as needed. One-to-one advice and support for the Navigator is also provided by the volunteer co-ordinator.
4. Navigators then facilitate referrals by supporting people to attend groups, activities and services that can help meet their needs. Links to the community are also facilitated so people can re-engage and reduce their isolation.
5. Once a facilitated referral has been made, the Navigator contacts the patient to find out if they were able to take up the service, group or activity and offers further support if needed.
6. When the case is closed, a short summary of the Navigation process is given to the GP to place on the patient's medical record, including issues identified and which services or groups have been referred to. Patients are made aware of this during their first session and can request to opt out of any or all information being entered on to their medical record.
7. Staff and volunteers in the office contact clients 3-6 months after the case is closed to conduct a follow up interview over the telephone. Patients can be re-referred to the service if needed.

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

1.3 About this evaluation

This evaluation was collated by Impetus staff following guidance from Brighton & Hove Clinical Commissioning Group (CCG). Patient interviews, volunteer surveys and GP practice surveys were conducted and analysed by an external consultant to counteract reporting bias and to advise on ensuring our methodology was sufficiently robust.

The evaluation has five main aims;

- Assess the impact of the pilot; for patients, volunteers and GP practices
- Analyse costs-benefits and social value
- Outline key lessons, challenges and successes
- Discuss opportunities and risks
- Present a business case with options for a future model

An interim evaluation, published in July 2015[2], outlined key findings, recommendations and next steps to inform stakeholders and commissioners for the future. These are included within this full evaluation of the pilot, along with further evidence and the learning it describes.

2 EVIDENCE ON SOCIAL PRESCRIBING

2.1 Policy Context

The Community Navigation service is particularly relevant in the current context of policy that aims towards a more efficient use of NHS services, as well as practices that enable people to access the right support at the right time.
Community Navigators (CNs) are an example of a Voluntary & Community Sector (VCS) role that helps improve people's experience of health services. Community Navigation is person-centred, utilising a whole person approach that considers the personal circumstances of a person's life and their broader health and wellbeing needs, not only the services they want to access or the condition(s) they have. The CN has a key supporting role that enables and encourages people to improve their own wellbeing through identifying and achieving their goals. They also support the patient to re-connect with their community through accessing groups and activities in their local area.

Current Government policy on health care rests on two main principles[3]:
• Everything should be done to prevent, postpone and minimise people's need for formal care and support. The system should be built around promoting people's independence and wellbeing.
• People should be in control of their own care. Growing emphasis on choice, personal budgets and direct payments, backed by clear, comparable information, will empower individuals. Local authorities will have a duty to shape the local market and work to integrate services.

In response to the NHS Five Year Forward View[4] which calls for a new relationship between our health services and patients in their communities, it is argued that place based approaches, drawing on the assets and resources of an area, are a key part of developing local solutions to improve health and wellbeing and reduce health inequalities.
In a jointly commissioned report, NHS England and Public Health England respond to this by outlining proven community approaches that can improve health and wellbeing[5]. In drawing together a large body of research, the report concludes

"There is a compelling case for a shift to more person and community centred ways of working in public health and healthcare."

The report outlines a 'family of approaches' to achieve this shift:
- ✓ Strengthening communities "where approaches involve building on community capacities to take action together on health"
- ✓ Volunteer and peer roles "where approaches focus on enhancing individual's capabilities to provide advice, information and support"
- ✓ Collaborations and partnerships "where approaches involve communities and local services working together at any stage of the planning cycle"
- ✓ Access to community resources "where approaches connect people to community resources, practical help, group activities and volunteering opportunities"

The Community Navigation service incorporates all four of these approaches via its model of social prescribing.

Extract from 'Improving Care – Helping organisations to improve the lives of vulnerable people', Age UK.

The Community Navigator service supports the following high level outcomes for the CCG, Public Health and Adult Social Care:

Department of Health outcomes framework, in particular:
Domain 2 – Enhancing quality of life for people with long term conditions (health related quality of life for patients and carers, proportion of people feeling supported to manage their condition)
Domain 4 – Ensuring people have a positive experience of care (improving people's experience of integrated care)

It also contributes to the **Adult Social Care Outcomes Framework** in particular:
Outcome 1: Enhancing quality of life for people with care and support needs (People are able to find employment when they want, maintain a family and social life, and contribute to community life, and avoid loneliness and isolation)
Outcome 3: Ensuring that people have a positive experience of care and support (People know what choices are available to them locally, what they are entitled to and who to contact when they need help)

It also contributes to the **Public Health Outcomes Framework**, in particular:
Outcome 2: Health Improvement (People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities)

It contributes to the **CCG Strategic Commissioning Framework** outcomes primarily:
Primary Care Development:
Increase capacity and capability in primary and community services so that we focus on preventative and proactive care, particularly for the most frail and disadvantaged communities
• Help direct patients and the public to the right level of support and advice to keep them well
• Forge greater working relationships between Primary Care and the wider health and social care system, including the third sector
• Invest the necessary resources to expand Primary Care and rebalance the healthcare system from one that is bed-based and reactive to one that is community-based and proactive.
Participation & Empowerment:
Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
Integrated Care:
Plan services that deliver greater integration between health, social care and housing and promote the use of pooled budgets

2.2 What is social prescribing?

"Social prescribing is a means of enabling Primary Care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. " (Friedli & Watson, 2004)[6]

Nesta further describes social prescribing as "a clear, coherent and collaborative process in which healthcare practitioners including GPs, practice nurses and community matrons work with patients and service users to select and make referrals to community-based services"[7]. Social prescribing is sometimes called 'community referral'.

A growing body of evidence on social prescribing suggests that real change for patients can be identified after 18-24 months, though behaviour and wellbeing changes can also be effected as early as 3-6 months. RAISE identifies the following five benefits of social prescribing systems[8]:

- Better outcomes for health and social care
- Improvements in mental health and wellbeing
- Cost-effective use of NHS resources
- More effective use of GP time
- An opening up of the provider base and increase in the range of services offered (diversification of the marketplace)

2.3 Models of social prescribing

Evidence and learning can be drawn from a number of other social prescribing pilots nationwide. Three of the earliest, largest and most robust studies are described below. Five other projects are also summarised and compared with the Brighton & Hove Community Navigation model.

Age UK Penwith & Cornwall Living Well Programme[9]

This is a large programme involving three projects; Pathfinder (Newquay), Penwith Pioneer (West Cornwall) and Living Well East Cornwall. It is one of the earliest we found, beginning in 2012. It employs 67 volunteers, 12 staff co-ordinators and has seen 844 patients so far.

Similar to the CN model, it asks GPs, nurses and practice staff to identify patients who are most likely to benefit, e.g. those with long term health conditions and frequent attenders at the surgery. It also uses a similar model of volunteer navigation, combined with the addition of coordinating care via individuals' care plans. Employed staff co-ordinators are assigned to specific practices and supported by a team of voluntary workers. Co-ordinators carry out an initial guided conversation and assign a volunteer to visit the patient either in the surgery or in their own home. The volunteer then sees patients, referring them onto groups, services and activities that can support them.

This programme aligns most closely with Community Navigation combined with the Care Coaches model about to be launched as part of Brighton and Hove's Pro-Active Care programme and, considering it conducted a matched cohort study, also demonstrates the most robust evidence on the impact to primary and secondary care (see chapter below).

Rotherham Social Prescribing pilot[10]

Rotherham is one of the earliest and largest pilots we are aware of, commissioned by their very forward thinking CCG in 2012. Referrals were sought for the 5% of residents with the greatest usage of Primary Care services. In addition, Voluntary & Community Sector support services were funded to meet patients' needs. This resulted in 1607 referrals from the Rotherham area during the two year programme, from which 1118 individuals were referred on to support services funded by the project and a further 200 people referred to services already in existence prior to the project.

Assessment was undertaken in the patient's home by 'community sector advisors' employed by the project. There was no discussion within the evaluation on the number of visits conducted with each patient but there were positive outcomes related to the approach. As patients were seen in their own home, they were less likely to break an appointment, felt more comfortable and had the time to complete the evaluation and data capture as required.
This project contains similarities with the Care Coaches model, in that it offers a service for the most vulnerable or frail patients identified through risk stratification. However, it does not provide care co-ordination as Care Coaches will and as such is providing a social prescribing service very similar to Community Navigation.

Bristol Wellspring Social Prescribing Programme [11]

In Bristol patients are referred by GPs and offered 12 weeks of one-to-one appointments followed by a further 12 months of group support around a particular activity. The aim of the initial 12 weeks is to create a social contract between the patient and support service to encourage the formation of habitual engagement, build resilience and personal accountability. This service was delivered to 128 patients over an 11 month period and similar to Rotherham, appears as a combination of Care Coaching and Community Navigation.
Bristol's report also suggests "there is no single, agreed, understanding of what constitutes social prescribing" The report seeks to address this by outlining three different models of social prescribing to help outline the types of social prescribing services delivered nationally which it describes as: Social Prescribing Light, Social Prescribing Medium and Social Prescribing Holistic. In their definition, Community Navigation could be described as medium with Care Coaches being described as holistic.

Other social prescribing pilots also assessed include;

Yorkshire and Humber Age Concern Social Prescribing Primary Care Liaison Project[12]
Dumfries & Galloway 'Putting You First' project[13]
Southwark social prescribing project[14]
Rugby 'ConnectWell' Social Prescribing project[15]
Dundee 'Equally Well'[16]

These pilots were relatively small in size, receiving between 39 and 123 patient referrals over a period of 3 to 15 months.

Most projects created a directory of local services similar to the one created by the Community Navigation team for Brighton & Hove Navigators. In some projects, GPs referred patients directly to voluntary and community support services through a directory of services they were provided with (Dumfries & Galloway, Southwark, Newcastle). Alternatively, referrals were made to an organisation employing paid support staff who contacted patients directly (Southwark, Greenwich, Newcastle).

A significant difference between some of the other pilots and the Community Navigation model was the use of predominately paid staff (Southwark Dumfries & Galloway, Dundee, Rugby). Where volunteers were utilised, this was usually following an initial assessment completed by a staff member.

Another important difference is the location in which the assessment takes place. Assessments or 'guided conversations' mostly took place in the patient's own home by a paid support worker (Rotherham, Yorkshire & Humber) or at a time and venue to suit the patient, which also included the use of telephone assessments.

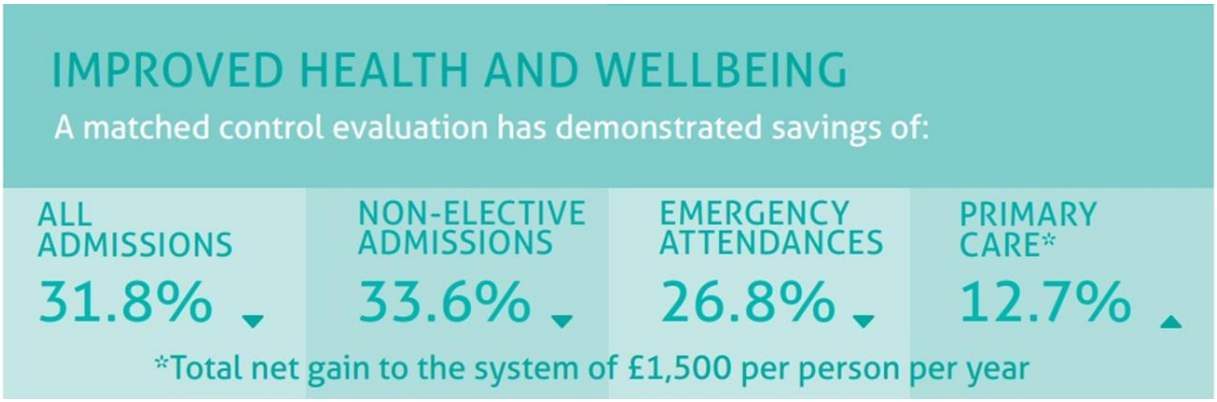
Some programmes also offered longer term support rather than short-term facilitation. This is seen in Bristol and Rugby which provides longer one-to-one support (up to 12 weeks in Bristol), followed by an option of ongoing group support.

Overall, there is significant evidence that offering an assessment by a staff or volunteer acting as a central point of referral works well, with appointments being conducted either at the surgery, in the patients home or over the telephone.

3 IMPACT ON PRIMARY AND SECONDARY CARE

A recent study[17] on social prescribing suggests that to assess impact on primary and secondary care involves conducting a matched cohort study. This is where a control group of patients with similar characteristics, health conditions and attendance in primary and secondary care that have *not* accessed the service are carefully matched with a group of patients that have accessed it. The difference in number of GP appointments, non-elective admissions and emergency attendances is then assessed and reported on. Community Navigation was based on the model used by one such programme that conducted their study in this way.

Age UK's Penwith & Cornwall Living Well Programme conducted a matched cohort study. Primary and secondary care attendance and admissions were assessed for both sets of patients 6 months prior to the initial guided conversation and followed for between 3 and 11 months after the intervention. The following infographic describes percentage reduction in admissions and an increase in 12.7% Primary Care capacity for patients that accessed the service. Overall, the net financial gain to health service system was £1500 per person per year.



Conducting a matched cohort study is intensively resource heavy, requires specialist support and would have resulted in a significantly greater cost during the pilot, but the Community Navigation service, having been based on the Age UK model, is almost identical to the Living Well Programme so it is fair to assume the impact on primary and secondary care is similar.

3.1 Local limitations in demonstrating impact

Describing actual impact on primary and secondary care necessitates a study of improving clinical effectiveness. This involves assessing whether time is used more effectively, e.g. whether a social prescribing service results in a reduction in GP appointments, non-elective admissions and emergency attendances.
In other social prescribing pilots, a variety of methods have been used to evidence impact, the most notable being in Rotherham, which compared the number of appointments and admissions patients took up both before and after intervention.
However, this is deemed problematic if the reason(s) for attendance before and after are not taken into account. To extrapolate the difference Community Navigation has made to a patient's condition(s), it is necessary to identify changes in attendance at a GP surgery or admission to A&E under the same condition(s). According to BICS, this information is unobtainable due to inconsistencies with coding the reason(s) for attendance. Considering the information available is inconsistent, this is not something we are currently able to show and the Community Navigation service has no control or influence over

consistency of coding. Enabling future evidence based reporting on the impact of Navigation in relation to patient attendance and admissions would require further development work by Brighton & Hove CCG.

3.2 GP Practice Outcomes

In addition to the comparison of a similar service that has assessed impact on primary and secondary care, we wanted to assess the change felt by GP practices. GPs and other practice staff were asked what impact they thought Community Navigation has made for their patients and their practice.

The results showed a vast majority of GPs and practice staff were satisfied with the quality of the Community Navigation service. Most respondents thought it had improved wellbeing of their patients and increased the surgery's links with the local community. The majority of GPs suggested the service has decreased the amount of times patients came in to the surgery for non-medical issues.

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87% GPs and Practice staff think the Community Navigation service is effective at improving the wellbeing of patients.
84% think the Community Navigation service is effective at improving the surgeries' links to other resources and services in the community.
68% of GP practice respondents think the Community Navigation service is effective at reducing the amount of time patients attend the surgery with non-medical matters, whilst 19% did not know.

GPs commented:

"I would really value having our Community Navigator stay on for our practice. I know patients have gained a lot from her too."

"I really think the service is a good one to offer help to patients and point them in the right direction with non-medical problems therefore 'freeing' GP appointments to be used for the unwell and those that need them."

See Appendix 2 for the full survey results.

4 COMMUNITY NAVIGATION ACTIVITIES, OUTPUTS & OUTCOMES

4.1 The development process

The pilot project was originally funded via BICS by the Prime Minister's Challenge Fund for 9 months from August 2014 to May 2015 and was then granted a 6 month extension to November 2015.
Brighton & Hove Impetus developed the Community Navigation model in partnership with AUKBH and under the guidance of the lead partner Brighton & Hove Integrated Care Service (BICS).

Impetus has developed and hosted the Neighbourhood Care Scheme (NCS) over the past 15 years, which recruits, trains and supports volunteers to reduce social isolation by working within their neighbourhood to support older people, adults with physical disabilities and their carers. NCS has over 200 active volunteers and experience in providing volunteer training related to promoting community health and welfare.
AUKBH have a nationally established model of providing care co-ordination that utilises social prescribing as part of a broader range of more complex support for people with long term health conditions.
Together these two organisations framed the model for Community Navigation and made recommendations for good practice methods and procedures to be used in the pilot.

As the clinical lead and the main body responsible for the EPIC programme, BICS provided guidance throughout the pilot on overall objectives, aligning protocols and processes within a clinical environment as well as advising on EPIC data collection. BICS hosted two Implementation meetings and four Action Learning Sets per month from August 2014 to July 2015. Implementation meetings discussed and developed operational protocols whilst Action Learning Sets provided a space for sharing learning and troubleshooting issues that arose in implementing the agreed model.

4.2 Patient Outputs

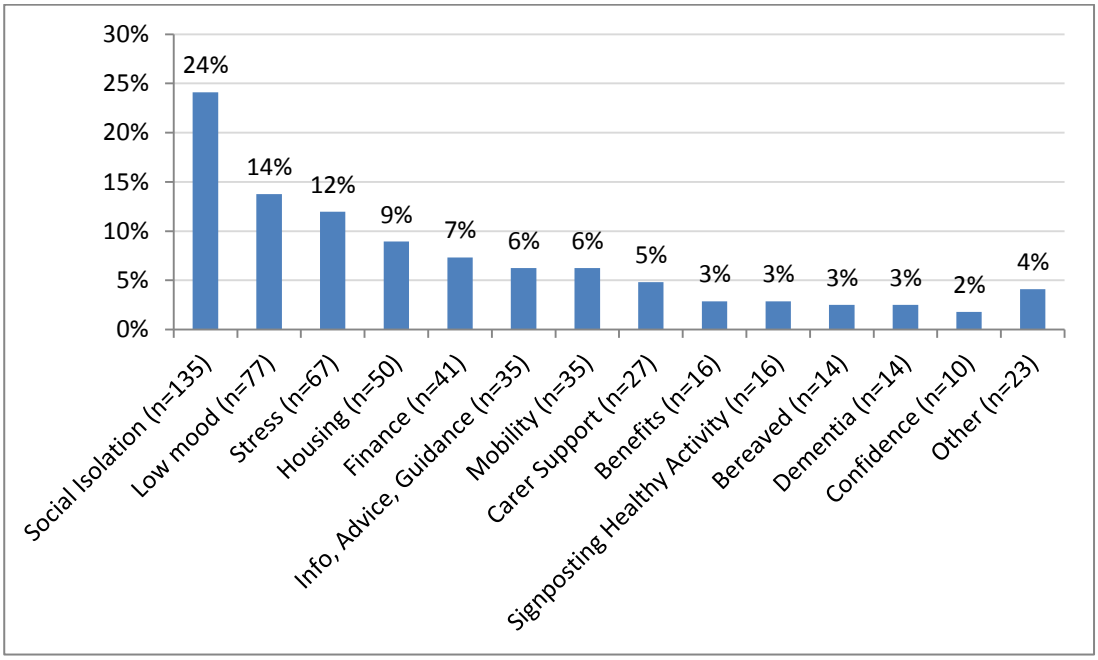
A year in numbers

During the reporting period (October 2014 – September 2015):
393 referrals were made by GPs
322* patients seen by a Navigator
1188 total number of navigation sessions
741 total number of referrals to groups, services and activities
3 per patient, average number of sessions
16 days/ 2.3 weeks, the average patient wait time from visiting the GP to the first session with a Navigator
4% (16) patients referred had complex needs that required specialist support or care co-ordination
23% of patients that saw a Navigator had mobility needs including wheelchair use
62% of patients referred to navigation were over 55.

