Independent evaluation of Care Navigators on the Isle of Wight

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Disclaimer
This report presents the findings of an independent evaluation of the Isle of Wight Care Navigator Team. The findings of this independent evaluation are those of the author and do not necessarily represent the views of the Care Navigator team.

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Executive Summary

The Care Navigator (CN) service is an integral part of the Isle of Wight’s (IW) My Life a Full Life system transformation. Age UK led its introduction, based upon similar models elsewhere. The first three CNs were recruited in 2014/15 and two subsequent waves of recruitment have taken the team to 9 whole time equivalent posts, with leadership and administration support. The service was funded using non-recurrent lottery and vanguard funding – and is now a commissioned recurrent service.

The service provides time limited support to those aged over 50. It works with large numbers of people, with an average of 130 referrals a month. The CNs are aligned to the 16 general practices across the Island, and the majority of referrals come from GPs (70%), with 13% coming from the voluntary sector and 9% as self referrals. CNs take time with each person referred to undertake a holistic assessment and develop a plan. Up to 6 visits/meetings are provided for each person and the CNs are able to help each person connect with up to 100 services across the Island.

R-Outcomes were recorded by 238 people being supported by the CN service to evaluate whether they reported an improvement. Significant improvements were recorded in all four measures – health status, health confidence, personal wellbeing and experience. Some of the largest reported improvements were for - being limited in what I can do; requiring help from others; being able to get the right help; my life is worthwhile; the service listens and explains; and sees me promptly. Compared with a Wessex social prescribing reference group, there is evidence that the people supported by this CN service are older, take more medications and have higher need. Their scores at referral are lower but achieve similar levels of improvement. Staff R-Outcomes were also collected twice and were very positive – with maximum scores for believing their job is worthwhile and that they listen and explain.

A comprehensive qualitative evaluation included four components – staff interviews; person interviews; case studies and a survey of staff that engage with the CNs. These findings were brought together into a single synthesis to identify the active ingredients, influential factors and impacts. It found good evidence of a positive impact on the people supported, staff and the system. For the people it found that it improved their confidence to self manage, make healthy lifestyle choices, improve safety in their home, reduce social isolation and improve their quality of life. For staff, the CNs are helping connect and join up services and help reduce the workload in general practice while giving them improved knowledge of their patients. For the system it is improving the knowledge and integration of health, care and voluntary services.

Reducing the use of health and social care services is one of the planned outcomes of the CN service. It was the intention of this evaluation to analyse this by comparing people’s use of health and care services in the period before, and after, they were referred to the CN service. If activity changes and trends were evident, these would be used in an economic model to identify potential system financial savings and to calculate potential returns on investment for a number of scenarios. Unfortunately this has not been possible for two reasons. The first was that information governance support could not be obtained for analysing social care and general practice activity. The second was that following a decision to bring forward the timescales for this evaluation, it was decided to try to get retrospective consent from previous patients to analyse their secondary care activity usage. Despite the CNs attempting to contact 378 people, just 49 gave their consent – and this wasn’t a big enough sample. The evaluation team recommends that the service commence proactive consent now, and that the analysis is repeated in the spring.

Information on the cost of the service was not provided at the time of writing.

The report provides a set of active ingredients identified by the CN team and from the range of good qualitative evidence of improved care. These cover the things that CNs do that work and what is required from the health and care system.
1. **The Care Navigator service**

The Isle of Wight (IW) Care Navigation (CN) service is a key part of the programme to deliver the *My Life a Full Life* model of care and shares its 4 key aims:

- Preventing people from becoming ill – access to information, advice and support; take control and manage own health more easily
- Collaboration across services and with people
- Making sure people can get the right support, at the right time and place from the most appropriate service – across the Island
- Changing the way we provide better quality of care, with the money and people we have available

The CN service was developed as a different way of working with and utilising the voluntary and community sectors, to build capacity in stretched services and support the Island’s new model of care and system redesign, as well as contribute towards cost savings. Age UK has played a leading role in its development and operation and the model is based upon similar Age UK models elsewhere.

The CN service began in 2014/15 with the appointment of 3.5 FTE Care Navigators in the North East Locality. In 2015/16 lottery funding enabled a further 3 FTE CNs to be appointed to provide Island wide coverage. In 2016/17 a further 3 FTE were appointed using vanguard funds to provide a CN for every one or two practices, a team leader, locality lead roles and administration support. This team supported 1,900 older people that year (2.7% of people aged 50 and over). In 2017 the statutory funding for this service was mainstreamed and no longer resourced using Vanguard transformation funding.

CNs work with the statutory and voluntary sector to provide the following service:

- Available Monday to Friday 9-5
- 9 FTE CNs based in three localities in 16 GP surgeries
- Offer time limited support to people aged 50 and over and their carers (average age 80.5 years)
- Work with people for up to 6 visits (typically ranging from 6 to 18 weeks)
- The people they work with often have complex physical and/or mental health needs and/or are isolated. 25% are in their last year of life. 30% have a lack of mental capacity usually due to dementia
- CNs support people to ‘navigate’ their way around health, social care and voluntary sector services. They provide information, coordinate care, reduce social isolation and improve planned take up of services
- CNs make onward referrals to over 100 services across the Island

The CNs come from a wide range of backgrounds including social work, healthcare, housing, information and advice. They work as a multidisciplinary team that supports each other through peer review and joint working. To date, when these roles have been advertised there have been between 10 and 15 applicants per post.

Referrals are mostly from GPs (70%) but can come from any health or social care professional in any sector (the voluntary sector is next largest source at 13% or referrals). Self referrals are also accepted via Age UK, (they are checked with the person’s GP) and these account for 9% of all referrals.
Referrals are made using a CN referral form, usually electronically. The CN will then undertake a home visit to undertake a holistic assessment of need covering the following 6 areas:

- Looking after myself
- Keeping safe
- Managing my home
- Meeting people and doing things
- Managing money
- General confidence

The assessment is undertaken as part of a conversation and if necessary can take more than one visit to complete. The CN is led by the person’s priorities and the resulting plan is left with them so they can share it with family, friends and other professionals. The CN will make the necessary onward referrals to appropriate services on behalf of the person and arrange to visit again to support clients with their progress. Up to 6 visits are provided.