The number of referrals varied between surgeries and throughout the year. See table in Appendix 3.

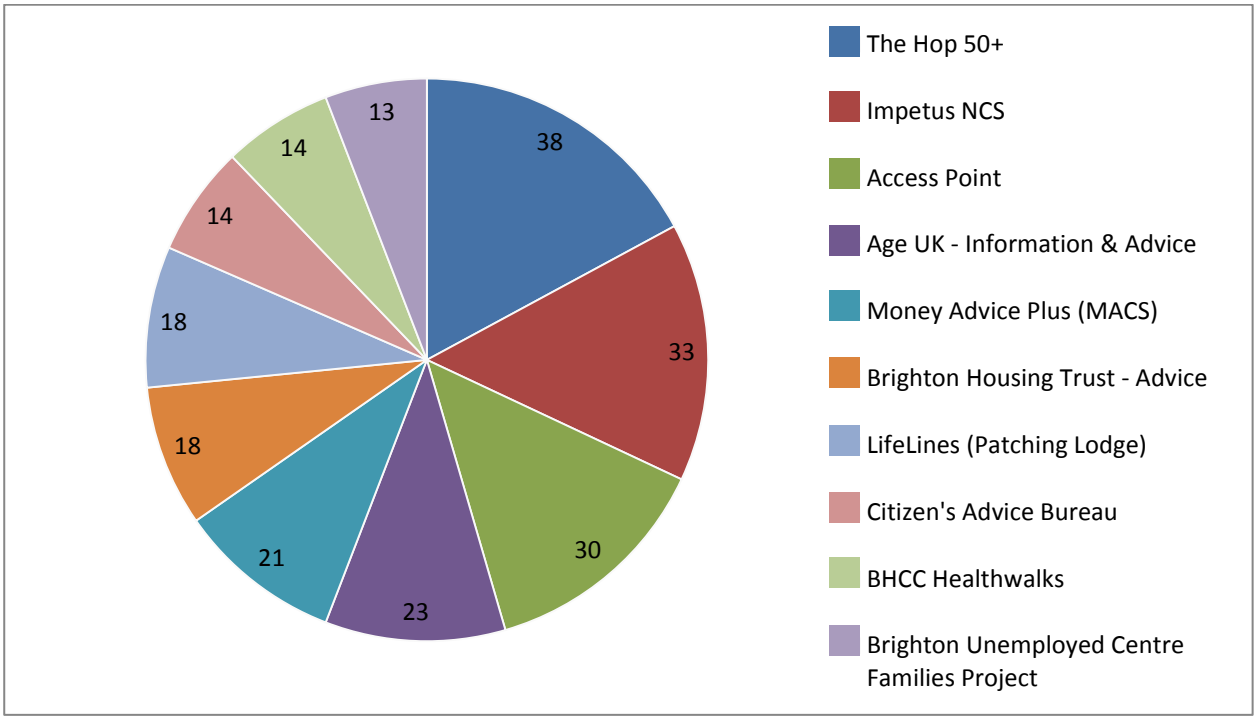
*(The 71 patients who were referred but did not see a Navigator either did not attend any appointments made or did not want the referral.)

Chart showing reasons for referral



The most frequent referrals reasons were; social isolation, low mood, stress, housing and finance issues. Most clients presented with multiple referral reasons. ('Other' referral reasons consisted of: not specified 8, inappropriate 6, volunteering 2, nail cutting 2, adult learning 1, employment 1, family difficulties 1, help with housework 1, serious illness 1)

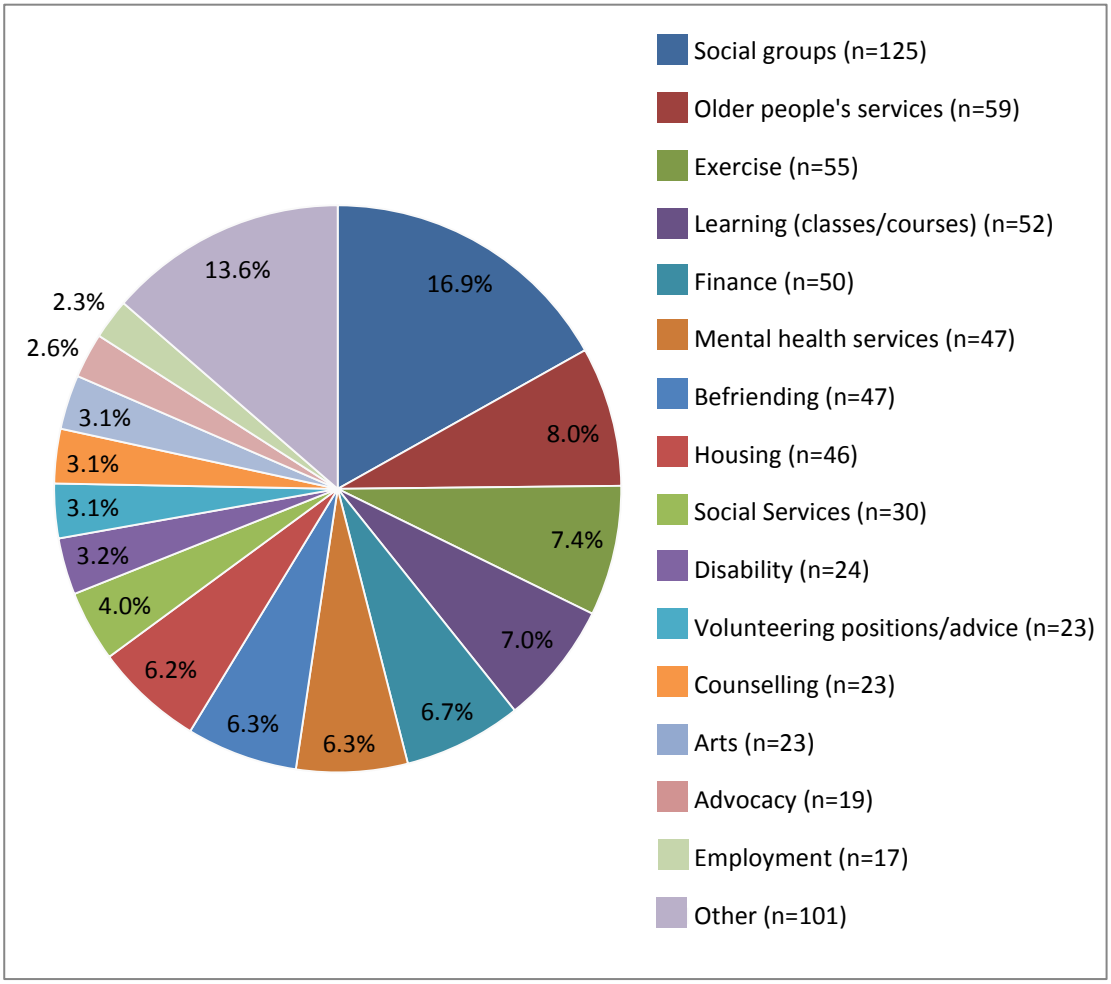
Top 10 groups, services and activities referred or signposted to



The top five services Navigators refer clients to include;

1. The Hop 50+ Centre (social and practical support for older people)
2. Impetus Neighbourhood Care Scheme (Befriending Service)
3. Access Point (Social Services)
4. Age UK Information and Advice Service
5. Money Advice Plus (debt and benefits advice)

Categories of groups, services and activities referred to

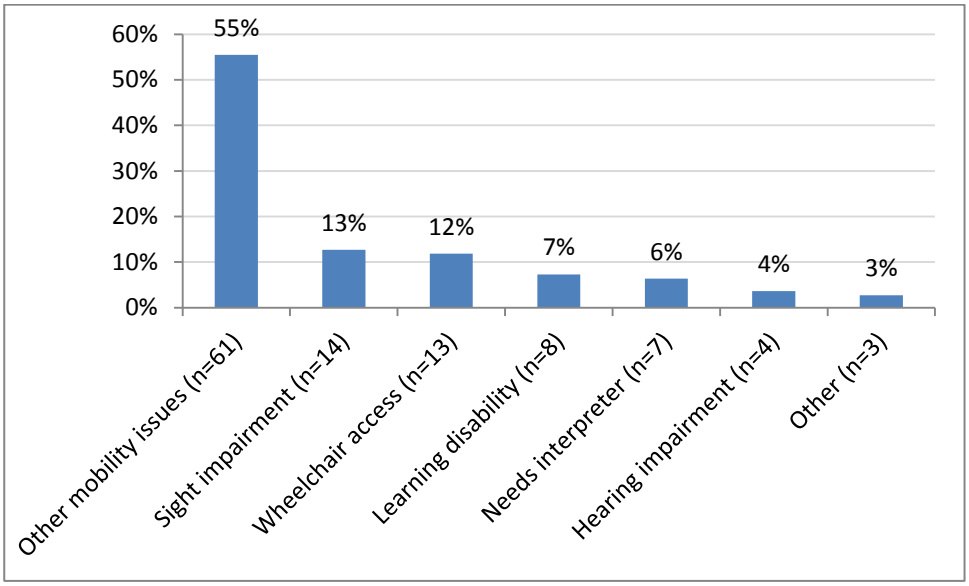


741 referral s were made to groups, services and activities.

The top five categories of referral include social groups, older people's services (e.g. Age UK Help at Home, nail cutting, LifeLines), exercise, adult learning courses and support with benefits and finance.

The 'Other' segment consists of categories where referral numbers were very small. In order of the highest number first these were: mobility, general information, carers, healthy living, form filling, drug & alcohol recovery, learning disability, BME services, home food delivery, care services, outings, LGBT services and food banks. 'Other' included services or groups with only one or two referrals, e.g. library home delivery service, aqua therapy, Buddhist centre, UNISON.

Chart showing additional support needs



This chart shows the number of patients referred with or identified as having additional support needs, defined by categories.

95 patients had an additional need, which represents 29.5% of people that saw a Navigator. Some presented more than one additional support need. Over half of patients with an additional support need had mobility needs other than wheelchair access, e.g. difficulty walking or climbing stairs.

'Other' consists of: Agoraphobia 1, Speech impairment 1, Autism 1.

Overall, 23% (74 of 322) patients that saw a Navigator had mobility needs including wheelchair use.

Chart showing gender of people referred

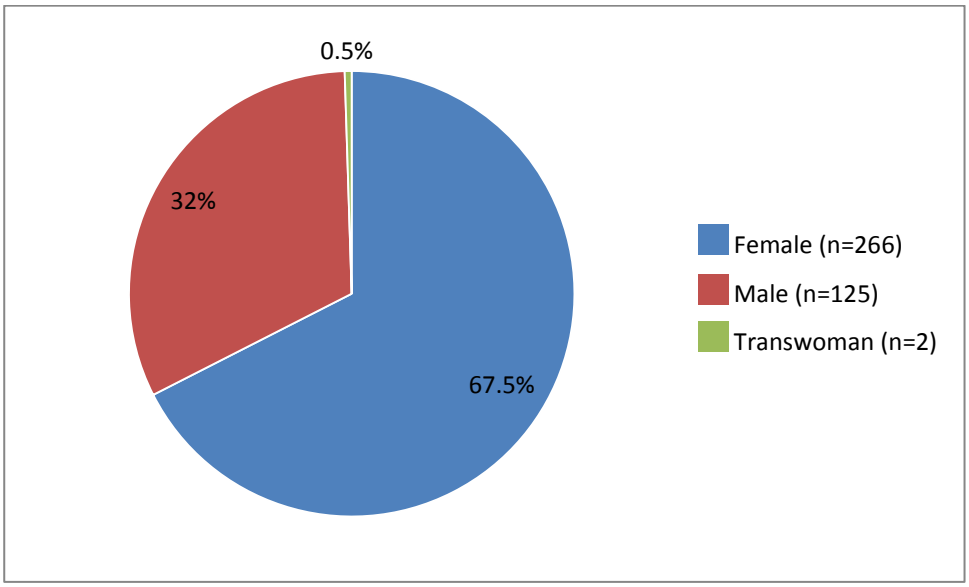
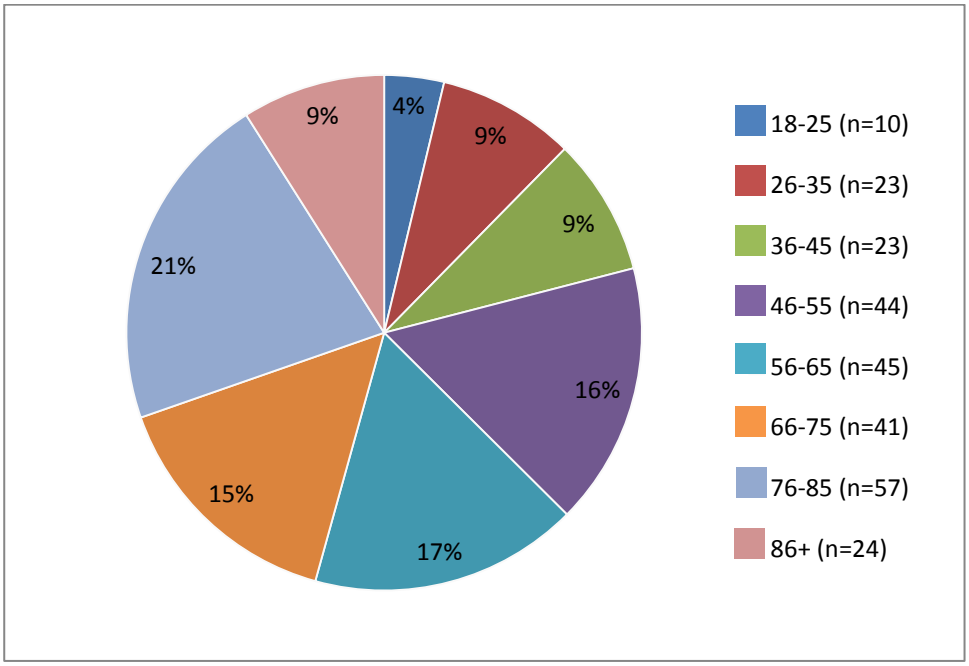
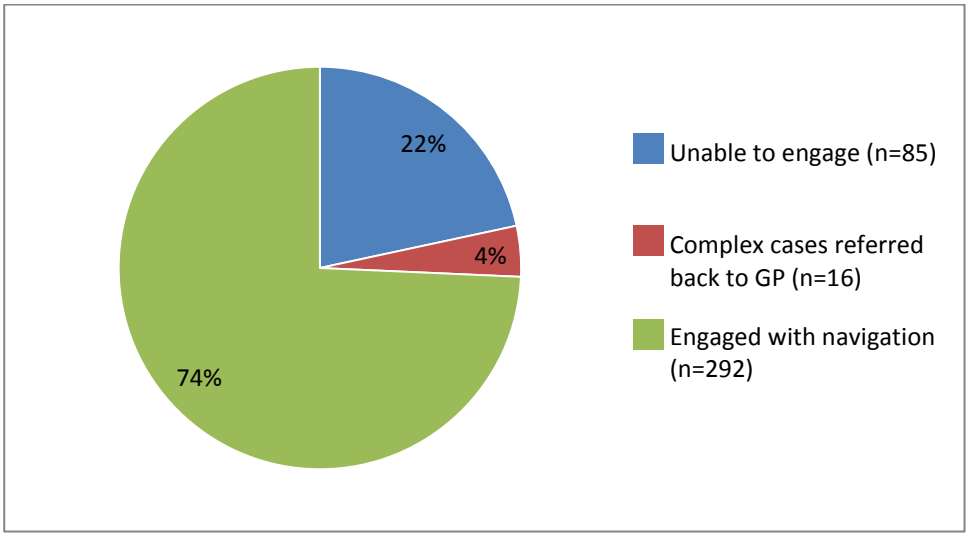


Chart showing age-range of people referred



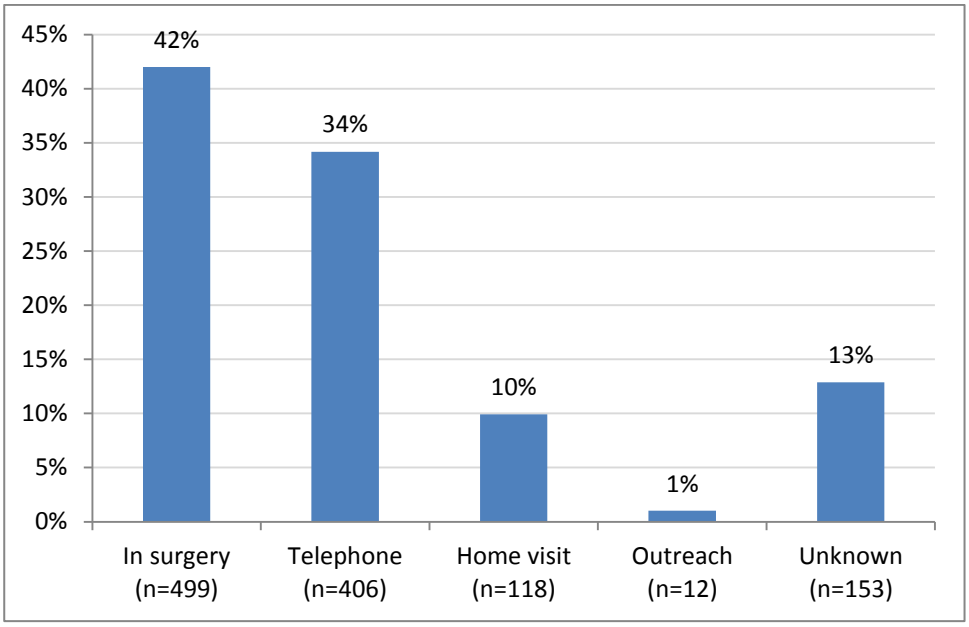
62% of patients referred to Navigation were over 55.
(Data on age range is recorded for 268 of the 393 patients referred as some surgeries do not include date of birth when making referrals.)

Chart showing patients unable to engage & referred back to GP



101 patients of the 393 referred were not able to complete the Navigation journey.
71 did not attend the service at all, either because they were too ill, did not want the referral, were not feeling ready to think about solutions to problems or did not attend appointments made.
30 people began working with a Navigator but became unable to engage with the process for similar reasons.
4% (n=16) of patients were referred back the GP with complex needs that required specialist support or care co-ordination. Reasons for referral back to GP include; needing complex medical support, being on the 'Dementia Pathway' or already having specialist support that included access to groups, services and activities, e.g. having active social work support. This group of patients could be referred to a Care Coach under the new Pro-Active Care model. If the service were to be scaled up and provided citywide, this would result in approximately 45 referrals made per year from Community Navigators to Care Coaches.

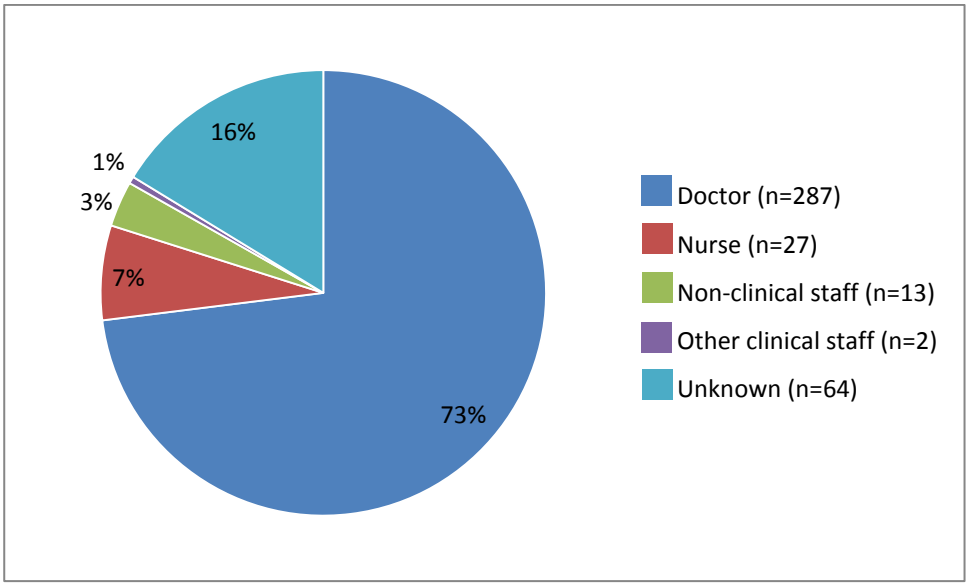
Chart showing session type



1188 sessions took place during the pilot with most being either in the surgery or via telephone calls following initial face to face contact.

'Unknown' session type is owing to alterations in data recording and was not collected during the first weeks of the pilot.

Chart showing referring professionals



73% of patient referrals came from GPs and 7% from nurses. Other clinical staff refers to midwives, CPNs etc. Non-clinical staff were mostly Practice Managers. The number unknown is owing to referral forms being incomplete and the Navigator being unable to determine who made the initial referral.

4.3 Patient Outcomes

Evidence derived from follow-up interviews suggests patients feel listened to, more connected and have greater access to groups, services and activities they would have otherwise not known about.

4.3.1 Background

A total of 393 were referred and 322 patients were seen during the first year of the pilot between October 2014 and September 2015. 174 patients who had completed the Community Navigation process 3-6 months prior to evaluation, were contacted and 100 patients completed follow up telephone interviews. Reasons for being unable to complete interviews for all patients contacted were numerous. Several contact details were wrong numbers, some patients could not remember attending the navigation sessions, a few patients did not want a follow-up and 49 respondents were unavailable despite being called on numerous occasions at different times during the day.
However, 100 respondents represents 31% of patients seen and the sample is broadly representative in terms of age, gender and referral reasons.

4.3.2 Patient outcomes summary

Results showed that 3-6 months after completing the process, Community Navigation proves effective. Patients feel listened to and understood by the Navigator, are more able to access the right service at the right time and are able to take the next steps towards improving their health and wellbeing.

85% of patients said they would recommend their Community Navigator to family or friends
98% felt listened to and understood by the Navigator
84% experienced improvements in their sense of wellbeing
93% said they had gained access to the right information to help address their issue
49% were able to access services, groups or activities following the Navigation process. Barriers to access include; lack of disability access, not feeling welcomed at the group or activity and lack of response from the service they were referred to.
62% of patients interviewed were able to take the next step identified with their Navigator after 3-6 months.

Analysis of results showed that Community Navigation is more effective in supporting people to make positive choices and take the next step when 3-6 sessions are offered. Facilitated referrals are slightly more effective at supporting people to access services, especially when those services are limited or challenging to access e.g. housing and benefits advice. However the relationship with the Navigator is a key defining

factor in supporting people to improve their health and wellbeing, so that even when clients make contact themselves, they are accessing services with a background of relevant information and support.

More patients who were referred for information, advice and guidance (IAG) were able to take the next identified step in resolving their issue than those referred with low to moderate level mental health issues or social isolation. This was largely due to being supported with facilitated referrals instead of signposting, which suggests that the intensive support offered by facilitated referral is more effective in assisting people access support with housing, benefits and finances issues, these being the main reasons for referral to IAG services.

A higher percentage of patients with low to moderate mental health issues experienced improvement in their sense of wellbeing, 95% compared with the overall percentage of 84%. This was linked to the supportive and understanding relationship with the Community Navigator, suggesting that Navigation is especially helpful in supporting people who are experiencing mental ill-health.

Of the 100 patients interviewed, 66% were female and 33% male. 1 patient was a transgender woman. 68% were over 55.
The sample is representative in terms of age, gender, referral reason and services accessed.

4.3.3 The follow up telephone call

The follow up telephone call was a semi-structured informal interview which comprised of 9 open questions relating to the navigation journey. Patients were asked to comment and scale their response 1-5 (1 being not at all, 2 being slightly, 3 being satisfactorily, 4 being good and 5 being very good) or N/A (not applicable). See appendix 4 for patient follow-up interview questions.

4.3.4 Outcomes Measured

Questions were designed to measure patient outcomes under three broad categories:

1. Enhanced well- being and quality of life.

Indicators: Reduced Isolation, increased social activity, community links, improvement in wellbeing

2. Access to the right levels of support.

Indicators: Being able to access services, being well-informed and able to access information

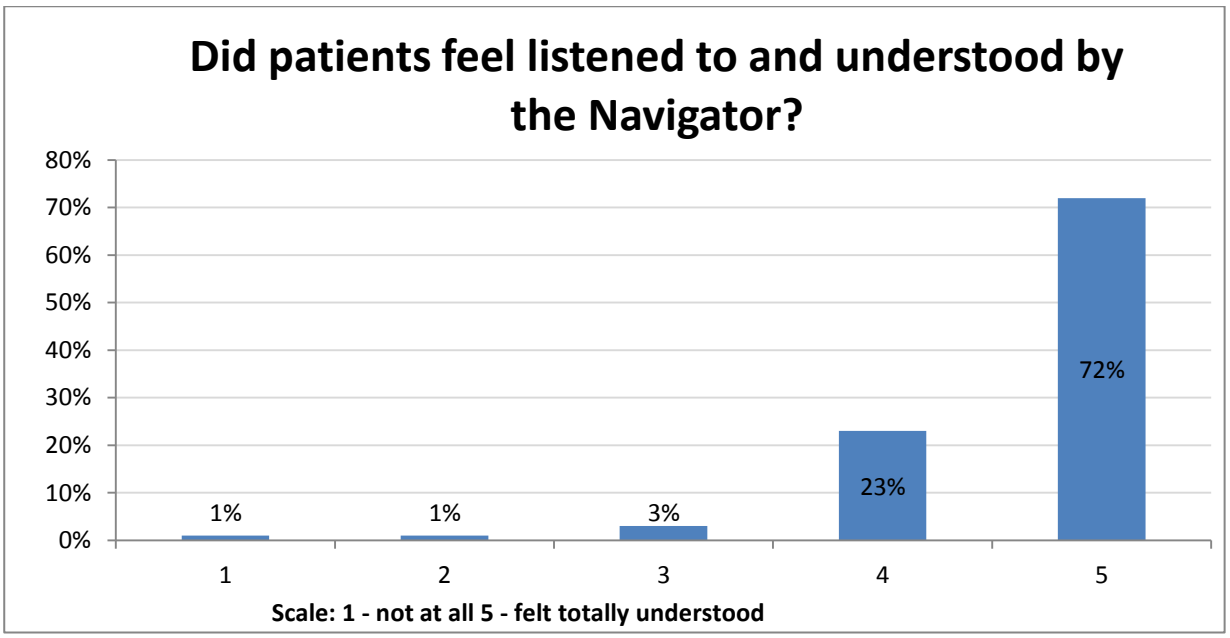
3. Empowerment and choice.

Indicators: sense of control, self-management, ability to make positive decisions

4.3.5 Patient Outcomes full results

Results for each question are shown in the graphs below. The vertical axis represents the percentage of people and the horizontal axis is for the scale 1-5 or N/A in answer to each question.
A scale of 3 or above shows improvement to the patient's health or issue.

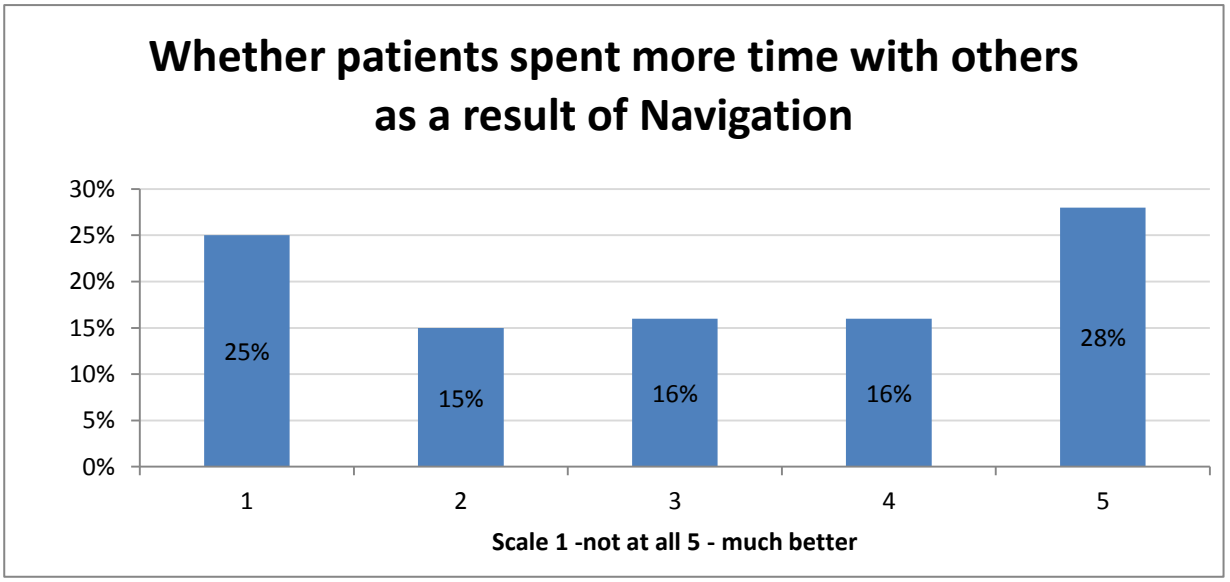
Firstly we asked patients a general question regarding their experience of the navigation process and whether they felt understood and listened to by the Navigator.



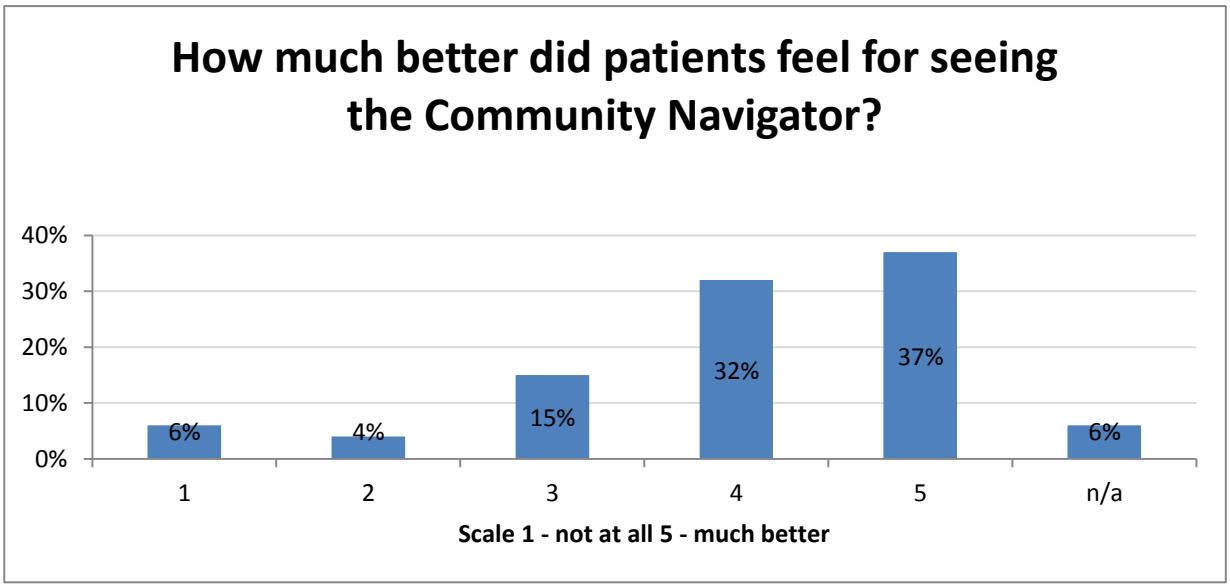
The graph shows 98% of the patients felt satisfied to very satisfied or above in terms of feeling listened to and understood by the Navigator when they were discussing their issue and 2% of patients did not feel heard or understood. Of the patients who did not feel understood, this was partly due to not wanting to engage with the process.

Wellbeing

We asked two questions relating to the overall outcome of wellbeing. The questions asked whether the patient was satisfied with the amount of time they spent with others as a result of Navigation, and whether there had been an improvement in their general sense of wellbeing after seeing the Community Navigator.



60% of patients that were social isolated scaled 3 or above in terms of feeling more satisfied with the amount of time they now spend with others. Of those who scaled the question at a 1 or 2, some did not feel ready to make the next step or felt well enough to spend more time with others even when they identified the need to. Some patients tried a service (e.g. lunch club) but felt it was not for them and could not currently find anything they were interested in doing.

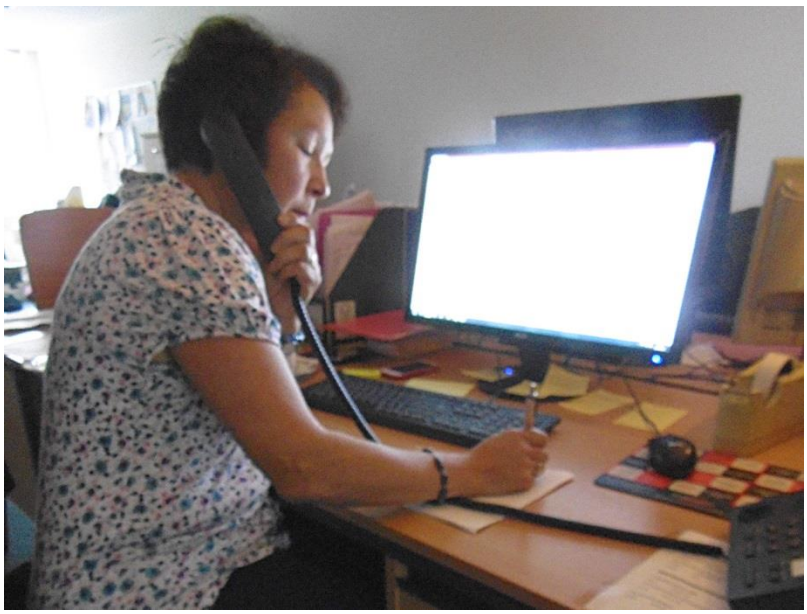


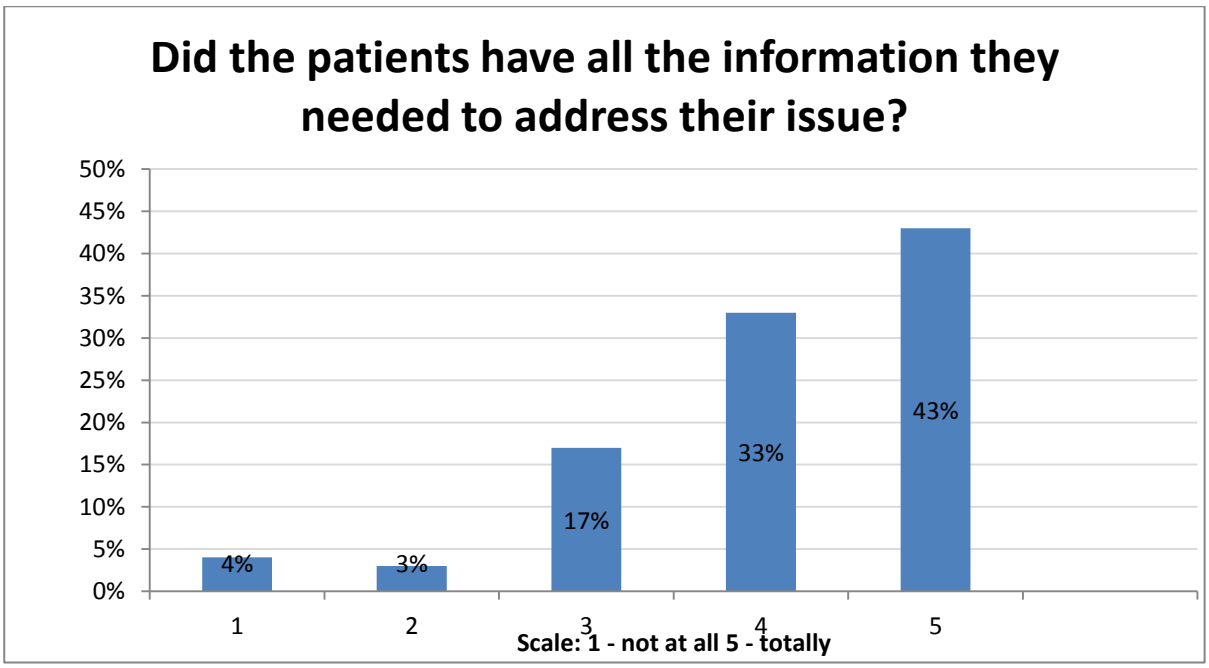
84% of patients said they felt satisfied to much better for seeing the Community Navigator (scales 3-5). Of the 10% who scaled the question at 1-2, reasons included; the Navigator was not able to help them with their issue, they felt the referral was not right for them at the time or whilst they could see it was a good service it was not appropriate for them.
6% of patients were either too unwell to comment or could not remember the Navigation process well enough to comment.