The CN service is an important part of a wider Ageing Better Programme that has set the following outcomes:

<table>
<thead>
<tr>
<th>Ageing Better Programme outcomes</th>
<th>Care Navigator outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people will feel they have improved connections within their local community and reduced social isolation.</td>
<td>The extent of improved local connections will be shown through social networking model. Older people will report greater community involvement in their lives. There will be a reduction in the number of older people stating that they feel socially isolated. Number of older people involved in activities.</td>
</tr>
<tr>
<td>Older people will feel the Island is age-friendly; those under 50 years old will see older people as an asset, recognising their contribution to the community.</td>
<td>Older residents and visitors to the Island will state they feel supported to live well. Older people will state that services met their needs.</td>
</tr>
<tr>
<td>Older people will feel an increased sense of health, wellbeing and quality of life.</td>
<td>There will be an increase in the number of older people feeling/reporting an increased sense of health, wellbeing and quality of life. Older people will report an increase in their level of activity both physical and social. A reduction in the use of health and social care services by older people engaged in Ageing Better projects contributing to overall cost management of services.</td>
</tr>
</tbody>
</table>
The following charts give information on the number of referrals, caseloads, referral source and demography.

Between April 2016 and August 2017, the service has received a total of **2,161 referrals**. These charts show referrals by month, cumulatively and by locality.

Data on **caseload** has been collected since April 2017. The average caseload for a CN is 41 and for the team 367.

71% of **referrals are from** primary care; 13% from the voluntary sector and 9% are self referrals.

Most people supported by the service are aged over 80.
2. Self reported outcomes

2.1 R-Outcomes

Information was collected for this review using the R-outcomes measures. These are a set of validated short generic self reported outcome measures (PROMs) being used by Wessex AHSN as a way to evaluate innovations and new services. This review used four of the R-outcomes measures:

**HowRu – Health Status**
People record how they feel physically and mentally and how much they can do in terms of loss of function and independence. It asks how are you today? – meaning the past 24 hours. It has been validated against other measures including SF12 and EQ-5D.

**Health Confidence Score**
This score monitors people’s confidence in their ability to manage their own health and engage with health care providers. The first two questions address personal capability, while the second pair are informed by provider engagement. This measure is closely associated with the concepts of empowerment, perceived self efficacy, activation and engagement.

**Personal Wellbeing**
This is a short generic measure of happiness or subjective wellbeing and is closely based on the Office of National Statistics personal wellbeing questions used in the Annual Population Survey.

**HowRwe – Patient experience**
This is a person reported experience measure of patients’ perception of their care. It includes both relational aspects of experience, such as kindness and communication, and functional aspects such as promptness and organisation.
2.2 People reported outcomes

The CNs supported 117 people to record their R-Outcomes when the service first made contact with them and 121 people once they had been supported by a CN. This enables a comparison to be made of these two cohorts.

Demography

The following charts describe the demography of the people that recorded their R-Outcomes. It shows that the majority of people in the service are aged over 80 and that most were taking between 3 and 5 medications.

Outcomes

All of the results show mean scores on a 0-100 scale. If all respondents choose the best response, the score is 100. If they choose the worst, the score is 0. What we are looking for is evidence of an improvement in reported scores from the two cohorts and whether those improvements are statistically significant. The results are set out in the following four charts. The yellow bars represent how people scored themselves when the service first made contact with them, and the green bars show how people scored themselves once they have been supported by a CN. The lines at the end of each bar signify the confidence intervals for each score – where the lines do not overall, the observed change is statistically significant. P values have also been calculated – where values are less than 0.05 the change is considered to be statistically significant.
Health status

People record statistically significant improvements in being limited by what they can do and requiring help from others.

Health confidence

People record statistically significant improvements in knowing enough about their health; being able to look after themselves and being able to get the right help if they need it. However, surprisingly they don’t record an improvement in being involved in decisions about themselves.

Personal wellbeing

People record statistically significant improvements in their long term personal wellbeing – life satisfaction and life is worthwhile. On the short term measures they record themselves as being happier but not less anxious.

Experience

People record statistically significant improvements in being treated kindly; listened to and explained; being seen promptly and the care they receive being well organised. They record less improvement in having to repeat their story and the degree to which services talk to each other.
Comparison with Wessex

Wessex AHSN has evaluated eight different services providing social prescribing in Wessex (including the IW CNs) and all of them have collected R-Outcomes from the people they support. The following chart compares the results on the IW with the scores for Wessex.

The people recording their outcomes on the Island are older and take more medications than the Wessex social prescribing group. The people supported by the IW CN service record lower outcomes for all four measures with the Wessex benchmark group, which could mean that they have greater or more complex need when referred to the service. The improvement following the support from the CN’s are similar to the benchmark group.

2.3 Staff reported outcomes

Staff reported outcomes have also been collected from the 17 people that work in the CN service, over two periods, in February and August 2017. The outcomes are very positive. Scores over 80 represent good reported outcomes, and the CN team report high scores for 18 of 20 questions. Slightly lower scores were given for being involved in decisions (78) and being aware of other relevant services (76). Maximum (100) scores were given for their job being worthwhile and treating people kindly.
2.4 Conclusions

The R-Outcomes measures provide good evidence of significant improvement being reported by the people who are supported by the CNs across all four measures. There is some comparative evidence that the people supported by the IW CN service have higher or more complex needs than the Wessex Social Prescribing benchmark group. The improvements to outcomes reported by people are of a similar level to this group.

The next section presents the synthesis of a range of qualitative evaluation methods and triangulates these with these R-Outcomes findings.
3. Synthesised qualitative findings

3.1 Overview of the synthesis

Evidence from four qualitative method components have been brought together into this single synthesised qualitative set of findings. The four components are:

i) Staff interviews – these sought to understand the development, implementation, barriers, facilitators, and gather perceptions of impact on patients, staff, general practice and the wider system.

ii) Person interviews – these sought to understand people’s general experience of receiving care navigation support.

iii) Case studies provided by staff – these sought to collect in-depth stories to compliment other qualitative and quantitative data collected.

iv) Staff survey – this sought to gather views of the service from other professionals who engage with care navigators on a regular basis.

Whilst the aims and methods were slightly different in each element, they all contribute to answering an overarching evaluation question: \textit{What are the processes and contextual requirements to allow a feasible and impactful care navigation service?}

To address this question, it was important to examine the overlap between themes from each of the 4 components. An understanding of the processes and contextual factors revealed by this analysis has also helped to determine active ingredients of the care navigation role. Factors were considered active ingredients if they were discussed as important and in the context of a described impact. Once active ingredients had been identified it was possible to present these as potential precursors of the suite of impacts identified. The approach taken by each qualitative component and to constructing this synthesis is described in Appendix 1.

\textbf{Figure 1} provides a graphical representation of the qualitative synthesis describing three categories of active ingredients of the CN service and the factors that influence them; the impacts they have on people, staff and the system. The three categories of active ingredients are:

1) Organisational capacity to support care navigation
2) The approach taken to providing care navigation
3) The processes that underpin care navigation

The remainder of this section provides more details on the findings in Figure 1.
Figure 1: The work of care navigation: A framework of active ingredients, influential factors and impacts

Active ingredients category 1: ORGANISATIONAL CAPACITY
- Essential preparatory work for new staff
- Broad skill mix of team vital
- Physically integrated position within a GP practice
- Processes integrated within a GP practice
- Ongoing training provided

Active ingredients category 2: APPROACH TO CARE
- Willingness to engage with, and be proficient with, the 90-91% of further referral destinations
- Up for a challenge attitude
- Ability to work in a pre-crisis role
- Ability to work in a post-crisis role
- Person centred approach
- Flexible working approach
- Willingness to sustain positive relationships with health professionals

Active ingredients category 3: PROCESSES OF CARE NAVIGATION
- Good organisational skills to manage referrals at different points of action
- High level of IT competency to manage paperwork
- Willingness to work in an independent manner
- Collaborative working approach
- Prevention approach
- Persistent nature to engage/encourage those who have serious problems but unwilling to engage with options offered

CARE NAVIGATION INTERVENTION
- Quick response to patient needs
- Providing patients with the tools to self-manage
- Managing the fine line between dependency & self-management
- Working with new referral processes
- Provide tailored help that’s right for patients at the time it is needed
- Good coordination with other teams vital

Barriers/disruptive factors:
- Willingness of patient to engage
- Excessive expectations of people
- Poor working with other organisations
- Fluctuations in referral levels
- High level of evaluation requirements on care navigator team
- Re-referrals / ongoing caseload to manage
- Short term contracting of CN role is stressful for CNs
- Balancing (triage) priorities between dealing with new referrals and ongoing cases

PERSON / CARER IMPACTS
- Improved patient confidence
- Patients not falling between the cracks of existing services
- Better awareness of benefit of services available (health/social services/voluntary sector)
- Improved healthy lifestyle for those they support
- Improved safety in the home
- Reduction in social isolation
- Families and carers felt listened to during difficult times
- Quality of life improved

R-Outcomes – improved health status; health confidence; personal wellbeing and experience

PRACTICE/STAFF IMPACTS
- Practice staff have an option for residents who frequently, and sometime inappropriately, access services
- GP surgeries have an option to refer residents whose problems fall between the cracks of existing services
- Care navigators are forging new working relationships with other healthcare staff
- Care navigators reported they are frequently joining up services for residents, acting as link-points and organisers of a broad holistic tailored plan for residents.
- CNs provide live feedback to the GP surgeries and enhance residents’ records
- GP visits avoided

WIDER SYSTEM IMPACTS
- Increasing health professionals’ awareness of available voluntary/community services
- District nurses visits avoided
- Avoided unplanned demand on hospital services
- Support the system when a resident has been erroneously discharged too early/in a fragile state

R-O’s – work wellbeing and job confidence high.

R-O’s – service integration.
3.2 Further context on people supported by care navigation

The 11 case studies described a wide range of people and situations. They demonstrate a number of complex situations, often discovered after a simple reason for referral, and cover physical, mental and social concerns that involved not just the one person, but their families and communities too.

The survey of other health professionals identified the people they believe benefitted the most from care navigation. These were people with complex needs; for example, some had social and psychological needs, learning disabilities, were frail, had a low education level, were older, socially isolated, and those whose needs did not meet local authority criteria and meant they fell between NHS and social care services. People least likely to benefit from care navigation were younger, self-managing people with good access to family/friends support.

3.3 Overall perceptions of care navigation

A range of overall support for the care navigator role was apparent across all 4 qualitative components. People, care navigation staff and staff associated with the role strongly supported the role. This was demonstrated by these views:

“I wouldn’t be here today if it wasn’t for the care navigator” (Person interview)

“We provide a tailored and intensive intervention for those who have a range of complex needs. Our ability to signpost patients to part of the system helps them make the best use of their time and professionals’ time. Much of the strength of our role comes from the diversity and dedication of our team, and without our role we’re certain these people would use GP and hospital services more often.” (Staff interview)

The survey highlighted that several agencies rely on care navigation and would struggle or “wouldn’t survive” if the service was withdrawn, e.g. the ‘Safe and Well Agenda’ could not function without care navigators. In the case studies gathered by care navigators, the descriptions demonstrated a genuine empathy for people and emotion about their success made or lack of success.