Access to the right levels of support

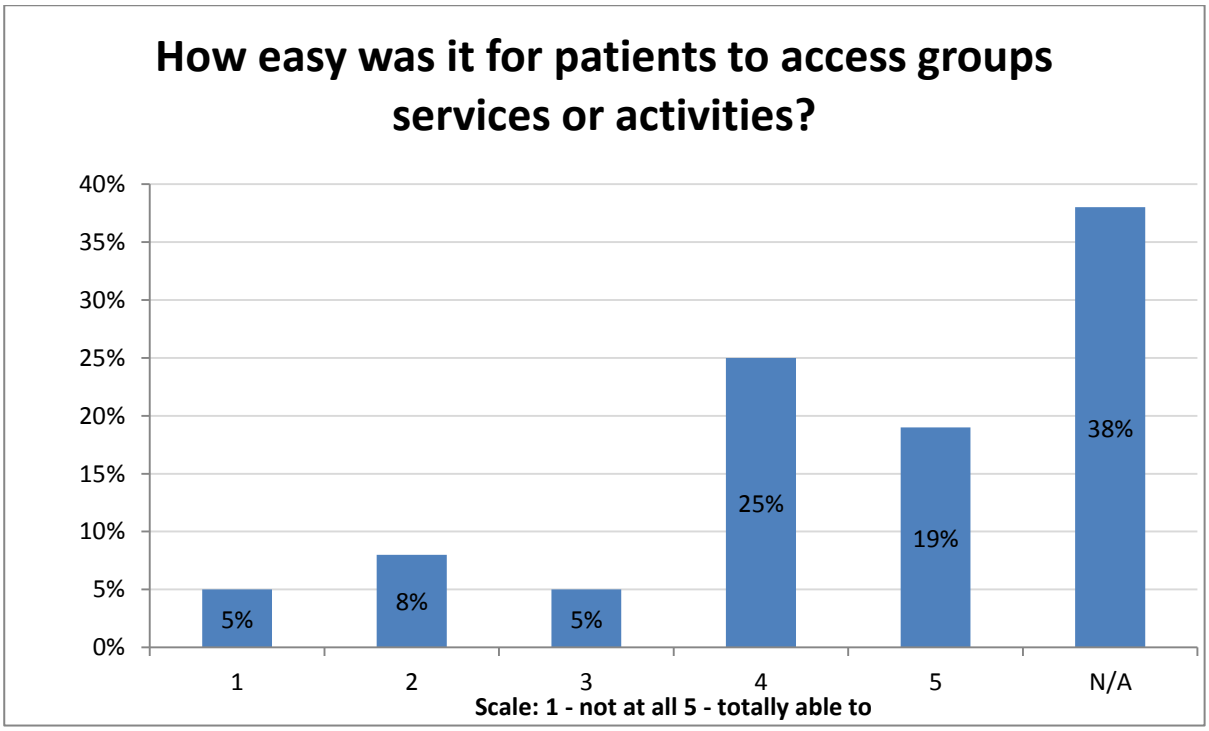
Some patients need more support with making contact with others. This section assesses the difference in patient outcomes between utilising facilitated referral (when detailed information is given and/or appointments are made on the patient's behalf) and signposting (where basic information is given for patients to follow-up themselves) as methods of encouraging people to take up services and activities.

We asked three questions relating to this outcome. Firstly we asked if patients had all the information they needed to address the issue discussed with the Navigator. Secondly we assessed whether they had been signposted or referred on to services. Thirdly we asked a more detailed question regarding people's experiences of accessing services, including whether there had been any barriers to access.





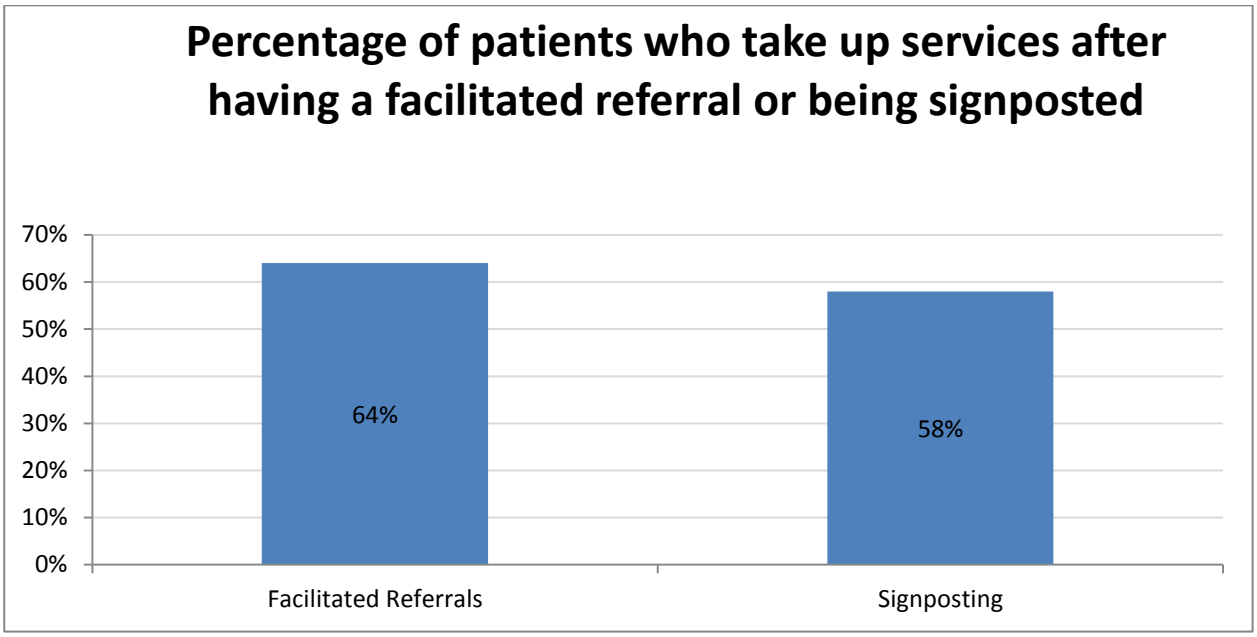
93% of patients felt they had all the information they needed to address their issue as a result of working with the Community Navigator. Of the 7% who didn't feel they had the information they needed, this was because the issue was too complex to be resolved through social prescribing or the patient did not feel that Community Navigation was the right process for them and had therefore gained very little from the experience.



A total of 62% of patients interviewed remembered being referred or signposted on to services, groups or activities to help meet their identified need (though our records suggest the actual figure was higher). Patients were asked whether these services had been easy to access and if not, why.
49% of patients felt able to access services (scaling the question at 3 or above).
38% of patients said this question was not applicable to them mainly because working with the Navigator had resolved their issue (e.g. they had received information, advice or guidance on an issue which was then resolved) or they could not remember whether they were signposted or referred on to services.

Of those who could not access the services (13%) there were several reasons for this including:

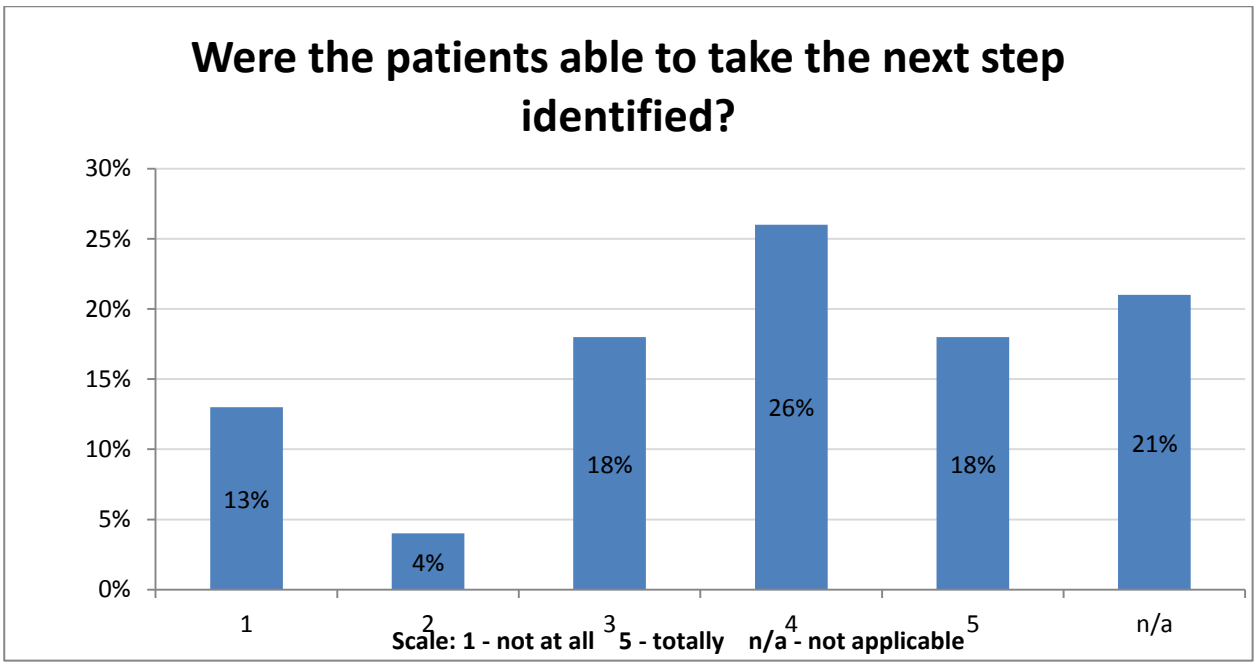
- Their needs were complex and they needed specialist support or care coordination
- The service, group or activity had not been disability friendly
- They did not feel a welcoming response from a group and did not want to go back
- They had contacted the service but received no reply
- The service, group, or activity was closed for a period of time, e.g. summer holiday



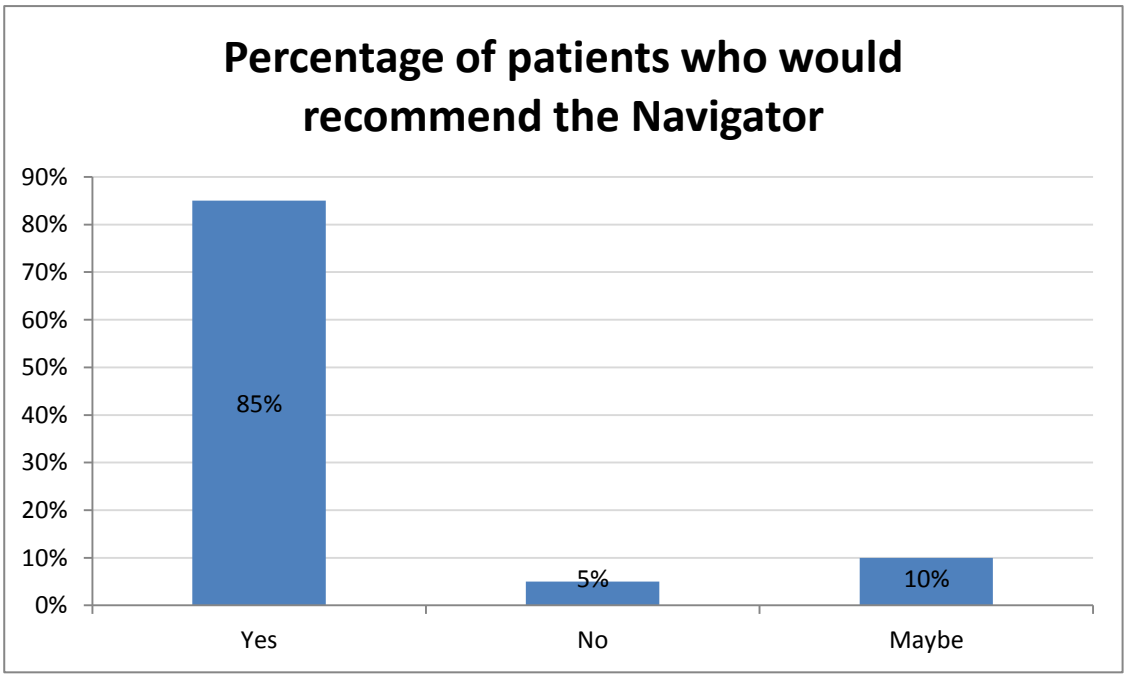
Patients who received a facilitated referral had a slightly higher rate of accessing services than those who were signposted. This indicates that the extra support given to individuals via facilitated referral enables patients to take up services more effectively that sign posting. This was especially true of services with limited provision that patients find it challenging to access e.g. housing and benefits advice.

Empowerment and choice

Patients were asked whether they felt able to take charge of their own life and the decisions affecting it by being asked if they were able to take the next step in resolving the issue they had identified with their Community Navigator.



62% scaled a 3 or above in acknowledging they were able to take the next step identified. Many patients acknowledged this was in part due to having a supportive relationship with the Navigator who had supported them to identify what they needed and helped them take the next step.
During the telephone follow up interviews it was noted that patients who were offered shorter navigation experience (e.g. one or two sessions) had not always followed up the leads given to them by the Navigator and so had not necessarily been able to make the next step.
Patients who attended 3-6 sessions were able to go back to the Navigator and discuss what happened next and were more empowered to take the next steps needed.
Patients greatly appreciated Navigators contacting them to find out if their issue had been resolved.



Incorporated in our patient follow-up interviews was the NHS England 'Friends and Family Test'[1] where patients are asked whether they would recommend the service to family and friends.

[1] http://www.england.nhs.uk/ourwork/pe/fft/

85% of patients said they would recommend the Navigator with 5% saying they would not.
Of the people who said they would not recommend the Navigator reasons included the service not being right for them at the time or that they were too unwell to engage with it.
The 10% who answered 'maybe' found it did not necessarily meet the need they had identified with the Navigator, for example the service they had been signposted to was not accessible or the Navigator was not offering any new information or insights to their situation due to the complexity of their need.

Analysis of main referral reasons

Of the 100 patients interviewed, the three main reasons for receiving a referral to a Navigator were mental ill-health, social isolation and advice and guidance.
To discover whether a referral reason affected a patient's ability to improve their health and wellbeing or to take the next step, we compared responses to these two questions with the overall sample.

Mental health

For the purpose of this survey, mental health is defined as patients experiencing low to moderate mental health problems such as stress, anxiety and depression. Of the patients interviewed, 23% were identified as having low mood or depression. (This shows a representative sample, being similar to the overall figure of 26% patients referred to the service with low mood or stress).
A comparison was made to assess how much better patients with low to moderate mental health issues felt after seeing the Navigator compared with patients in the sample overall.

A higher percentage of patients with low to moderate mental health issues experienced improvement in their sense of wellbeing, 95% compared with the overall percentage of 84%.
This was linked to the supportive and understanding relationship between the Navigator and the patient:
"She was the one person I trusted"
"I found her really easy to talk to, she just listened and didn't judge me"
"I felt much better for seeing her"

We also made a comparison between patients with mental health issues and the overall percentage to see whether people with mental health issues were more or less able to take the next steps identified through their work with the Navigator.

Marginally less patients went on to make the next step (62% compared with 66% overall). This was not due to the number of sessions the patients were offered (all patients in this group received between 3-6 sessions of navigation) but instead due to the higher levels of signposting in this group. Navigators signposted patients in 65% of cases compared with 35% facilitated referrals, indicating that patients experiencing poor mental health are more likely to take the next step when facilitated referrals are made.
Patients also expressed appreciation of the follow up phone calls made by some Navigators before closing cases, saying they felt supported and encouraged to continue making positive decisions to improve their health and wellbeing.
These results suggest that Navigators need to avoid signposting people with mental health problems and ensure referrals are fully facilitated and followed up.

Social Isolation

A comparison was made to see whether patients who were referred with or identified themselves as being socially isolated experienced an improvement in wellbeing after seeing the Navigator compared with the overall percentage in the sample group.

In total 82% of patients who were socially isolated experienced an improvement in wellbeing (a scale 3 or above) compared with the similar figure of 84% total patients interviewed.

Overall the same percentage (62%) of people who were socially isolated felt able to make the next step compared with patients in the overall sample. This coupled with the result for wellbeing suggests that being socially isolated does not present an additional barrier to Navigation.

Patients commented:
"She gave me the boost to go along"
"Loneliness can be so hard. This has helped a lot"
"This has put me in the right direction"

Information Advice and Guidance (IAG)

Patients who had been referred for Information, Advice and Guidance were compared with the overall sample to assess the effectiveness of Navigation in this group.

There was no significant difference between improvements in wellbeing for these two groups.

Observing comparisons regarding ability to take the next step, it is clear that a significantly higher percentage of patients were able to take the next step in relation to resolving their issue compared with those overall.
We found that a higher number of patients were offered a facilitated referral for IAG than for any other issue (50% were facilitated referrals and 50% were signposted) and more patients were then able to take the next step as a result. This shows that facilitated referrals are more effective at supporting patients to take the next step than signposting when patients have an IAG need. This is largely owing to the challenges in accessing IAG services in Brighton and Hove, especially relating to housing and benefits advice, suggesting that facilitated referral is effective in helping people access what few services exist.

4.3.6 Equalities Monitoring

Community Navigator volunteers are carefully vetted at interview stage for limiting beliefs and prejudice and receive equalities training as part of their induction process. They also receive on-going individual and group support, taking part in a range of discussions about clients' needs and characteristics.

Community Navigation works in direct partnership with Primary Care and is not an open access service. All options for a future model involve GPs and practice staff being the main referral route. As such, equalities monitoring data about patients that have accessed the service should be available via Brighton & Hove CCG.
During the pilot, it became clear this data is not consistently collected by Primary Care services. In discovering this, the CN service adapted the client recording mechanism to include some of the protected characteristics as outlined in the Equalities Act 2010 namely; age, gender and additional support needs e.g. disability. However, we do not ask volunteers to collect information about a patient's race, religion or belief, sexual orientation or marital status at present.
Volunteers are resistant to asking these more personal questions of vulnerable people, many of whom are elderly, isolated or experiencing low mood. One of the key values of Community Navigation for patients is in the felt difference from statutory services. The essence of Community Navigation is patient-centred and focussed on listening to patients' needs. There are no forms to fill in and questions are focussed on the needs of the client rather than the needs of the service.

However, we do collect equalities monitoring data on volunteers (see Appendix 5) and should equalities monitoring data about patients become available via CCG in future, the service will of course report on it.

5 SOCIAL VALUE

Social Value outcomes draw on learning from the Community Navigation pilot as well as from the broad body of evidence already established.
We know that Community Navigation contributes to the Five Ways to Wellbeing or 'CLANG' (Connect, Learn, be Active, take Notice, Give) principles as outlined in Happiness:
Brighton & Hove's Mental Health and Wellbeing Strategy[18].

In addition, the evidence gathered during the pilot suggests Community Navigation;

- Supports patients' wellbeing by utilising a whole-person approach
- Increases access and contributes to health equality
- Supports partnership working between Health and Voluntary and Community Sectors
- Improves community cohesion and integration of services
- Provides an opportunity for the city to utilise a highly skilled volunteer team
- Provides an opportunity for local people to gain additional skills and compete in the job market

5.1 A whole-person approach that supports wellbeing

The use of guided conversation and facilitated referral methods put patients at the heart of their navigation journey. This collaborative relationship provides an empowering space for patients to explore options and make decisions about the support they access, encouraging informed choice and promoting patient self-management. An independent inquiry into patient-centred approaches in Primary Care suggest that 'holistic' or whole-person approaches "improve health outcomes and quality of life for patients, as well as reduce avoidable demand for health and care services"[19]
The whole-person approach to Community Navigation contributes to patients' wellbeing and ability to self-manage, which in turn releases pressure on NHS resources.