3.4 First category of active ingredients - organisational capacity to support care navigation

Five individual active ingredients that support the capacity to do care navigation work were identified. These came from the staff interviews and explored the development and set-up issues of the service. Staff felt it was essential to engage in detailed planning work to set up a new role within a GP practice. Types of preparatory work included organising physical space and working practices at GP surgeries, and using shadowing of experienced care navigators to train new staff quickly to meet a rising demand for the service. Interestingly, staff capacity for the care navigation service was phased over a long time period. Those starting in the early days had a harder time and faced more barriers than those starting months/years later. The first group of care navigators undertook a range of work to develop the service and organise the key relationships in general practice.

Two major components of preparatory work stood as separate themes. Care navigators felt it vital to be physically integrated at the GP surgery to be effective in their role. In addition, it was also vital to co-produce integrated processes to manage referrals, action plans, and feedback to practice staff. Importantly, this required access to practice IT systems and training in their processes.

The broad skill mix of the care navigation team was celebrated by staff. This was considered influential in their ability to manage a highly variable caseload. This care navigator described what it meant to them:
“Our team has different background experience, so I’ve got a social care and housing background and help navigators with a health or voluntary background. I’ve helped them help people with things like attendance allowance forms and they tell me about new groups or ideas they’re aware of, it’s really good.” (Staff interview)

Another important and clear message was the importance of ongoing training. They highlighted how all care navigators had attended a wide range of training. For example: training about adult safeguarding, the mental capacity act, dementia awareness, the bereavement process, ‘making every conversation count’, and disability inclusion awareness. These were considered particularly vital to the sustainability of the role.

3.5 Second category of active ingredients – the approach taken to providing care navigation

Thirteen individual active ingredients were considered vital to the approach, or mindset, of care navigation work. Two can be considered very important active ingredients as they appeared in all the qualitative evaluation components. Stakeholders strongly believed care navigation undertook and required a person centred approach to be successful. These quotes described how this was reported:

“The care navigator opened doors I didn’t even know existed.” (Person interview)

“We want to be as patient-centred as possible. We want to help them achieve their goals, not tell them what to do. It’s about tailoring help out there for the person in front of us.” (Staff interview)

“My number one worry was getting out and walking the dog” (Person interview)

The second strongly identified ingredient was about taking a collaborative approach to their work to be successful. This included work with people and their colleagues. The majority of evidence showed close collaboration and appreciation of the role. Colleagues rely on care navigation services and stated they “wouldn’t survive” if the service was withdrawn (survey of professionals). It was identified there were close links with other community roles (e.g. Local Area Coordinators) and with the Integrated Locality Service (ILS).

Undertaking a prevention approach was also strongly reported in the staff interviews, people interviews and survey. It was seen as important and necessary for success to be pro-active in their role and seek out problems and issues once engaged with a person. The other active ingredients related to approach are presented in Figure 1. These are considered vital to the mindset of care navigators in order to reproduce the impacts identified.

“I wouldn’t be here today if it hadn’t been for the CN” (Person interview)

3.6 Third category of active ingredients - vital processes of care navigation

Seven individual active ingredients were considered vital to the day-to-day process of care navigation work. These involved working in a repeated problem solving capacity that often required them to respond quickly to the needs of people who were either in or close to a crisis point. They were often setting up and managing new referral processes with their practice colleagues and coordinating with other teams such as hospital discharge staff, district nurses, local area coordinators, and community navigators. In terms of team processes, they were repeatedly providing people with advice, equipment, and adaptations to their homes, i.e. the tools to self-manage effectively in their own homes. Importantly, help was also required in a timely manner so care navigators were always looking to arrange tailored help at the time it’s needed. An important challenge for navigators was to manage the fine line between dependency and self-management. This was always a tension for care navigators and they sought to empower people to seek solutions for themselves once they were through the crisis period.
3.7 Barriers and disruptive factors for care navigation

The staff interviews reported numerous accounts of people declining support or having to be convinced that issues existed. The willingness of people to engage with the care navigation role was a barrier to its success. It is likely the impacts identified from the care navigation approach may have been better if better engagement was achieved. It’s possible the role was new to many people and they had no frame of reference to judge if it would be worth engaging. Interestingly, some care navigators were told by people the positive credibility of Age UK (who organise the care navigation service) was a deciding factor in deciding to engage.

Another reason for a lack of reported success was the excessive expectations of people being supported. Care navigators reported some people were angry they could not be helped by the care navigators more. It was reported these individuals asked for help beyond the abilities of the care navigators. In particular, assuming care navigators would be around in the long-term and work in a life-coach role, rather than supporting self-management to occur. This demonstrated how the fine line between dependency and self-management was difficult to manage and movement toward the latter may not be achieved.

Issues around referrals were reported as barriers to success. Firstly, the fluctuating level of referrals (overall and by practice) were considered missed opportunities and a proxy for either fluctuating practice disengagement or misunderstandings about the role of the care navigation service. Ultimately, a poor referral situation was a proxy for poor working relationships with practices. Care navigators now have their own caseload and this has grown quickly as the service expanded to full-island coverage. The management of re-referrals was a second referral-related barrier to managing new referrals. Staff reported the situation was often blurred as to whether a person was discharged, active, or re-referred on their caseload. The effect of this being confusion about who to see, when, and in what order. Work to balance priorities across their caseloads was a regular activity. There was also the additional problem of post-discharge worry which might affect decisions, as described by this care navigator:

“I know the patient had been physically discharged but that doesn’t mean they been mentally discharged from the care navigators mind.” (Staff interview)

A final barrier was the pressure of being involved in multiple evaluation activities. The care navigation service was funded by three different sources and this meant significant demand on their time. Care navigators estimated the evaluation requirements represented 20% of care navigation administrative work on a weekly basis. Whilst acknowledging the need for evaluation to determine the effectiveness of the service, it does raise questions about how services should be funded to not add unnecessary burden on staff. It is possible greater impact from the service could have been found from more coordinated evaluation activities.

3.8 Perceived impacts of care navigation on people

A strong finding was an increase in confidence to self-manage. Confidence building was important to address so people access care, socialise and negotiate with organisations, e.g. community activities or social services. One case study highlighted a person already engaged with services but isolated and lacking confidence. After care navigator intervention, the person accepted several new home aids and was more socially involved, stating they “feel brilliant, confident and happy” (Case study); “It has reduced their reliance on the practice helped them be independent with help from the correct agencies” (Staff comment)

Care navigators work to ensure healthy lifestyle choices for those they encounter. As described by this care navigator:

“I had a lady who was eating junk food because she said it was cheaper because she had to spend money to get to the shops to get the food she needed. There were lots of other issues as
well as that but we helped her to get attendance allowance which meant that she had the extra income and could pay for the taxi to get to the shops, which meant that she had a little bit of money from her pension allowance to pay for healthier food. Sometimes we have to go around the houses to get to where we need to be.” (Staff interview)

Care navigators also work to improve safety in the home, as described by this care navigator:

“Checking that people are safe in their homes is a large part of our job now, during our visits we look for potential problems and often refer on to the fire service to judge fire risk and maybe fit smoke detectors. Quite often we get involved in arranging equipment, like hand rails and non-slip bath equipment, things like that.” (Staff interview)

Reducing social isolation was another important reported impact. Many people referred to care navigators are isolated for short-term sudden reasons or have been long-term. In both cases, they lack support to interact with increasingly complex health and social care services. Care navigators represent the bridge between the people and the myriad of options system wide. The breadth of their knowledge was considered a vital reason for this impact. The work to explain how systems/services worked and how to join social groups and clubs was vital. It was reported to lead to better awareness of services available and the avoidance of people falling between the cracks of existing services. “They opened doors I didn’t even know existed.” (person).

Due to the time care navigators have to offer and the person-centred tailored approach of the service, a rise in quality of life was reported by most elements of the qualitative evaluation. Many of the people interviewed expressed great improvements in their quality of life overall. “I wouldn’t be here today if it hadn’t been for the CN” (people interview). The mechanisms for which were as varied as their own situations, for example, better quality of life due to being relieved of money worries, feeling secure in their homes, getting health needs met appropriately, being helped to remain independent and be more resilient to further problems.

Finally, families and carers felt listened to by care navigators. The staff interviews and survey described how family and carers were involved in decisions and felt listened to during difficult times.

“We hear quite often from carers that we listen to them. They don’t often feel listened to, so whether we have been able to make a difference or not, or the situation they’re in not easily changeable, we listen to them and get them through a challenging time.” (Staff interview)

3.9 Perceived impacts of care navigation on staff and practices

An important impact for practices was the increase in options available to them. Care navigators have increasingly become the option for people who sometimes inappropriately engage GP services and for those whose problems fall between the cracks of existing services (e.g. tackling social isolation, having the time to improve self-management).

“The CNs streamline professionals into seamless care.” (Staff interview)

Capacity and willingness to engage in issues such as social isolation are difficult for established practice roles. Many stakeholders reported these issues, for example, “If we had more time we would do some of the things care navigators presently do.” (Survey of professionals)

It was widely reported that GP’s workload had changed as a result of care navigation. Stakeholders stated, for example, “They take a lot of pressure off the GPs” and highlighted “We do not have the time or resource to give them [patients] the help they require.” (Survey of professionals)

Other benefits to practices include helping with practice processes and providing live feedback to GPs to enhance care. Care navigators reported they are frequently joining up services for
people, acting as link-points and organisers of a broad holistic tailored plan for residents. All of which is beneficial to the practice and instrumental in reducing unnecessary practice appointments.

Care navigators do not work in a vacuum; they have developed their own working practices and links with other roles. Care navigators have forged new relationships with established healthcare roles and newer roles (e.g. Local Area Coordinators, Community Navigators). Care navigators have worked with the latter two roles in particular in the West Wight area of the island. They have developed their own multi-disciplinary team and refer to each other if the person’s needs require different support than originally anticipated.

3.10 Perceived impacts of care navigation on the wider system

Stakeholders reported care navigators are directly increasing health professionals’ awareness of available services/voluntary services/local assets in the community. This was seen as beneficial to the wider system and likely to positively affect other health professionals’ activity with people.

Care navigators were reported to often set up and manage new referral processes with their practice colleagues and coordinating with other teams such as hospital discharge staff, district nurses, and community roles. Several care navigators reported this led to reduced activity for district nurses. In addition, a number of people were supported by care navigators, undertaking a coordinating role, when a resident has been erroneously discharged too early/in a fragile state.

The most widely reported impact on the wider system was about avoided unplanned demand on hospital services. This was described in a number of ways, some of which are reported below:

“It took me ages to get through the [patient’s] front door, I phoned him every week for about two months before he said ‘yeah, you can come out’, and when I went out there, we had a lovely little chat and I thought it might be helpful if the GP saw him so I went back to the surgery, and he’d agreed that the GP could go out. This patient’s legs had wounds and were in a bad way. The GP did some blood tests and got the nurse in. The practice staff had gone out of their way to say thank you because that would have become a big problem for the practice and likely the hospital.” (Staff interview)

“We’ve walked in and had to call the crisis team, there have been a lot of those. They [patient] have got in a bad way and couldn’t get to the toilet themselves. Those situations could have got a lot worse if we hadn’t have been scheduled to visit [for the care navigation assessment]. In fact, I’m sure it would as the gentleman had very low blood pressure. Once that was discovered after my visit he was monitored all weekend to get him back on his feet. His chances of having a fall were very high before I went in.” (Staff interview)

“We’re doing a lot of falls assessments, if we see anyone wobbly on their feet we’ll do a falls prevention assessment. We may put in grab rails, a bath support, or raise their toilet which will likely stop them from falling and becoming an admission.” (Staff interview)

“We also ask about medications, it does happen that we find someone with a whole cupboard of out of date medication. We report that back to the GP as it can be dangerous for the patient and may lead to a hospital visit.” (Staff interview)

3.11 Reflections on improvements

The care navigator interviews focused largely on the early days when the service was being set up. They lamented the slow progress of GP engagement and getting embedded in practices. Referrals were slow at the start and much of the work was trial and error. An important lesson
learnt from this being the vital need for careful planning in the area of engagement with the key partner, in this case GPs, as they were in the beginning unsure who and how to refer to care navigators. This was also hampered by slow progress to set up processes to communicate with practices/GPs about people referred to care navigators.