5.2 Increased access and contribution to health equality

Evidence from patient follow ups along with GP and Volunteer surveys tells us that Community Navigation contributes to health equality by providing increased access for people that would not otherwise be attracted to or engaged with community activities and services. Not only does this support patient wellbeing but also addresses health inequalities associated with lack of access to groups, activities and services in the wider community, especially concerning patients from deprived communities. Additionally, increased use of social and physical activities are known to promote wellbeing and positive health outcomes.

5.3 Partnership working between Health and Voluntary and Community Sectors

The Community Navigation pilot worked across organisational boundaries and sectors by forging partnerships between GP surgeries and the Voluntary and Community sector.

Voluntary & Community Sector groups and services are developed based on need. The VCS has a tradition of innovation, identifying and filling gaps in public services. As a sector, it provides expertise and knowledge on good practice specifically around flexible services, person centred approaches and volunteering. Many of the services it provides offer early prevention of issues that affect a person's long term health.
The UK's well established Health sector is greatly respected worldwide. Its knowledge and expertise aligns with the medical model and is based on trusted relationships with patients.

Together these two sectors have the opportunity to build a mutually beneficial partnership based on their unique strengths and abilities. In forging a relationship with VCS colleagues, Health Sector staff are better able to keep up to date with non-clinical service developments and changes that affect their patients. By working closely with health colleagues, VCS services are able to keep abreast of services within the NHS that have an impact on the health and wellbeing of their client groups.

5.4 Improved community cohesion and integration of services

Community Navigation improves connections in the community, enabling people to utilise existing community assets to support improved health outcomes. Community Navigation bridges the gap between GP's and community activity, providing a more integrated service. There is greater understanding of the mutual support available between Primary Care and the community and voluntary sector locally. GPs have an increased awareness of the contribution that small, local organisations make to the health and wellbeing of the patient population.
As the first programme of its kind in Brighton and Hove, further development work to increase the effectiveness of this partnership is necessary, yet we have a strong foundation of shared understanding and goodwill on which to base these evolving relationships.

Community links are also supported by making appropriate referrals, helping ensure the 'right' people access relevant community activities at the right time and by providing 'new' people who would otherwise not access community activity.
Awareness of active, vibrant community activity is raised amongst residents and in so doing volunteering within community-led activities is further encouraged and enabled.

5.5 Social value associated with volunteering

There is a substantial body of evidence about the benefits of volunteering to organisations, volunteers, their beneficiaries and the wider community. Locally, we have a robust strategy that provides guidance on good practice and evidence from consultation with agencies that have experience of putting it into practice.

Key messages in Brighton and Hove's 'Joining the Dots A triple impact Volunteering Strategy 2010 – 2015'[1] suggest volunteering:

- Builds social capital, the social glue that makes society work, and thereby improves community safety.
- Has a major impact on the volunteer themselves; improving both mental and physical wellbeing and thereby enhancing quality of life for the individual.
- Improves self-confidence and skills, gives a sense of social value to those who cannot work and is often a route back into employment for those who can.
- Has a particular benefit to the more vulnerable and socially excluded members of our community and can provide them with opportunities they otherwise would not have.
- Brings skills, time, energy, passion and diversity to the organisations that host them; enhancing, enabling and developing service delivery.

"This Triple Impact, on society, the individual and the organisations for whom they volunteer, is why volunteering is so important to the City. Public, private and third sector agencies need to work together to ensure that these crucial opportunities continue to be supported and developed."

The Volunteering Strategy goes on to provide evidence for this[1] suggesting:

- Volunteers provide support and inspiration for service users, encouraging them to think more positively about their own lives
- Well managed volunteer opportunities provide support in developing skills and links to employment
- Utilising volunteers enables organisations to meet the increased demand on services in an economic downturn

In addition, some Community Navigator volunteers have joined the service with the specific aim of enhancing their CV, either for a career change or to re-enter the job market after a period of unemployment or caring for children. During the pilot, three of our Navigators gained employment in the health sector as a result of their experience. Being a Community Navigator provides an opportunity for local people to enhance their skills and experience, enabling them to compete in the local job market. It also provides a good opportunity to work in a health related role, encouraging new people to the Health sector workforce.

5.5.2 Provision of highly skilled volunteers

We can conclude that operating the service with volunteers brings an added benefit to patients and has assisted the growth of the project. When patients arrive at the appointment expressing anger with either clinical or non-clinical services they have received, our volunteers have been able to dissipate the frustration and begin a constructive dialogue by explaining their role and providing a space for the patient to talk about what is important to them. In addition, CN volunteers have previous experience of supporting people and bring vital skills and experience to the role. Most Navigators have a background career in related fields of healthcare, teaching, social services or counselling.
During the first twelve months of the pilot, the service recruited and trained 34 volunteers, of which 24 became active Community Navigators. 10 left before becoming active due to personal circumstances or realising the role was not right for them after undergoing training.
8 active Navigators left the service for a number of reasons, including personal health and circumstances changing, low referral numbers, or being offered paid employment in a related role.
This is a 1 in 3 turnover of volunteers per year, which is natural for a role of this kind that asks for a minimum six month commitment.

5.5.3 Community Navigator survey results

As part of this evaluation, we consulted volunteers on their experience of working as Community Navigators and found;

Volunteer Community Navigators are highly skilled individuals with a wealth of experience and skills to offer. Most have worked or are currently working in a related profession, e.g. healthcare, teaching, social services or counselling. Volunteers feel well trained and supported to carry out their role effectively and value the experience and opportunity it brings them.
Navigators want to feel part of GP surgery teams and need to have direct follow up contact with GPs regarding cases. Community Navigation is an effective volunteer opportunity to support people into employment or to change to a health related career. Navigators value further opportunities for training on key issues affecting patients (for example mental health, housing).

For the full survey results, see Appendix 6.

6 COST-BENEFIT ANALYSIS

The nature of a pilot is to lay the groundwork for a future model of good practice as well as to identify indicators for a longer term study. Analysing true cost savings will need to take account of the longer term impact of Community Navigation, not only on patients' health, but also on the use of Primary Care resources and unplanned hospital admissions as described in chapter 3 of this report. BICS inform us that qualitative evidence about the impact of Community Navigation is not currently available due to variations in the coding of reasons for attendance.
Furthermore, we can presuppose that attendance at a GP surgery may increase for a period of time following Navigation as patients engage more fully in managing their own conditions and identify solutions to their needs. We know that a robust study of impact on Primary Care would need to follow patients' attendance over an extended period, using a control group with similar conditions that did not take up Navigation, which would necessitate a significantly larger resource.

It is however possible to collate evidence about the number of times a patient presents at a surgery or A&E before and after Navigation. Other social prescribing pilots have shown a generalised steady decline in attendance following intervention, e.g. Penwith & Cornwall and Rotherham. (See Social Prescribing review in chapter 2.)

6.1 Unit costs comparison

It is worth noting that very few initiatives in Primary Care will demonstrate cost savings while health budgets remain siloed. Although preventative services are known to produce cost savings in the long term, these are likely to show up across a range of health and social care services and not necessarily within Primary Care budgets, making it difficult to assess cost benefits in real terms.
However, we do know that Community Navigation can free up GP time that can either be put to more effective use in achieving patient outcomes or reduce the additional hours GPs are required to work attending to non-clinical matters.

The total cost of the pilot including set up costs from August 2014 to November 2015 was £172, 276. This funding included £35k of one-off support to B&H Impetus as a whole, to reflect the neighbourhood connections, volunteer management expertise and systems across the organisation drawn upon to develop the CN service. (This has been excluded from unit calculations as it was not a direct service cost.) The majority of project costs relate to the core team of three staff members, volunteer training, support and governance.

This equated to the following unit costs;
£8579 per participating surgery over 16 months
£6434 per surgery per year
£262 average cost per patient referred during the first 12 months of the pilot
£17.68* per hour cost of providing Navigation

According to government approved analysis of unit costs in health and social care[20] the average cost of a GP appointment without prescription is £46, which translates as £234 per hour, more than thirteen times the cost of seeing a Navigator during the pilot. Owing to economies of scale, this would rise to around eighteen times the cost of a citywide service provision.
See Appendix 1 for the unit costs of providing a citywide service.

*A Community Navigator's time includes all project costs for service management and development, volunteer co-ordination, Community Navigator recruitment, training and support.

6.2 Net savings in Primary Care

As described within 'Impact on Primary and Secondary Care' chapter 3 above, the Community Navigation model was based on an Age UK service in Penwith and Cornwall. Evidence from a matched cohort study there showed a 12.7% increase in Primary Care capacity, translating as a £1500 cost saving per patient per year. The cost per patient of providing the Community Navigation service citywide is approximately £135 depending on the model chosen. If we extrapolate and assume a comparable effect in Brighton & Hove, this would result in Community Navigation providing a net cost saving of £1365 per patient.

If the service was provided citywide, at least 1000 patients could have access to it each year. Considering this as a conservative estimate (as more patients per year are likely to access a Navigator) this means that;

£1.36 million per year of GP time could be put to more effective use by providing the Community Navigation service as part of the Primary Care offer in Brighton and Hove.

6.3 Cost effectiveness through economy of scale

Rolling the service out citywide will bring cost savings and economies of scale. If the service continues from April 2016, no set up costs will be needed and the staff team need only expand by a third. A full budget breakdown is included with the model options in Appendix 1, showing a citywide rollout would approximately halve the unit costs listed above.

The cost per patient of the entire Navigation journey (which includes up to 6 x 45 minute appointments, research for referrals, bookings, admin & record keeping) is equivalent to half an hour of GP time.

In addition, Volunteer Community Navigators have given 5824 hours to the service during the one year reporting period. We calculated the costs of providing Community Navigation with paid staff and compared it with that of recruiting, training and supporting volunteers. Providing the service with same quantity of paid staff hours would have raised the cost of the pilot by £98, 197 (57%) and would raise the cost of providing one of the proposed options in Appendix 1 by £140, 800 (85-94% depending on the model chosen). Considering the background, experience and skills that Community Navigators bring to the service, with most having a background career in health, teaching, social services or counselling, the quality of the service would be largely unaffected by recruiting paid staff in their place to carry out the same role.

7 LESSONS, CHALLENGES AND SUCCESSES

7.1 Lessons Learnt

Numerous lessons can be drawn from developing and implementing the Community Navigation service, which can be broadly described under the following key headings;

- Developing shared perspectives between Health and Voluntary and Community Sectors
- Voluntary & Community Sector learning
- Health sector learning
- Utilising volunteers in providing a social prescribing service
- Governance and Management
- The need for flexibility
- Building relationships with GP surgeries
- Definition of 'being Navigator ready' to support development of the service in GP surgeries

7.1.1 Developing shared perspectives

The principles of mutual trust, respect and understanding underpin all effective partnerships and the Community Navigation service has a great opportunity to develop these principles in action.

For the Community Navigation service to continue working effectively in the long-term, it is vital that partnerships between the Health and Community and Voluntary sectors continue to develop according to shared goals and an understanding of the unique strengths each partner brings to the service. In carrying out a clinical assessment, GPs and Nurses are best placed to decide which patients can be most appropriately supported by Navigation. The VCS, with its roots in supporting emotional and social wellbeing, is best placed to refer patients to the right services, groups and activities that can improve broader health and wellbeing outcomes.

The pilot benefited from opportunities to understand the difference in perspective and language between clinical and voluntary sector partners as well as differing practices used to achieve positive outcomes for patients.

7.1.2 VCS partner learning

As the voluntary sector service delivery partner, Impetus was invited to a large number of meetings between all five EPIC workstreams. In the first nine months, 'Implementation meetings' were held every two weeks to discuss clinical processes and arrange operational procedures. In addition four 'Action Learning Sets' were held each month to share learning and troubleshoot issues that arose in implementing the agreed model. Alongside developing relationships with BICS as the lead partner, CCG, GPs and other surgery staff, being present during these discussions enabled Community Navigation staff to develop a broader perspective on how the service fitted alongside other workstreams. It also fostered a detailed understanding of GP surgery systems, which influenced the development of the pilot e.g. by highlighting the need for flexibility in providing an individually tailoured service to align with each surgery's system.

7.1.3 VCS partnership development

Brighton and Impetus & AUKBH began as well-matched organisations to work collaboratively on designing and implementing the Community Navigation service. Both organisations share similar beneficiaries with a focus on whole person approaches that encourage and empower people to improving their health and

wellbeing. A national Age UK model was used in the design of the service along with Neighbourhood Care Scheme operational procedures and good practice in working with volunteers.
The two organisations began collaborating on the pilot with agreed parameters and goals but without a clear service level agreement. The shared ethos and understanding of client needs was a key factor in fostering the trust needed to collaborate with this informal arrangement and both organisations demonstrated an ability to share detailed evidence, methods and solutions. This resulted in the development of a mutually effective working relationship which can be continued in future.

7.1.4 Utilising volunteers in providing a social prescribing service

The section 7.3.1 below outlines the CN process and good practice in supporting volunteers, which is essential for providing a safe and effective service for patients. Alongside this, the pilot identified a number of lessons about operating the CN service with volunteers.

The CN role is an intensive one and requires the volunteer to already possess a level of skill and experience in supporting people before they began CN specific training. Volunteers often receive challenging disclosures from patients concerning their thoughts, feelings and the context of their lives. Often the Navigator is the only person a patient may have spoken to in detail about their situation in a long time, if at all. This necessitates a level of emotional and mental resilience which precludes some people from becoming a Navigator.
The selection process for CNs was developed during the pilot to make this clear from the outset. All potential volunteers are asked why they want to be a Navigator and some suggested their own mental ill health was a reason for wanting to be a CN, to provide support for others in similar situations. Whilst this may sound reasonable and CN staff are able to make adjustments for including a volunteer with additional needs, we found that the role is too intensive for a volunteer currently suffering with mental ill health. It can be triggering and add undue pressure at a difficult time in a person's life. With this in mind, we make this clear when a potential volunteer makes such a disclosure, suggesting they contact the service again after one year of feeling well. We then navigate them to other volunteering opportunities that may be more suitable at the time.

Secondly, operating the service with volunteers requires a higher level of flexibility and negotiation than is usually necessary with paid staff. For example, some Navigators can offer additional time to accompany patients to their first group or to an appointment whilst others are only available during their weekly shift in surgery. This means that accompanying patients to appointments can only be offered on a case by case basis.
Changes to processes and procedures can take longer to cascade to all Navigators than would be expected of paid staff and more intensive support is needed when systems are altered. Volunteers by definition are giving their time without pay, and this needs to be considered at all times when developing the service. For example, there were inconsistencies in record keeping at times, which resulted in staff needing to telephone Navigators for clarification. There were also changes in the recording system, which took several weeks each time to cascade throughout the whole CN volunteer team.
We also found that the most effective changes to systems happened in consultation with our Navigators, via their monthly team meeting, a further reason for ensuring good practice in involving volunteers in the development of the service.

Thirdly, the expertise of volunteer support staff in providing the right specialist support to CNs was paramount in providing an effective service as well as retaining volunteers. The staff team's work to develop bespoke systems for Navigation in consultation with Navigators means that volunteer support needs are well understood and effectively met. Volunteers can access support at any stage of the Navigation process as needed and there is always a member of staff on call whilst CNs are working in surgeries.

Finally, expectations about the number of volunteers that are available for the role need to be carefully managed. The CN role is an interesting and exciting volunteer opportunity which Navigators suggest they value highly, yet it is not right for everyone and it is important to allow time to attract the right people to the role as well as to allow for natural volunteer turnover. We found that, even considering the extensive volunteer networks both AUKBH and B&H Impetus have access to, an average of 6 volunteers per quarter became fully trained and ready to work in surgeries, with an average of 1 in 3 volunteers leaving the role within a year. Whilst this is to be expected in a volunteer role with this level of responsibility, it is generally higher than paid staff turnover and needs to be considered in plans for volunteer recruitment, training and support.

7.1.5 Health Sector learning

The lead and clinical partners also benefited from intensive dialogue by developing a deeper understanding of volunteering good practices and how volunteers can add value to the health sector. Impetus and AUKBH consistently shared the message throughout the pilot that, similar to paid staff, volunteers need to be recruited, trained and supported and this requires staff time and resources if a service is to be developed and maintained effectively.
Clinical partners also developed a broader understanding of the need for reward and recognition in utilising volunteers. In the first stages of the pilot, there were frequent requests from the lead partners for Community Navigation staff to 'tell' volunteers to attend various meetings, events and presentations. Impetus and Age UK staff clarified that requests can be made for volunteers to do additional work, but this is ultimately their choice. There was also further good practice information shared about when it is appropriate to request support from a volunteer and when a staff member is needed instead or in addition. VCS partners continue to share experience and expertise of volunteering good practice by clarifying that volunteers should be well trained, supported and recognised for their work at every available opportunity. All staff and partners that work with volunteers are encouraged to demonstrate respect and appreciation for the vital contribution volunteers make by freely giving their skills and time to the service.

7.1.6 Governance & management

The EPIC programme operated using a governance structure based on leads for each of the five workstreams. Each worksteam lead was the key person responsible for overseeing developments and contributing their expertise to board decisions for the programme as a whole, as well as liaising on behalf of their particular workstream. Considering Community Navigation was based on Age UK models already in existence, drawing heavily upon established expertise in this area, the CN workstream lead was Jess Sumner, CEO of Age UK Brighton and Hove.

Board meetings were held on a monthly basis and involved all partners including representatives of; CCG, participating GP surgeries, pharmacists, BICS staff, AUKBH and the Citizens Panel. Agendas focussed on progress reports on each workstream, identifying challenges and solutions, sharing expertise, scrutinising the financial progress of the project in line with the budget and reviewing the overall impact of the EPIC programme. A Citizens Panel was created to provide service user engagement in the design and delivery of the programme. It involved citizens of Brighton & Hove who felt able as service users to contribute to the development of the programme by drawing on their lived experience.

Workstream leads also participated in development meetings to assist in implementation and were consulted when particular challenges arose.

Jess Sumner worked closely with Jenny Moore, the CN Development Manager at Impetus during the first months of the pilot, to agree processes, procedures, documentation and training for the Navigators. The expertise of existing Age UK projects across the country was used to ensure the work retained the levels of quality assurance and person centred practice valued by both VCS organisations.

Following this, there were regular meetings between the Impetus Service Manager, the workstream lead and staff from BICS to support the on-going development of the project. BICS was often consulted as a key access point for information around working with surgeries.

Learning from the governance structure suggests that it would have been more effective to have less board meetings, using working groups instead for issues benefing from further board knowledge. The Board should also have considered who needed to be present to be quorate, as a lack of quoracy interfered with decision making at times. Being clear about the level of discussion to be held at board and which discussions should be held outside of the board meeting process would have ensured time was protected for more strategic discussion and guests could have presented to the board more often on specific items as required.

Being a learning programme involving five different workstreams coming together to implement change in Primary Care and share learning necessitated a lot of meetings. Now that the EPIC programme has come to an end, there is an opportunity to streamline governance and management systems and utilise the more commonly used 'steering group' approach, which brings a group of stakeholders together at one regular meeting to provide strategic direction. Key issues identified for development can then be explored through working groups.

7.1.7 The need for flexibility

As a learning project, we were careful to listen to the needs of practices throughout the pilot. We heard what GPs, Practice Managers and support staff needed from the project, altering our systems, processes and communications accordingly. For example, a client record sheet was designed with GP systems in mind, taking into account the information GPs needed from the service about patients accessing it. This recording mechanism was altered five times throughout the pilot as reporting needs were further clarified.