In the people interviews, they reflected on whether six visits were enough to help them. Some asked for more visits as it could take time to develop a trusting relationship with the care navigator. It was, however, acknowledged by care navigators that they work in a flexible and responsive manner, referring people back into the service if more support was needed. Interestingly, some people did not like the name of the service and it put them off it. Some felt the word ‘care’ in the title could refer to ‘going into care’. Also, a few people thought they wouldn’t be old enough to be referred to and supported by staff from Age UK.

The survey of professionals called for care navigators to have a larger ‘list size’, all be full time staff, and support people in the long term (more than 6 visits). They also called for activity to increase public and professional awareness of the service. They also called for improved collaboration with other services, less bureaucracy around confidentiality, access to computers systems in other services to speed up activity, joint funding, co-location and better understanding of the different job roles within the system. In light of these findings, it may be an opportune moment to consider if care navigators could have a greater impact if they were not limited in the number of visits. In addition, better engagement with the general public about the role may also reduce the unwillingness of people to engage identified earlier in the report. Finally, other professionals are more and more linked with care navigation, either referring to or receiving referrals from, and their inter-connectedness should be investigated further to understand the potential benefits and knock-on effects.
4. Activity impact

Reducing the use of health and social care services is one of the planned outcomes of the CN service. It was the intention of this evaluation to analyse this by comparing people’s use of health and care services in the period before, and after, they were referred to the CN service. If activity changes and trends were evident, these would be used in an economic model to identify potential system financial savings and to calculate potential returns on investment for a number of scenarios.

Unfortunately this has not been possible, although a lot of work has been undertaken by the CN team and the evaluation team in an attempt to provide this analysis. Some results have been generated from the available data but we have agreed with the Transformation Team that we will not include this analysis because it is partial and likely to be misleading.

There have been two material constraints to completing this analysis. The first has been the availability of activity information beyond that undertaken in the acute sector. In particular, the island was keen to investigate the impacts of the service on the use of social care and primary care. The evaluation has been unable to include data from either source as explained below.

In respect of social care data, at the time of writing, the AHSN is working with the Isle of Wight Council to determine a method for data sharing and analysis of social care data. It was not possible to conclude the method and agreements prior to the completion of this report.

In respect of primary care data, the AHSN developed a methodology for studying the impact of the CN service on primary care and was reliant on the CN service to undertake the required audits of consenting participants. Information Governance issues prevented the CN services accessing the required data and therefore this analysis was not possible.

The second constraint has been the availability of sufficient data on people’s use of emergency secondary care to generate reliable comparisons of rates of service usage before and after referral. Our usual method is to obtain prospective consent from people to be included in this analysis. This is a reliable way of building large enough cohorts for analysis – though it does take some time for this to grow (typically 3 or 4 months). There was a desire to bring forward the completion of the CN evaluation and so retrospective consent from people that had already been referred to the service was attempted. The CN team reviewed 840 service users as potential study participants and 462 people were discounted (e.g. mental capacity issues or were deceased). The service then attempted to make telephone contact with the remaining 378 people, and of those that answered just 49 gave their consent to be included in the analysis. The CN service has on average 130 new referrals each month – 49 consenting individuals is therefore not considered representative of the thousands of people that have been supported by the service.

When we have used prospective consent to analyse larger groups of people in similar services elsewhere, we have found encouraging evidence of a positive impact on people’s use of emergency secondary care after they have been supported by a CN service. The following table shows the reductions in activity in the 4 months following referral to 4 other services that provide social prescribing in Wessex:
The advantage of prospective collection is that it can continue beyond the initial evaluation period to build a large and continual evidence of impact on activity. For one of these services we have evidence of sustained reductions in activity over a year after referral.

There are two recommendations from the evaluation team about how to progress with a more meaningful activity analysis:

- The first is that the service commences prospective consent for newly referred people to agree that their secondary care activity can be included in this analysis. With around 130 referrals per month, if this started now there would be meaningful activity information in February, which would then improve further over the following months.

- That the discussions with the IoW Council are progressed to try to include use of social care services in this prospective analysis.

<table>
<thead>
<tr>
<th>Service</th>
<th>Service 2</th>
<th>Service 3</th>
<th>Service 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals analysed</td>
<td>1,757</td>
<td>1,500</td>
<td>183</td>
</tr>
<tr>
<td>Change in A&amp;E</td>
<td>-31%</td>
<td>-46%</td>
<td>-50%</td>
</tr>
<tr>
<td>Change in NEL</td>
<td>-32%</td>
<td>-20%</td>
<td>-32%</td>
</tr>
</tbody>
</table>
5. Economic evaluation

The New Care Models evaluation team’s expectations of economic evaluations in 2017/18\(^1\) are that there will be equal attention to documenting and analysing the inputs (resources used) and the outputs (economic impact).

We know that it has not been possible to analyse changes in health and care activity for a large cohort of people that have been supported by the CNs. If this can be done proactively, then it should be possible to use the AHSN’s economic model to estimate a return on investment, in Spring 2018.

Resource and costs of providing the ERS@H service

Funding to the CN service has grown as the scale of the service has developed, but in 2017/2018, the total service funding was £254,000.

The table below provides the total annual funding for the service by year, along with funding source.