This flexible approach allowed us to tailor aspects of the service according to individual surgery systems. We found this to be of particular importance when working in partnership with GP surgeries, as each one is a unique organisation in its own right with its own working practices. To ensure the service was successful, we needed to ensure our systems harmonised with those of each surgery, e.g. there are several different ways of making a referral to a Navigator. Some surgeries use a digital form that is completed and accessed on screen and some use a form that we created on paper and place this in a designated Navigator's tray. Others print contact information and a brief reason for referral.

Flexibility was also needed during the development stage of the pilot whilst training GPs and surgery staff about the service. Some surgeries were able to send most of their staff to an hour long session whilst others were only able to spare one staff member for 20 minutes, so the training was tailored to accommodate surgery staff's availability. This worked well in theory, though it did result in some surgeries having a greater depth of understanding than others, which tended to make a difference to the number and appropriateness of referrals made throughout the pilot and whether or not the Navigator was treated as a member of the team. When implementing a new service based in GP surgeries, it is clearly more effective for CN staff to meet the whole team, which may require a longer lead in time at development stage. See 'Being Navigator Ready'.

7.1.8 Building relationships with GP surgeries

Developing the pilot opened the door to a more developed dialogue on what the VCS brings to broader health and wellbeing aims. BICS as the lead partner provided a gateway to GP surgeries in the first instance, which supported the CN service to foster relationships with surgeries. As the pilot continued, it became

clear that communicating directly with GPs and surgery staff gave a more direct route to providing an effective service and this is further ratified by responses to the GP practice survey.
During the pilot, it became clear that providing direct feedback to GPs and practice staff either via the Navigator and/or more formally via a short periodic report was effective at encouraging a higher number of referrals from GPs as well as ensuring greater appropriateness of referral.
In addition, we found that some GPs and Practice Managers are able to support the service and refer more patients than others. Utilising these practitioners as champions of the service encourages 'buy-in', fostering support and encouraging more regular referral.

One of the reasons that people volunteer is to feel part of a team and Navigators' experience of this varied depending on the GP practice they were working in. Where Navigators were welcomed and treated as a member of staff, positive relationships with GPs, Practice Managers, Nurses and Receptionists were more easily built. This was further expressed in the detail of the volunteer survey we conducted (see Appendix 6). For example, some Navigators said that when they have concerns about a patient, they can easily contact the nurse or GP in their practice and have a conversation about what needs to happen next, whilst others were not sure how or when a GP could be contacted.
We found that where practice staff were responsive, welcoming and made consistent referrals, Navigators were more likely to stay in their role, leaving the project only when their personal circumstances changed. Developing a solid relationship between the Navigator and practice staff takes 3-6 months and when a Navigator leaves, this process has to begin again with a newly trained volunteer.
This, along with other learning as described above, led us to develop an understanding of what it means for a surgery to be 'Navigator ready'.

7.1.9 Being 'Navigator Ready'

Learning from the pilot revealed a clear understanding of effective working practice when providing the Community Navigation service within GP surgeries. The following is a definition of how a surgery becomes 'Navigator ready' and forms a basis for implementing the service citywide.

1. When implementing the CN service, it is important that CN staff meet the whole practice team before the Navigator begins. This is to ensure all clinical and non-clinical staff fully understand the scope of the service, which patients to refer and how they can be helped, the skills offered by the Navigator and good practice when working with a volunteer. This could be offered via a CN staff visit during a surgery's practice meeting or training session, and CN staff will take steps to ensure they work flexibly when arranging a visit. (It can take a significant lead in time when implementing the service in multiple surgeries and expectations around this need to be carefully managed.)
2. A partnership agreement needs to be made between the Community Navigation service and the GP surgery hosting it, outlining the scope of the service and what can be expected by each partner.
3. Make regular referrals. Details of the Navigator's capacity will be made clear in the partnership agreement. This may differ between surgeries depending on patient list size, location and availability of the Navigator.
4. Community Navigators work most effectively when treated as a member of the staff team. To ensure this happens, surgery staff need to;
    - Understand the Navigator's role, skills and scope of the CN service.
    - Provide an accessible, pre-booked room that allows patients to see the Navigator without interruption. Some rooms are unsuitable e.g. a treatment room that requires constant access to supplies or an upstairs room with no lift for patients with mobility needs (This was 23% of patients during the first year).
    - Provide an induction including staff facilities available, safety procedures in the event of an incident, computer login details and telephone access.
    - Invite the Navigator to appropriate meetings e.g. part of a practice team meeting. Where the Navigator is unable to attend due to time constraints, work flexibly to offer other opportunities for the Navigator to communicate with the staff team.

- Clarify a mechanism for the Navigator to contact GPs directly with any concerns about patients who have been referred.
- Provide a lead staff member that is available during the Navigator's shift. This could be a Practice Manager or any member of the staff team who is able to answer queries relating to surgery systems and communications.
- Provide a secure space for Navigators to keep confidential records.

Where it is not possible for a surgery to achieve the above, this needs to be made clear to the Community Navigation Service Manager who will work as flexibly as possible to support the surgery in putting other appropriate arrangements in place.
In the event of a surgery being identified as not yet 'Navigator ready', additional support may be offered by the CN staff team within an agreed timeframe.

7.2 Challenges

Learning is also drawn from observing key challenges during the pilot, which include working with GPs, differences in the size and scope of staff teams across differing sectors and agreeing service parameters and associated costs.

7.2.1 Working with GPs

The Community Navigation service was part of a larger pilot made up of five projects and taking place amidst a raft of other new initiatives within the Health Sector. The ability of GPs and practice staff to prioritise developing new relationships with non-clinical partners varied across surgeries. GPs who engaged with the service more fully tended to have a higher level of trust in their Navigator than those who did not, which in turn affected the number of referrals made to the Navigator.
Differences between clinical and community centred approaches mean that all partners involved need to give time and energy to develop new relationships of reciprocity and trust.

Gaps in services to meet the care coordination and advocacy needs of the most vulnerable meant that 16 (4%) referrals were made to Navigators for patients whose level of need was too high to engage effectively with a social prescribing service. Making the right referral can be a challenge for GPs when faced with patients who attend the surgery frequently with very complex needs. Where there is a lack of service provision, e.g. care co-ordination, specialist mental health support and advocacy, some clients fall through the gaps.

7.2.2 Differences in the size and scope of staff teams

Differences in understanding of the size and scope of the Community Navigation staff team led to some misgivings in the first months of the pilot. The Community Navigator service team consisted of three part time staff, employed to develop brand new systems and partnerships at the same time as recruit a new group of suitable volunteers that could deliver a safe, effective service for patients. Expectations of the time it would take for changes to cascade through the service were at times unrealistic. For example, changes in client data recording were requested by the lead partner during an implementation meeting. This required CN support staff to design a new form and cascade it to all 16 volunteers, re-training them in how to use it. CN support staff were asked a week later why it had not yet been fully implemented.
The speed of changes to data requirements also led to misunderstandings. The Community Navigation team was often asked to respond to additional data requirements and meeting changes at very short notice. Although the CN team were quick to respond, this did lead to some tensions.

We identified a mismatch in expectations of change between Health and VCS services. It is understood that system and service changes in the Health sector require significant development and lead time to

implement, yet there was an expectation that a VCS service with a small part time staff team could implement change immediately. Although smaller organisations that have a history of working flexibly with their service users are often able to respond more swiftly to change than larger organisations or institutions, the pilot would have benefited from a service level agreement that set out clear guidelines and expectations with associated timescales from the outset.

It is understood that changes to systems are a necessary feature of pilot projects, though the speed and frequency of operational change during this pilot was high, and the size of the Community Navigator staff team compared with that of the lead partner had to be frequently emphasised to ensure time expectations were realistic.
For example, the requirement to attend six meetings a month with the lead partner caused time constraints on delivering the service. The implementation of 'Go Live dates' to initiate the service in surgeries meant that both CN and surgery staff were rushed into hosting the service without having sufficient time to develop a shared understanding of outcomes to be measured or agree mutually effective working practices. A phased roll-out approach to implementing the service would have been more effective in developing new partnerships between GP surgeries and VCS, allowing time to share understanding and expectations between partners.

7.2.3 Agreeing service parameters and associated costs

Hosting a pilot project without a Service Level Agreement meant that the agreed model and data requirements changed at intervals, resulting in an increase in staffing costs for service management, volunteer co-ordination and data monitoring. These increased costs were funded during a 6 month extension to the pilot from May to November 2015. This positive learning derived from the pilot will assist in developing a more cost effective service in the long term.

7.3 Successes

Key Successes include;

- 393 patients were referred across 16 surgeries during the first 12 months of the pilot and 741 referrals were made to groups, services and activities patients would not have otherwise accessed.
- There were overall improvements to patients' health and wellbeing as a result of Community Navigation with 93% saying they had all the information they needed to address their issue and 62% being able to take the next step within 3-6 months.
- Patients reported 98% satisfaction with the service saying they felt listened to and understood. 85% said they would recommend their Navigator to family and friends.
- GPs and Practice staff reported 89% satisfaction with the Community Navigator service with 95% saying the service is effective at providing a referral route to non-medical services and 87% reporting that the Community Navigation service is effective at improving the wellbeing of patients.
- The service attracted a highly experienced and skilled volunteer team to carry out the Community Navigator role. Most Navigators have a previous or current career in healthcare, social services, teaching or counselling.
- Volunteer retention throughout the pilot was high, with over half of Navigators remaining on the team after one year, despite only signing up to an initial six month commitment.
- Volunteers gave an average of 7 hours per week of their time during the first 12 months of the pilot, which calculates at 5824 volunteer hours given to Community Navigation.
- The service developed positive and effective relationships between Health and VCS partners, fostering a shared understanding and learning.
- A positive and effective partnership between two VCS charities was developed; Brighton & Hove Impetus and AUKBH.
- Effective working practices and procedures were developed, to meet the needs of patients, Navigators and GP practices.

- The pilot saw an upward trend in referrals throughout the first year of reporting.

7.3.1 Good practice in supporting volunteers

The success of the pilot is in part owing to the knowledge and experience of its two VCS partners in recruiting, training and supporting volunteers. The Community Navigators service was recently asked to present its methods at the Brighton & Hove 'Volunteering Champions Group' hosted by Community Works. The pilot received numerous positive comments from its members, a group of experienced, well-respected practitioners and service managers in the City that meet to share learning and good practice concerning the recruitment and support of volunteers.
The following information was shared concerning methods used in recruiting, training and supporting volunteers to deliver the Community Navigation service;

1. Providing an **interesting and varied role** that involves a sense of responsibility
2. Having a well-developed and transparent **recruitment process;** application form and interview
3. Having a **clear role description** and person specification that outlines the expectations of the role and minimum time commitment
4. Having a well-designed **training programme** that meets the needs of the role
5. Putting a **support package** in place for volunteers to carry out the role effectively and with confidence; ongoing training, shadowing, team meetings and action learning, 1-2-1 debriefs, news bulletin, telephone support, paying expenses, DBS checks
6. **Encouraging active involvement** of volunteers by being open and responsive to changes and developments in the process; e.g. provision of surgery introduction meetings, changes to monitoring system, use of email.
7. **Flexibility**, e.g. doing 2 shorter sessions, other service support roles within the team, sabbaticals. Support in researching community activities/resources and making links themselves at their own speed so their roles develop as their confidence increases.
8. Putting a **quality control** process in place, e.g. observation visits, review meetings, caseload discussions, patient follow-up by staff members.
9. **Supporting professional/personal development** and longer term goals of volunteers, e.g. training, support record and references.
10. **Working with other partners** as appropriate to assist them in understanding the context of working with and needs of a volunteer

8 RISKS AND OPPORTUNITIES

8.1 Risks

Below is a series of risks to maintaining an effective service in future along with associated solutions to mitigate them.

8.1.1 Lack of support

The opportunity for patients to see a Navigator relies, in the service's current form, on patient referrals from GPs and other practice staff. Although we have seen an upward trend in referrals throughout the pilot, we are aware that some GPs trust in the effectiveness of Navigation more than others and results from our GP practice survey tell us we have a clear role to play in developing relationships and improving communications with practices (see Appendix 2).

8.1.2 Reduction in community resources

To ensure effective patient outcomes, it is vital that services exist in the context of a thriving Voluntary and Community Sector. The risk in the current climate is that services may be cut below the levels of patient need or may disappear altogether. This risk is especially pertinent to the most commonly referred-to services.
The findings of the Community Navigation pilot suggest patients have the greatest need for;

- social and practical support for older people, e.g. The Hop 50+ Centre
- Befriending services e.g. Neighbourhood Care Scheme and Time to Talk
- Information, advice and advocacy, e.g. AUKBH IAG, BHT
- Welfare benefits advice and advocacy, e.g. Money Advice Plus and CAB

Most of these services are limited, having already received or being at immediate risk of funding cuts. Navigators have reported reduced ability to refer to these services throughout the year due to reductions in scope and client criteria as well as longer waiting lists.
In addition, funding cuts disable small community and self-help groups from thriving as support and running costs become less readily available.

The effect of these preventative services and groups being less available is not yet fully known, yet it is likely to have an impact on patient wellbeing for the most vulnerable and require more costly intervention in the long term.
VCS partners continue to engage commissioners and strategic partners in the city to ensure that information gathered about growing service needs and gaps is available when decisions are being made.

8.1.3 Filling gaps in services

The reduction in community resources presents a prevailing risk of the Community Navigation service being used to plug gaps in services. As available funded services for the most vulnerable in our society are cut (e.g. people with learning difficulties, mental health problems, disabilities and those on low incomes) this places added pressure on Primary Care to deal with the associated decline in health and wellbeing.
Although Community Navigation is shown to be effective for supporting vulnerable people, individuals in need of the kind of intensive support and advocacy provided by a specialist worker are unlikely to be able to engage with Navigation productively if there are long waiting times to access support or if they are suffering the effects of reduced provision.

8.1.4 Closure of the Community Navigation service

Due to the vulnerability of clients seen by Community Navigators and the fact that the navigation journey can often span several weeks, it is vital that expectations are managed sensitively and adequate notice is given if the service needs to come to an end. Added to this, volunteers value their role and the CN service has a responsibility to provide support for those who wish to find suitable alternatives. There is also a risk that in the current economic climate with higher levels of job competition, staff are likely to seek alternative employment if the future of their role remains unclear for long. Lastly and of equal importance is the need to maintain our relationships and goodwill with GP surgeries, who should be kept well-informed of any impending closure of the service.

To mitigate this risk, we have a plan in place to wind the project down beginning 1st February 2016. If funding is not received before this date, all new patient referrals will cease, Navigators will be supported to close their existing cases and seek alternative volunteer opportunities and all staff will be given 2 month redundancy notices. We would also meet with GP practices individually to support them in winding the service down and to discuss any issues they may wish to raise.
If the service is to be continued, a decision about the option and level of funding would need to be made by end of December 2015 at the latest to allow time for a new service agreement to be developed and funding received by 31st January 2016.
In this case, development work on the future model would begin in February 2016.

8.2 Development opportunities

8.2.1 Aligning Community Navigation with Care Coaches

The similarities and differences between Community Navigation and other models of social prescribing present opportunities for further development. In particular, there is clear evidence that the Community Navigator and Care Coach models can work effectively together in providing a wide range of support for patients to improve their health and wellbeing.

The current plans for Proactive Care in Brighton & Hove present an opportunity for Community Navigation to align with the Care Coach model (sometimes called Care Coordinator elsewhere). Care Coaches will link with Multi-Disciplinary Teams to coordinate care in complex cases and be a main point of contact for patients. They are responsible for ensuring the patient's wishes are included as a central element of the care planning process and will be a reference point for health and adult social care professionals to confirm the care plan is person centred. They will also be available as a resource for Community Navigators when barriers in the system create difficulties for patients in following their treatment plan or accessing services.

The Care Coaches will have expertise in liaising with surgeries and health professionals within an MDT environment to achieve outcomes defined by the patient. They can be another point of referral alongside GPs, where there are non-medical issues that a Navigator can help find support for. The referral for social prescribing then forms part of the individual's care plan.

8.2.2 Partnerships

As the first programme of its kind in Brighton and Hove, further development work to increase the effectiveness of partnerships between the Health and Voluntary & Community Sectors is necessary, yet we have a strong foundation of shared understanding and goodwill on which to base these evolving relationships.

In addition, partnerships continue to develop between VCS organisations through sharing information, good practice and patient outcomes, including reasons for referrals, the demand for services and patients' experiences of VCS services they have been referred to.

8.2.3 Links with other social prescribing services

Community Navigators operate within a broader local context of services that include a social prescribing or signposting element in their work, e.g. Health Trainers and ESFRS health and wellbeing visits/ home safety assessments. Navigators can refer patients to these services for additional support where needed and partnerships with these services will continue to develop.

8.2.4 Governance

Many of the challenges discussed above could be abated by a clear service level agreement that is developed in dialogue with the partners involved, including the scope, model and data requirements at the outset to ensure project costs remain consistent.
To ensure success with future arrangements, the service would also benefit from the commonly used steering group approach, inviting all key stakeholders to a regular dialogue that provides strategic direction and an opportunity for operational reporting. It may be pertinent to align a steering group with the pro-active care cluster model, considering this will provide similar opportunities to work towards shared goals with the same partners.
This evaluation has provided a positive opportunity to reflect more closely on effective partnership working. Considering the vast changes and developments in both Health and Voluntary & Community Sectors, a future service would benefit from periodic 'partnership review' to share learning and ensure efficient and effective working practices for all partners involved.

8.2.5 Measuring Patient Outcomes

Considering the parameters of the service were developed alongside the pilot, measurable patient outcomes were also developed throughout the year. Client data records were altered several times throughout the pilot, resulting in additional data management to ensure this evaluation reported on consistent findings.
Further opportunities exist to broaden the scope of a patient outcomes measure to include not only patient identified outcomes via follow up interviews but also 'distance travelled' data. Where appropriate, this could be aligned with patient outcomes data collected by Care Coaches.

8.2.6 Developing a communications strategy

Results from our GP practice survey suggest the service has a clear role to play in developing its communications with practice staff. This includes the need to;

- Provide greater clarity on the background and skills of Navigators
- Share information about the on-going training and support Navigators receive
- Share patient outcomes in a systematic and timely manner
- Enlist the support of referring GPs that understand and trust the service to share their experience
- Continue to ensure the referrals process is easy and individually tailored to the administrative system of each practice

8.2.7 Specialist equalities navigation

It has been suggested by VCS colleagues that in future, the service could recruit specialist equalities Navigators for clients with specific needs, e.g. LGBT or BME. The Community Navigation service is broadly supportive of this and could include specific equalities training for experienced Navigators who have helped more than 30 clients. This would provide an improved bridge to specialist services that are best placed to serve the needs of people with protected characteristics and would assist in the development of partnerships with vital specialist gateway services.