<table>
<thead>
<tr>
<th>Year</th>
<th>Funder</th>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>MLAFL</td>
<td>£93,000</td>
<td>£93,000</td>
</tr>
<tr>
<td>2015/16</td>
<td>Ageing Better</td>
<td>£97,000</td>
<td>£213,000</td>
</tr>
<tr>
<td></td>
<td>IoW CCG</td>
<td>£93,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vanguard</td>
<td>£23,000</td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>Ageing Better</td>
<td>£99,000</td>
<td>£285,000</td>
</tr>
<tr>
<td></td>
<td>IoW CCG</td>
<td>£93,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vanguard</td>
<td>£93,000</td>
<td></td>
</tr>
<tr>
<td>2017/18</td>
<td>Ageing Better</td>
<td>£101,000</td>
<td>£254,000</td>
</tr>
<tr>
<td></td>
<td>IoW CCG</td>
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</tr>
<tr>
<td></td>
<td>Vanguard</td>
<td>£23,000</td>
<td></td>
</tr>
</tbody>
</table>

The table below provides a summary of how the staffing for the service is made up, whether a post is a new role, and how the staffing model has evolved with time. Other assumptions include:

- For one whole time equivalent member of staff (WTE), there are 42 working weeks a year after annual leave, training, sickness etc. and one WTE member of staff works 37.5 hours per week
- A 20% uplift of salaries has been included to account for National Insurance, Pension, and on costs to the organization

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\(^1\) New Care Models. The local evaluation of the new care models vanguards: our expectations and offer of support for 2017/18
<table>
<thead>
<tr>
<th>Year</th>
<th>Role title</th>
<th>WTE</th>
<th>Pay scale (exc. Oncosts)</th>
<th>Total Staff costs</th>
<th>% time for care</th>
<th>Hours available for patient care</th>
<th>Number of permanent posts (WTE)</th>
<th>Number (WTE) New Roles</th>
<th>Number (WTE) of posts re-assigned to this team</th>
<th>Number (WTE) of posts backfilled in former teams?</th>
</tr>
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<tbody>
<tr>
<td>2014-15</td>
<td>Care Navigator</td>
<td>3.5</td>
<td>£20,000</td>
<td>£84,000</td>
<td>60%</td>
<td>3307.5</td>
<td>3.5</td>
<td>3.5</td>
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<tr>
<td>Total</td>
<td></td>
<td>3.5</td>
<td>£84,000</td>
<td></td>
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<tr>
<td>2015-16</td>
<td>Care Navigator</td>
<td>6</td>
<td>£20,400</td>
<td>£146,880</td>
<td>60%</td>
<td>5670</td>
<td>6</td>
<td>2.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>6</td>
<td>£146,880</td>
<td></td>
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<tr>
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<td>60%</td>
<td>5670</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care Navigator Team Leader</td>
<td>1</td>
<td>£24,000</td>
<td>£28,800</td>
<td>40%</td>
<td>630</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Care Navigator Locality Leader</td>
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<td>£22,400</td>
<td>£52,800</td>
<td>40%</td>
<td>1260</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
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<tr>
<td>Total</td>
<td></td>
<td>9</td>
<td>£228,480</td>
<td></td>
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<td>9</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2017-18</td>
<td>Care Navigator</td>
<td>6</td>
<td>£20,808</td>
<td>£149,818</td>
<td>60%</td>
<td>5670</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
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<tr>
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<td>£29,376</td>
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<td>630</td>
<td>1</td>
<td>0</td>
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</tr>
<tr>
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<td>1260</td>
<td>2</td>
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<tr>
<td>Total</td>
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<td>£233,050</td>
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<td></td>
<td></td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
6. Active ingredients

The synthesis of four qualitative evaluation elements identified many active ingredients that were described as having an effect on the outcomes delivered by the service (Figure 1). Five of the active ingredients were important to support the capacity, thirteen to the approach or mindset of care navigators, and seven considered vital to the day-to-day process of care navigation work. Each of these contributed to the whole picture and suite of impacts identified.

The evaluation team met with the CNs to share and discuss a draft of this evaluation report. They were disappointed that evidence of an impact on the use of other services (e.g. A&E) had not been obtained. However, they recognised the qualitative evidence of the impact that their service provides on people and of how their service is provided. They were asked to distil from this what they thought the ‘active ingredients’ are that make an effective Care Navigator service.

By combining the four elements of qualitative evaluation and care navigators’ views at the share and discuss meeting, a number of important messages can be discerned from the evidence. The care navigation service was dependent upon:

- **Patient centredness**: This was a central and required approach in order to see impact from the role
- **Problem solving and thinking creatively**: The team required and used their ability to problem solve individually and together to create impact. This was often done by drawing on the diverse range of experience in the team
- **Empowerment and training support**: The team were encouraged and empowered to work proactively. This was supported by a wide range of training
- **Transferrable skills**: The team had a wide range of backgrounds, and so had a wide range of transferrable skills. The wide range of backgrounds was facilitated by a job description and person specification that was not overly prescriptive in essential/desirable skills
- **Working across boundaries**: The team demonstrated they had the ability to work across services and sectors, and the ability not to be limited by traditional boundaries and roles
- **Proactive staff**: It was clear that the staff with the right attitude was important; welcoming staff; can do attitude; an openness to any new situation; common sense; and the ability to generate a sense of team spirit and resilience
- **Support of the GP practices**: It was vital to develop relationships and processes at the host practices. When this was absent or not working well, the ability to have a scalable impact was reduced
- **Coordinating support**: An important part of the success the care navigation role was identifying and coordinating the support each individual needs. This support was given in a number of ways and recognised as important by a range of staff and people involved in the evaluation. Sometimes the work of coordinating support could require additional capacity either for existing roles or new roles to deliver it. However, based on the impacts identified, the coordination work of care navigators can was a good example of “invest to save.”
7. Conclusions

Conclusions drawn from this report need to be considered as interim until the quantitative analysis of impact on activity and an economic evaluation have been completed. Nevertheless, from the synthesis of the qualitative data that has undertaken it is possible to draw the following conclusions:

- Overall, care navigation was well received and positively discussed. A range of people, staff, practice, and wider system impacts were identified. These have been themed for the purpose of this report but were numerous and detailed.