8.2.8 Interpreting

The need for interpreting services has been small throughout the pilot (7 of 393 patients had need of an interpreter) and was funded directly by BICS to Sussex Interpreting Services for providing interpreters. Future arrangements need to be made for the provision of interpreting

8.2.9 Home visits and accompanied visits

Research into other social prescribing pilots shows that home visiting is effective at encouraging patients to attend appointments and take up services along with accompanying patients on their first visit to a new group or service. The Community Navigation service currently offers home visits to people who are housebound and may need to consider offering a higher proportion of home visits in future. Accompanying patients to appointments or groups is offered on a case by case basis, according to the availability of volunteers. The CN service may need to do some development work around this or recruit volunteers specifically for this purpose.

9 CONCLUSION AND RECOMMENDATIONS

Community Navigation in Brighton & Hove has proved to be successful in providing a social prescribing service that is closely linked with Primary Care. The person-centred methods used resulted in significant improvements to patients' health and wellbeing. Patients have been provided with the right information to help them access social, emotional and practical support. Patients have also been able to make positive choices concerning their broader health and wellbeing needs and most have already taken steps to improve their situation.

Partnership working between the Health and Voluntary & Community Sector has promoted a shared understanding of the differing approaches and methods used to achieve positive outcomes for patients and a growing number of GPs demonstrate trust in the Voluntary & Community Sector by referring their patients to the service.

Numerous lessons have been learnt about working flexibly, building relationships between sectors, operating the service with volunteers and what it means for a GP surgery to be 'Navigator ready'. The pilot has also collected evidence about the need for and use of groups, services and activities in Brighton and Hove.

Analysis of key findings and learning throughout the pilot produced a detailed understanding of how to provide a suitable, high quality and cost effective service in partnership with Primary Care. The pilot can also share its awareness of challenges, risks and opportunities in developing and providing a social prescribing service using a volunteer model. Learning from the pilot led to key recommendations for longer term development and a series of model options and associated budgets for providing the Community Navigation service citywide.

9.1 Key Recommendations

1. Integration with Primary Care is vital to the success of the service. The main referral route should continue to be GPs, and Navigators should continue to be based within GP surgeries.
2. Community Navigation is more effective in supporting people to make positive choices and take the next step when 3-6 sessions are offered.
3. Volunteers need to be well trained and supported, as well as recognised for their contribution by all partners at every available opportunity. Operating the service with volunteers also requires a higher level of flexibility than is usually expected of paid staff.
4. When working across sectors, a well-developed service level agreement is needed from the outset to foster a shared understanding of aims and expectations as well as to ensure the service can be delivered as cost effectively as possible. This should include details of governance structure and arrangements.
5. When implementing a new service based in GP surgeries, it is important that CN staff meet the whole practice team. This requires an appropriate lead in time when implementing the service in multiple surgeries.
6. Some GPs and Practice Managers are able to support the service and refer more patients than others. They can be utilised as champions of the service to encourage others to refer.
7. All surgeries hosting the service need to be 'Navigator ready' to ensure an effective and equitable service is delivered for patients (see definition on page 42).
8. Referrals mechanisms should be simple for GPs, practice staff and volunteers to use, and tailoured flexibly to suit individual surgery systems as needed.
9. Providing regular feedback about outcomes for patients encourages a higher number of referrals from GPs as well as ensuring greater appropriateness of referrals. The CN service should provide regular reports for each surgery showing reasons for referral and services referred to.
10. Streamline the governance structure by utilising the more commonly used 'steering group' approach.
11. Patient outcomes have been measured using a variety of methods throughout the pilot, including patient follow-up interviews. As the landscape of health and VCS services shifts, new models of measuring outcomes need to be identified and implemented, e.g. monitoring of distance travelled, bench-marked with patients before and after navigation.

APPENDICES

Appendix 1 Community Navigation Service Model Options & Budgets paper

This paper draws on evidence and learning from the Community Navigation evaluation completed in Autumn 2015. It sets out three options for the future of Community Navigation in Brighton & Hove with reference to key elements that could be included.

It is assumed that Community Navigation would remain integrated with Primary Care and GP surgeries would continue to provide the location for and main referral route to Navigation. All models would involve a phased city-wide roll out, beginning with surgeries and/or clusters that are 'Navigator ready'[1]. It is also assumed that Community Navigators would continue to be volunteers and not paid staff.

Each model is presented with a description, pros, cons and associated cost per year. A full budget breakdown for each model is presented in Appendix 2.

Elements of service	**Model 1**	**Model 2**	**Model 3**
Navigators are based in GP surgeries	✓	✓	✓
GPs, nurses, other practice staff and Care Coaches can make referrals	✓	✓	✓
1 Navigator per surgery with up to 4 clients seen per week	✓		
Teams of Navigators aligned with pro-active care clusters. No. of Navigators and appts. determined by patient numbers		✓	✓
Other named agencies can make referrals, e.g. Wellbeing service, Access Point, NCS, CAB, BHT, MAP.			✓
Annual service cost (year 1)	**£170, 229**	**£156, 843**	**£197, 591**

Model 1: One Navigator per surgery

This is most closely aligned with the current pilot model with one Community Navigator per surgery, regardless of the number of patients or the surgery's circumstances. The only addition is that referrals from Care Coaches can be made. (Care Coaches are managed by AUKBH, with whom Impetus has a well-established partnership.)

Pros

This has been tried and tested locally and no additional development work would be needed beyond the phased introduction of training and support given to all surgeries that are new to Navigation.

Cons

The pilot demonstrated that Navigators do not receive enough referrals to work to capacity in smaller surgeries. There are also differing numbers of referrals between surgeries, depending on their current circumstances and whether they are 'Navigator ready'. Volunteers tend to feel despondent and leave the service when referral numbers are low.
44 Navigators would be needed and the service would need to recruit, train and support an additional 30 volunteers.

[1] For definition, see page 42

Cost

Staff costs include:
1 x Service Manager 24 hours per week. Service Development, quality control, relationship building and networking citywide, outcomes monitoring, evaluation and information sharing.
2 x Volunteer Co-ordinator, 26 hours each per week.
Volunteer co-ordination involves minimum support needed to ensure good practice; 1 hour per week per Navigator (44 hours) plus 8 hours per week team development & support, communications and liaison with surgeries.
1 x data and admin support 24 hours per week[1]. Input all data from client record sheets onto central database and generate monthly reports. General admin support to staff team including minutes of Community Navigator team meetings, producing documentation etc.

Model 1 Budget

Staffing	£90,583
Project direct costs	£35,542
Project running costs	£19,444
Central support costs	£24,730
Total cost	**£170,299**

Based on 44 Navigators seeing 1200-1500 patients each year, this equates to:
£3870 per surgery per year
£113-142 average cost per patient referred
£13.54 average per hour cost of providing navigation
56p per year per Brighton & Hove patient on list

Model 2: Flexible and linked with Pro-Active Care

This is similar to elements of Model 1 where Navigators are based in surgeries and referrals are made by GPs, other surgery staff and Care Coaches. Yet instead of providing one Navigator per surgery, teams of Navigators work together within each Pro-Active care cluster. The number of Navigators per cluster and where they are situated is determined by patient numbers on each surgery's list. Each surgery's ability to engage with the service and be 'Navigator ready' will also be assessed at onset to determine where Navigators can be most effectively placed.

Pros

This is a more flexible model than in the pilot. Teams of Navigators can work together, providing appointments when and where needed. This model also aligns the service more closely with developments in proactive care, linking more securely with Care Coaches.
It may happen that a cluster has one Navigator in each surgery or it could be that one Navigator works in two or more surgeries, depending on patient numbers and the surgery's ability or willingness to host the service. This enables greater consistency and a more equitable service for patients, as surgeries making occasional referrals could continue to do so without losing their Navigator altogether. Cover could also be more easily arranged between each team of Navigators during periods of absence.
Fewer Community Navigators are needed citywide, which reduces costs associated with recruiting and supporting volunteers, e.g. training and volunteer expenses, DBS checks etc.

[1] This assumes that CCG data requirements will remain as at the current level. If data requirements increase, so will staffing costs.

Cons

There is a small amount of additional development work to be done with surgeries at onset, to ensure consistency of service is being offered across the clusters.
Organising Community Navigators into six teams will increase volunteer co-ordination staff time needed to support them, but this is more than alleviated by having fewer Navigators citywide.

Cost

Staff costs include:
1 x Service Manager 24 hours per week (Same as Model 1)
2 x Volunteer Co-ordinators, 24 hours each per week.
Volunteer co-ordination involves minimum support needed to ensure good practice; 1 hour per week per Navigator (32 hours). 8 hours per week team development & support, communications and liaison with surgeries. 8 hours per week cluster team development and support.
1 x data and admin support 24 hrs per week (Same as Model 1)

Model 2 Budget

Staffing	£87,293
Project direct costs	£28,972
Project running costs	£18,364
Central support costs	£22,214
Total cost	**£156,843**

Based on 32 Navigators seeing 1200-1500 patients each year, this equates to:
£3564 per surgery per year
£104-130 average cost per patient referred
£12.52 average per hour cost of providing Navigation
52p per year per Brighton & Hove patient on list

Model 3: Flexible, linked with Pro-Active Care and with additional referring agencies

This contains the same elements of Model 2, except that other named agencies may also make referrals, e.g. Adult Social Care, Wellbeing service, Access Point, Neighbourhood Care Scheme, Citizen's Advice Bureau, Brighton Housing Trust, Money Advice Plus. The rationale for which agencies can refer is determined by which advice and support services Navigators most often liaise with and refer to.

Pros

In addition to pros associated with Model 2, other agencies referring in will offer a wider catchment of vulnerable adults, especially those who do not often visit their GP surgery. Developing relationships with other agencies could foster cross referrals and offer additional advice and support for Navigation clients.

Cons

This model is more complex and has not been tested. Development work with Adult Social Care and other referring professionals would be needed to build relationships, train external staff to make the right referrals and promote the service, which results in increased management costs. An additional staff member would be needed to assess all cases and decide which referrals are appropriate for a Navigator, especially considering the higher risk of complex cases being referred by Access Point. (Volunteer Community Navigators only see patients that can engage with social prescribing and are able to self-manage.)

Balancing the right number of referrals to keep Navigators busy but not overworked will also be a challenge and the number of Navigators needed would increase.
There is also a significant risk of a large number of inappropriate referrals being made by Access Point in the wake of service cuts, which would cause additional time and therefore project costs. Accurate costs could not be predicted until the model is tested and if this model is chosen, further contingency funds should be set aside.
This model is not recommended without an initial scoping exercise to test whether it would be effective for patients, volunteers and additional referring agencies.

Cost

Staff costs include:
1 x Service Manager 28 hours per week (Higher than Models 1&2)
2 x Volunteer Co-ordinators, 24 hours each per week. (possibly rising to 2 x 35hrs)
1 x Volunteer Co-ordinator/Assessor, 24 hours per week (possible rising to 35hrs)
Volunteer co-ordination involves minimum support needed to ensure good practice; 1 hour per week per Navigator (44 hours). 8 hours per week team development & support, communications and liaison with surgeries. 6 hours per week cluster team development and support.
1 x data and admin support 24 hrs per week (Same as Models 1&2)

Model 3 Budget

Staffing	£111,581
Project direct costs	£35,613
Project running costs	£20,564
Central support costs	£29,833
Total cost	**£197,591**

Based on 44 Navigators seeing 1200-1500 patients each year, this equates to:
£4491 per surgery per year
£132-165 average cost per patient referred
£15.60 average per hour cost of providing navigation
65p per year per Brighton & Hove patient on list

Calculation Notes:

- Cost per patient referred is the average cost for the entire navigation journey which includes up to 6 x 45 minute appointments, research for referrals, bookings, admin, record keeping and associated staff and project support costs.
- Cost per hour is calculated in relation to all project costs including a core team of 4-5 staff members, volunteer training, support, training etc. The cost of seeing a GP equates to £234 per hour, which is approximately 17-18 times the cost of navigation, depending on the model chosen.
- Precise number of patients to be seen is difficult to predict as it relies on the number of GP referrals made and the consistent availability of volunteers. A citywide service would see at least 1000 patients per year with 1200-1500 being likely
- Costs for model 3 are an estimate only, as additional staff hours would be needed if larger numbers of referrals or inappropriate referrals were made. A further £30k should be set aside if this model is chosen.

Appendix 2 GP Practice survey results

Summary

- 89% GPs and Practice staff are satisfied with the Community Navigator service.
- 95% of GPs and Practice staff think the service is effective at providing a referral route to non-medical services.
- 87% GPs and Practice staff think the Community Navigation service is effective at improving the wellbeing of patients.
- 84% think the Community Navigation service is effective at improving the surgeries' links to other resources and services in the community.
- 68% of GP practice respondents think the Community Navigation service is effective at reducing the amount of time patients attend the surgery with non-medical matters, whilst 19% did not know.

Overall a vast majority of respondents said they were satisfied with the Community Navigator service. Most respondents thought the service has improved the wellbeing of their patients, and increased the surgery's links with the local community. The majority of GPs think the service has decreased the amount of times patients came in to the surgery for non-medical issues.

GPs would like to maintain contact with the Community Navigator once a patient has been referred on to Navigation to see how patients are progressing. Navigators themselves agree, yet there are barriers to this within surgeries. A suggested solution is for practice staff to find ways of making it easier for GPs and Navigators to communicate directly.

Community Navigation has worked most effectively where there has been a good relationship between the Navigator and staff team. Ensuring the Navigator is part of the surgery team is an important aspect of raising the Navigators profile and ensuring referrals are made.

GPs commented:

"I would really value having our Community Navigator stay on for our practice. I know patients have gained a lot from her too."

"I really think the service is a good one to offer help to patients and point them in the right direction with non-medical problems therefore 'freeing' GP appointments to be used for the unwell and those that need them."

Background

A total of 38 responses were collected from 15 of the 16 surgeries that took part in the pilot.
GPs, Practice Managers, Nurses, Administrators and Receptionists responded with their views on the impact of the service. The survey asked a range of questions regarding:

1. Satisfaction with the Community Navigator (CN) service
2. Understanding of the work of the Community Navigator
3. How effective Navigation is
4. Further support which may be needed in relation to the role
5. The greatest challenge the surgeries face in hosting the role.

A total of 53% of respondents were GPs, 21% Practice Managers, 13% were Administrators and Receptionists, 11% Nurses, and 2% Area Practice Manager.

Respondents were asked to scale their responses from 1 – 5 (1 = not at all to 5 = very). Questions receiving a scale of 3 or above consider the respondent to have a good level of satisfaction or above with the service.

Two in-depth telephone interviews were also conducted with a Practice Manager and a GP regarding their experiences and to discuss the strengths and challenges of the Community Navigation project.

1. Satisfaction with the Community Navigator service

Respondents were asked how satisfied they were with the Community Navigator service. The questions asked respondents to scale and comment on their satisfaction with the availability of the Navigator, the ease of making referrals, the knowledge and skills of the Navigator, the information made available for patient records, and reporting practices for data.

89% of respondents reported good to high level of satisfaction with the **availability of the Navigator** and the ease of which they were able to make referrals. The only reason for dissatisfaction given was the Navigator being available only for a short period of time before having to leave due to personal circumstances.

76% of respondents also expressed good to high levels of satisfaction with the **knowledge and skills of the Community Navigator**, the information available and the reporting data practices. Not all respondents felt able to comment on the knowledge and skills of the Navigator, the information available or the ease of referrals. 24% of respondents scored these questions as not applicable, which may show a lack of understanding of the role of the Navigator or lack of contact with the Navigator.

Respondents' overall satisfaction with the Community Navigator service was high and dissatisfaction low, 89% of respondents were satisfied compared to 11% of respondents who were dissatisfied.
Of the respondents who felt dissatisfied with the service, reasons include;

- The Navigator resigned from the surgery (following low referral numbers) which meant that GPs could not make any further referrals
- The Navigator was only available at the surgery one morning a week
- There was no follow up communication between the Navigator and GP on what was happening with cases. It is important to note that Navigators themselves share this frustration. This points to a need for systems to be put in place in surgeries for GPs and Navigators to communicate with each other directly when they are unable to meet regularly face to face.

2. Understanding the work of the Community Navigator

Respondents were asked four questions regarding their understanding of the Community Navigator role based on the training, support and information they were offered during the pilot. GPs and practice staff were asked to comment on their understanding of the Navigators' role overall, which patients to refer and not to refer and their understanding of good practice when working with volunteers.

All respondents except one reported high levels of understanding in all these aspects. The one respondent who did not feel they had enough training and understanding of the work of the Community Navigator was a Receptionist at a surgery.

There was a mis-match here between GP and practice staff perceptions and the experience of the Community Navigation staff team. Learning during the pilot suggests there is still more work to do regarding GPs and practice staff understanding of which patients to refer for Navigation and good practice when working with volunteers. There has been a need to repeat messages concerning this and frequently remind GPs to make referrals, which suggests a need for further work in making clear how and why Navigation can benefit patients. In addition, Navigators encountered differing experiences depending on which surgery they were based in. Some were treated with respect and recognition for the contribution

they make, whilst others met with less understanding. The Community Navigation staff team has more work to do in publicising the background and skills Navigators already possess (most have a background career in healthcare, social services, teaching or counselling) along with the intensive training and support they receive.

3. Effectiveness of the Community Navigator

Respondents were asked how effective they think Navigation is at improving the wellbeing of their patients, providing a referral route to non-medical services that can support patients, improving links for surgeries to other resources in the community and reducing the amount of time patients attend the surgery for non-medical matters.

87% of respondents think the Community Navigation service is effective at improving the wellbeing of the patient. Only 1 GP expressed dissatisfaction with the effectiveness of the service on the wellbeing of the patients because they wanted to see further evidence of impact.
11% of respondents thought this question was not applicable to them (1 GP, 1 Receptionist and 1 Nurse).

95% of respondents think the service is effective at providing a referral route to non-medical services that can support patients. 2.5% of respondents thought it was not that effective and 2.5% did not answer the question.

84% of respondents think the Community Navigation service is effective at improving the surgeries' links to other resources and services in the community. 13% felt the service had had little effect and 3% answered 'non applicable'.

68% of respondents think the Community Navigation service is effective at reducing the amount of time patients attend the surgery with non-medical matters. 19% did not know and 13% felt that Community Navigation had not been effective at reducing patient attendance for non-medical matters.

These perceptions are supported by the evidence in the full evaluation of the pilot, which suggested 84% patients experienced improvements to their health and well-being and 93% say they have access to the right information to help address their issue.

4. What further support is needed?

Respondents were asked whether they needed or wanted further support from the Community Navigation staff team on how the service works, the quarterly referral figures for surgeries and clusters, and whether they would like a Navigators' news bulletin with updates, referral figures and reminders.

37% of respondents said they would like further training regarding how the service works, compared with 47% who said they did not feel they needed it. 16% of respondents did not respond to this question.

69% of respondents said they would like quarterly referral figures for their surgery and cluster and a Community Navigation news bulletin with updates, referral figures and reminders. 21% of respondents did not answer these questions.

Respondents were also asked to comment on other areas of work they would like support on, suggesting:

- Updates on patient progress for those who have been referred for Navigation
- To understand when patients are likely to be discharged from Navigation
- A Community Navigator to attend clinical meetings occasionally to share information
- Training opportunities on Community Navigation for new staff at surgeries

With this in mind, the Community Navigation service intends to change the way it reports on patient progress. In future, monthly reports will be sent directly to GPs and Practice Managers within each surgery including information on which cases are open or closed. Predicting when patients will be discharged is more difficult as this happens on a case by case basis and is subject to change depending on the patient's ability to take next steps. However, if surgeries provide a system for direct communication between GPs and Navigators, this level of detail could be shared when needed.

5. What are the greatest challenges for surgeries hosting the Community Navigation service?

Most respondents felt there were challenges to hosting the Community Navigation service. Key challenges include:

- The limited availability or lack of rooms in surgeries
- Raising the profile of the Community Navigator service amongst surgery staff to ensure regular and appropriate referrals are made
- Integrating the service and the Navigator with the team at surgeries to ensure there are opportunities to communicate with staff regarding patient progress
- Lack of feedback directly to GPs on patients' progress
- Boundaries around the confidentiality of patients in the GP/Community Navigator relationship
- Long term nature of 'learned behaviour' of some patients will take time to change

These challenges are shared between surgery and Community Navigator staff teams. Some solutions have already been identified and as the service continues to develop, further solutions and understanding will be shared.

6. GP surgery Case studies

Two in-depth conversations took place to produce case studies that can demonstrate the impact and value of the Community Navigation service from a GP surgery perspective. These are summarised and shared below.

Sue Angell, Practice Manager, Beaconsfield Medical Centre

Beaconsfield Medical Centre GPs made 30 referrals to their Community Navigator in past 12 months. GPs have made referrals easily are confident in the skills of their Navigator.

The Community Navigator is well integrated with the staff team and regularly speaks with staff on reception, where her in-tray is kept. Whilst the Navigator has few opportunities for face to face contact with GPs, communication happens easily via written notes passed on by receptionists.

Patients who have seen the Navigator gave positive feedback and reported improvements, saying they appreciate the amount of time the Navigator is able to give. Hour long sessions dedicated to supporting them and doing research with them has been very useful in helping them make positive improvements to their health and well-being.

Dr Abigail Fry, GP, Mile Oak Medical Centre

Mile Oak Medical Centre has made 59 referrals to the Community Navigator in the past 12 months. Dr Fry suggests the Community Navigator is helpful with supporting wider non-medical issues that affect patients' well-being and provides a great option for GPs in this regard. For issues arising from loneliness or being stuck at home, Dr Fry finds Navigation has been particularly helpful.

The Community Navigator is rarely able to see GPs face to face due to differing hours of work, but has attended a practice staff meeting to speak with whole practice team and communicates directly with GPs through written notes sent via reception.

Patients report positive outcomes and appreciation of the service, with most showing improvements to their wellbeing and ability to take the next step identified with the Navigator.

Appendix 3 Surgery referral numbers

	Surgery	2014/15			2015/16								
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Module 1	Benfield	7	4	9	4	3	4	1	8	9	10	2	5
	Hove Medical Centre			1	1	1	2	1	4	1	1		2
	Mile Oak			3	9	6	7	2	8	5	8	4	7
	Hangleton Manor										2		
	Module totals -	***7***	***4***	***13***	***14***	***10***	***13***	***4***	***20***	***15***	***21***	***6***	***14***
Module 3	Sackville				2	2	6	1	4	6	9		
	BHWBC	5	4		2			2	2	4	4	2	
	Charter				2	2	6	5		6	4		2
	Module totals -	***5***	***4***	***0***	***6***	***4***	***12***	***8***	***6***	***16***	***17***	***2***	***2***
Module 2	Warmdene				6	3	2	4	2				
	Stanford		3	1	1	3		3	2		5	2	4
	Beaconsfield				1	6	4	4		7	5	1	2
	Brighton Station							2	1				
	Module totals -	***0***	***3***	***1***	***8***	***12***	***6***	***13***	***5***	***7***	***10***	***3***	***6***
Module 4	Boots North Street				2		2	1		1	1	1	1
	Willow House					1	4	2	3	5			3
	St Peter's			1	6	4	6	6		8	4	2	1
	Ardingly				3	1	7	1	3	9	2		4
	Whitehawk					1							
	Module totals -	***0***	***0***	***1***	***11***	***7***	***19***	***10***	***6***	***23***	***7***	***3***	***9***
	Monthly totals -	***12***	***11***	***15***	***39***	***33***	***50***	***35***	***37***	***61***	***55***	***14***	***31***
	Grand total -	***393***											

Appendix 4 Patient follow-up interview questions

1. Do you feel the Navigator listened to and understood your needs?
Comments:

Prompt: On a scale of 1-5, 1 being not at all and 5 being completely listened to
1 2 3 4 5

2. Do you have all the information you need to address the issue you discussed with the Navigator?
Comments:

Prompt: On a scale of 1 – 5, 1 being not at all and 5 being all the information you need
1 2 3 4 5

If 1 or 2, did you have to go back to the GP surgery about the same issue afterwards?
(Yes GP Yes nurse Yes other medical professional No)

3. Did the Navigator only give you contact details e.g. a leaflet about a group, service or activity or contact them on your behalf? (tick below)

Signpost **Facilitated referral**

4. How easy was it for you to access the groups, services or activities?
Prompt: On a scale of 1-5 1 being not at all 5 being completely

1 2 3 4 5 N/A

Name of Group/Service/Activity

i) Were you able to contact the service? (e.g. telephone, make an appointment)
YES/NO Why? Client/Service

ii) Could you get there?
YES/NO Why? Client/Service

iii) Was it what you needed?
YES/NO Why? Client/Service

Name of Group/Service/Activity

iv) Were you able to contact the service? (e.g. telephone, make an appointment)
YES/NO Reason Client/Service

v) Could you get there?
YES/NO Reason Client/Service

vi) Was it what you needed?

YES/NO Reason Client/Service

Name of Group/Service/Activity

vii) Were you able to contact the service? (e.g. telephone, make an appointment)

YES/NO Reason Client/Service

viii) Could you get there?

YES/NO Reason Client/Service

ix) Was it what you needed?

YES/NO Reason Client/Service

5. Has the work you did with the Navigator helped you spend more time with other people?

*Comments***:**

Prompt: On a scale of 1-5, how satisfied are you with the amount of time you spend with other people? 1 being not at all, 5 being completely satisfied?

1 2 3 4 5 N/A

6. Were you able to take the next step you identified with your Navigator?

Comments/ if not why not?

On a scale of 1-5, 1 being not at all. 5 being completely able

1 2 3 4 5

7. How much better did you feel for seeing the Navigator?

Comments:

On a scale of 1-5, 1 being no different at all and 5 being a lot better

1 2 3 4 5

8. Would you recommend your Navigator to friends or family?

Comments:

Yes / No / Maybe

9. Any other comments?

Prompt: Is there anything else you would like some help with?

Appendix 5 Equalities Monitoring of CN Volunteers

Total equalities forms collected: 26

Age range		Gender		Ethnic origin	
18-25	2	Male	7	White – English/Welsh/Scottish/Northern Irish/ British	20
26-35	0	Female	19	Asian or Asian British – Indian	2
36-45	6			Black or Black British – Caribbean	1
46-55	2			Mixed – Other mixed background	1
56-65	4			Prefer not to say	1
66-75	8				
76-85	4				
86+	0				

Sexual orientation		Religion/belief		Limited by health / disability		Type of impairment	
Heterosexual/ Straight	19	No particular religion	10	Yes a little	5	Physical	4
Lesbian/ Gay woman	1	Christian	10	No	21	Long-standing illness	3
Bisexual	2	Hindu	2			Sensory	1
Prefer not to say	1	Buddhist	1			Learning disability	1
		Agnostic	1			Mental health condition	1
		Atheist	1			Developmental condition	1
		Other	1				

Carer		Care for	
Yes	2	Partner/ spouse	1
No	22	Other	1
Prefer not to say	1		

Appendix 6 Community Navigator volunteers survey results

Community Navigator volunteers were asked to complete a survey to describe their experience of being a Navigator. We asked volunteers to comment on and scale each question in relation to how satisfied they were 1-5 (1 being not at all 5 being very).
We received responses from all 11 experienced Navigators (The 5 other Navigators were too new to the role to offer a response).

A range of questions were asked regarding training, support, how satisfied they are with the role, what aspects of the role they find most challenging and how satisfied they are with the procedures used within the service.

Summary of key findings

1. Volunteer Community Navigators are highly skilled individuals and have a great wealth of experience and skill to offer the role. Most have worked or are currently working in a related profession, e.g. healthcare, teaching, social services or counselling
2. Volunteers feel well trained and supported to carry out their role effectively and value the experience and opportunity it brings them.
3. Navigators want to feel part of GP surgery teams and need to have direct follow up contact with GPs regarding cases
4. Community Navigation is an effective volunteer opportunity to support people into employment or change to a health related career.
5. Navigators value further opportunities for training on key issues affecting patients (for example mental health, housing)

Community Navigation Training

Navigators thought the training was very helpful in preparing them for the role and overall scaled it as 4/5. Navigators said they found the training thorough, fun and interesting and highlighted the need for further training on particular issues such as housing, mental health, and supporting clients with multiple chronic illnesses. A programme of guest speakers has been organised to give talks at team meetings over the coming months.

Support from the Community Navigators team

All Navigators find the news bulletin and team meetings very helpful. The individual telephone support is also highlighted as very helpful, as are individual review meetings. Navigators feel they have the right support to discuss challenging cases if they need to. Volunteers said the staff team responds quickly and with thoughtful practical answers to any concerns they have. Navigators feel well supported by the staff team.

Satisfaction with the role of Community Navigator

Most Navigators are very satisfied with the relationships they have built with their clients. Witnessing clients improve their situation and take up a group, service or activity is a particularly rewarding aspect of the work. One Navigator was dissatisfied with her role due to the lack of referrals she had from her surgery and as she was not able to see many patients, did not see much patient improvement.
Navigators were confident in making appropriate referrals and all Navigators feel very much part of the Community Navigators team.
There was a range of responses to being part of the GP surgery team. Navigators have mixed experiences depending on which surgery they work in. All of the Navigators except one felt they were in some way part of the GP Surgery, though some have more effective relationships with GPs and staff members than others.

There is some confusion about how best to contact GPs directly for follow up contact about particular cases. GPs are available and easy to approach in some surgeries but not in others.
The Navigator who did not feel they were part of their surgery found this aspect of the role dissatisfying and did not feel like surgery staff necessarily understood why they were there.

What are the challenging aspects of the role?

Navigators have a very mixed experience of what the challenging aspects of the role are. Generally Navigators are warmly received by surgery staff, although in some cases staff are unclear on the role of the Navigator and are slow to refer patients, which Navigators find frustrating. Navigators find making appropriate referrals straightforward and feel able to hear difficult and upsetting disclosures. 45% of Navigators found the short term nature of Navigation challenging and one Navigator commented they would like longer term timescales for some patients who needed more support.

Satisfaction with the systems of Navigation

All Navigators are satisfied with the referral and appointment systems used. Client record sheets have been altered in response to surgery and Navigator feedback and overall Navigators find the newest forms easiest to use. Navigators have been able to meet the monthly recording deadline, although at times this has been challenging for some owing to a range of personal circumstances and time constraints. Navigators feel very able to do their own research on groups, services, or activities.

What do Navigators gain from the work?

Navigators gain a wide range of skills and experiences from Navigation. Navigators are highly skilled individuals, most of whom have worked or are currently working in a related profession, e.g. healthcare, teaching, social services or counselling. They enjoy using their skills in a role that works directly with patients and feel they are making a difference in people's lives.
Navigators feel more connected to their community and the people within it they would not have otherwise met (e.g. isolated older people, newly arrived people with English as a second language).
Volunteers value being part of a team, within surgeries and as part of the Community Navigator team. Sharing experiences, ideas and knowledge with other Navigators has also been a valuable aspect of the work.
The role of Community Navigator has been particularly helpful for people looking to enhance their CV's. Three Navigators have been offered work in similar fields since being a Community Navigator, which suggests Community Navigation is a skilled role that is recognised within the job market.

"I feel like I am making a difference. I have gained confidence in an area I've always felt a leaning towards (social work/counselling/public health) and I also feel more connected with people in my community whom I otherwise wouldn't meet; isolated elderly people, newly arrived non-English-speakers etc."

"I have personally gained a great deal from being a Community Navigator; personal satisfaction, becoming even more aware of problems in society, networking, gaining knowledge of the NHS, charities and services in Brighton and Hove. Feeling useful in old age!"

"I think the project works well because it is short-term and solution-focused. This helps clients become empowered rather than dependent and also means there's an end in sight for the Navigator"

"I have enjoyed the relationships I have had with clients, though many have been challenging at times, I feel privileged to have shared their journey. Whilst not all service users were able to engage, I have seen positive improvements in the lives of others. I have enjoyed getting to know the team at the office and found it invaluable sharing ideas, knowledge and experience with the team of volunteers."

Appendix 7 Patient Case studies

The following case studies show examples of what Community Navigation offers and the impact this has for patients. Names have been changed.

Rita is 55, is housebound and isolated following an accident and has problems with welfare benefits and debts piling up. The Navigator applied for a grant from the Brighton District Nursing Association Trust and Rita now has a mobility scooter. The scooter has enabled her to attend the surgery, which has reduced the need for home visits from GP and nursing staff. She was also supported to apply for a Winter Warmth Grant to help with heating costs and was referred to Age UK to help apply for personal independence payments (PIP).
"Thank you so, so much, I can't believe it. You're like my guardian angel; you've got so much done!"

Eva is 84, struggling with mobility and becoming increasingly isolated. The Navigator makes a home visit, listens to the clients concerns and identifies a range of services and activities she may be interested in. After a second home visit giving further information, Eva expresses nervousness at going to a lunch club on her own for the first time, so the Navigator arranges to take her along. For the third session, the Navigator attends the lunch club, Eva enjoys it and says she would like to go again. The Navigator arranges transport to enable her to attend on her own and Eva now goes to the lunch club once a week. On contacting her for a follow-up phone call, Eva says she feels much better, is less isolated, is spending more time with other people and making new friends. She remarks "I have met so many people and they are all so kind".

Sarah is 45 and was referred to the Community Navigator with low to moderate Mental Health issues. After discussing her situation and needs, the Navigator referred her to the Southdown's Recovery Programme and signposted to Threshold and the Women's Centre drop-in. Over the course of six sessions the Navigator observed Sarah being more able to cope with her situation. Sarah said "I don't know how to thank you ... it's made such a difference. I feel good about Southdowns and think it will work."

Margaret is 53 and suffers with fibromyalgia with few pain relief options remaining. She receives Disability Living Allowance and is fearful of this being reviewed in case the amount is reduced. She struggles to shop and cook, feeling guilty she is not doing enough for her family. The Navigator contacted the Carer's Centre on her behalf as well as Age UK IAG for information about home help and The Fed for disability benefits advocacy. Margaret said "I wondered how you could help. I didn't realise there was so much out there."

Sheena is 32 and lives in a damp flat with her baby who suffers with allergies. She is isolated, struggles to navigate official systems and needs an interpreter. With an interpreter present, a referral is made to Brighton Housing Trust. She was also referred to an Arabic coffee morning for social support and now attends regularly.

Bob is 61, recently retired and has moved back to the UK after several years of living abroad.
He was lonely, isolated and feeling very low when he first saw the Navigator. The Navigator worked with him to identify his interests and he now regularly attends social groups and activities at The Hop 50+ Centre. He is also considering volunteering and has been referred to the Volunteer Centre.

Fred is 72, caring for his wife and feeling overwhelmed. The Navigator contacted the Carers Centre who helped him create an action plan. Fred is now accessing more support for himself and his wife. He says "Thank you so much, you've opened the door to things"

References

[1] http://epic-pmchallengefund.uk/
[2] http://www.bh-impetus.org/projects/community-navigators/
[3] Department of Health (2012). Caring for our future: reforming care and support https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf
[4] NHS England (2014). NHS Five Year Forward View. London; NHS England https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[5] Public Health England (2015). A guide to community-centred approaches for health and wellbeing. London; PHE https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402889/A_guide_to_community-centred_approaches_for_health_and_wellbeing__briefi___.pdf
[6] Friedli, L. and Watson, S. (2004). Social prescribing for mental health. Durham: Northern Centre for Mental Health. http://www.centreforwelfarereform.org/uploads/attachment/339/social-prescribing-for-mental-health.pdf
[7] Langford, Baeck & Hampson (2013). More than Medicine: New Services for People Powered Health. NESTA http://www.nesta.org.uk/sites/default/files/more_than_medicine.pdf
[8] http://www.raise-networks.org.uk/wp-content/uploads/Social-Prescribing-briefing-paper.pdf
[9] (2015). JSEC Briefing on the approach and findings from the matched cohort evaluation of the age UK Living Well programme. http://knowledgebucket.org/new-interactive-poster/
[10] Centre for Regional Economic and Social Research (2014). The Social and Economic Impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report. Centre for Regional Economic and Social Research, Sheffield Hallam University. https://www.shu.ac.uk/research/cresr/social-and-economic-impact-rotherham-social-prescribing-pilot-main-evaluation-report-pdf-109-mb
[11] Bristol (2014) Measuring the Economic Impact of Wellspring Healthy Living Centre's Social Prescribing Wellbeing Programme, Bristol Clinical Commissioning Group, https://www.bristol.gov.uk/committee/2013/ot/ot049/1128_7.pdf
[12] Age Concern Yorkshire & Humber http://www.ageconcernyorkshireandhumber.org.uk/uploads/files/Social%20Prescribing%20Report%20new.pdf
[13] Dumfries and Galloway (2015) http://www.nhsdg.scot.nhs.uk/Departments_and_Services/Putting_You_First/PYF_Files/Social_Prescribing.pdf
[14] Southwark (2015) 'Community Action Southwark Briefing: Social Prescribing 2015', Southwark Council, http://casouthwark.org.uk/sites/default/files/images/Social%20Prescribing%20-%20CAS%20Briefing_0.pdf
[15] Rugby, http://www.slideshare.net/mobile/AlisonOrr1/midterm-evaluation-of-rugbys-social-prescribing-pilot-50303785
[16] Friedli, L (2012) 'Evaluation of Dundee Equally Well Sources of Support: Social Prescribing in Maryfield' Evaluation Report 4, http://www.dundeepartnership.co.uk/sites/default/files/Social%20prescribing%20evaluation%20report.pdf
[17] Wilson, P & Booth A (2015). Evidence to Inform the Commissioning of Social Prescribing. Centre for Reviews and Dissemination, The University of York. https://www.york.ac.uk/media/crd/Ev%20briefing_social_prescribing.pdf
[18] http://www.brighton-hove.gov.uk/content/health/mental-health-and-wellbeing/our-mental-health-and-wellbeing-strategy
[19] Royal College of General Practitioners (2014). An inquiry into patient centred care in the 21st century; RCGP http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx
[20] University of Kent (2014) Unit Cost of Health and Social Care 2014. PSSRU https://www.gov.uk/government/publications/unit-costs-of-health-and-social-care--2