- Across the different qualitative data sources, a range of active ingredients, influential factors and impacts were uncovered. These all contributed to understanding what care navigation involved and how they had the impacts identified. Each of the active ingredients in Figure 1 should be considered vital to maintaining the impacts identified. Changes in the active ingredients would likely change the impacts in Figure 1.

- There were a number of important capacity issues, in order to undertake care navigation. Essential planning work, a broad team skill mix, physical integration in general practice and its processes, and ongoing training were considered vital.

- A wide range of active ingredients were vital in the approach, or mindset, of care navigators. In particular, several were reported in all qualitative elements; those being, undertaking a person centred approach, and undertaking a collaborative approach with people and colleagues.

- A number of processes were vital to enact care navigation on a day-to-day basis. Without attention to these, it would likely mean time and energy taken to set up care navigation would be meaningless. These active ingredients represent care navigators’ efforts to translate their various approaches into practice.

- A number of disruptive factors were identified. The hardest to improve may be the engagement of people who may benefit from the service. Continued promotion of the role in general practice and the voluntary sector may support the general public’s understanding of how care navigators can support them to self-manage.

- An emerging challenge of care navigation is managing the increasing caseload. General practice and others are relying more and more on care navigation to support people’s needs that fall outside traditional activity of health professionals. There is also a need for each care navigator to formalise their decision making about who to see and why. Some care navigators were often physically discharging people but not mentally discharging them from their own mind. This created tension and a burden to their workload.

- Important impacts for people were increased confidence to self-manage, better lifestyle choices, reduced isolation, and better safety in the home. Generally, people’s quality of life was reported as much better as a result of the care navigation intervention.

- Important impacts for staff, practices and the wider system were more options for general practice, better general practice awareness of voluntary sector services, the coordination ‘bridging’ role of care navigators, and avoidance of unnecessary GP, district nurse, and hospital visits.

- An important unintended positive outcome was the development of new working practices with other community roles, in particular, new roles such as Community Navigators and Local Area Coordinators. How these new roles work together and their combined value would be one area of future work.
Conclusions can also be drawn about the contribution that the CN service is making on the four key programme aims for My Life a Full Life:

i) Prevention of people from becoming ill – access to information, advice and support; take control and manage own health more easily.

There is good evidence that the CN service is meeting this aim. People reported statistically significant improved R-OUTcomes for their health status, wellbeing and confidence to look after their own health. The qualitative evaluation found that prevention was a vital active ingredient, with patients reporting a positive impact of healthier lifestyles and a greater awareness of services available.

ii) Collaboration of service and people

There is good evidence that the CN service is meeting this aim. People reported improved R-OUTcomes for not having to repeat their story and services talking to each other; and the CNs reported feeling empowered to work across boundaries and always considering other services when planning. The qualitative evaluation found collaboration was strongly reported – an active ingredient identified in all four evaluation components.

iii) Making sure people can get the right support, at the right time and place from the most appropriate service – across the Island.

There is good evidence that the CN service is meeting this aim. People reported statistically significant improved R-OUTcomes for being able to look after their own health and feeling that they can get the right help if they need it. The qualitative evaluation found that a person centred approach was strongly reported - an active ingredient in all four evaluation components. If the recommended quantitative activity analysis is undertaken, this could provide further evidence of changes in the pattern of care.

iv) Changing the way we provide better quality care, with the money and people we have available.

It hasn’t been possible to draw conclusions on whether this aim is being met by the CN service – and further quantitative activity analysis has been recommended. The qualitative evaluation has provided evidence that better quality care could be being provided with many examples of a greater use of voluntary and community services with clear benefits for the people supported to access them.
Appendix 1 - Qualitative evaluation components and synthesis methodology

Approach to each qualitative component

The staff and people interviews were semi-structured and promoted open-ended responses to allow room for divergence to expand on topics that were not pre-judged to be relevant. Semi-structured interview questions for both were based on the care navigation logic model. Participants were purposively invited to take part and consecutively sampled. Participants consented to interview were audio-recorded so their views could be thematically analysed. An iterative process of thematic analysis was used and recognised the goals of this approach were data saturation and a table of defined and described themes. The people interviews were conducted at one time-point only, were face-to-face or by telephone, and took approximately 30-45mins in duration. Staff interviews were conducted at two time-points and the themes identified synthesised for this report. Staff interviews were conducted in August 2016 (n=9) and January 2017 (n=3). Service user interviews (n=9) were conducted in July 2017.

Case studies were collected (n=11) by care navigators between April and August 2017. These were thematically analysed in the same manner as above. A number of health professionals (n=32) who collaborate with care navigators were invited to complete the survey in August 2017. In total, 24 completed the survey. The survey was hosted online and analyses included summaries of data collected. The data was themed and included in the synthesis presented in this report.

Approach to synthesis

A wide range of themes were identified in each of the 4 qualitative components. These are presented in a table in the Appendix. The relationship of each higher order theme, main theme, and data source is presented as an audit trail. Findings from the R-outcomes, the fifth data source, are synthesised into this table as well for use in the discussion section.

Figure 1 represents the cumulative assessment of the care navigation role. It presents participants’ themes as a synthesised framework of active ingredients, influential factors and impacts. This was undertaken to acknowledge themes could be conceptually different (e.g. a process or an impact) but also link together as a unified narrative. Themes about improvements and lessons learnt are not in the framework, as these views speak more to the future than of what actually happened. However, they are important reflections for the evaluation and reported after the main findings.

Propositions of the framework:

1. Each box and bullet point represents a theme identified in the qualitative analyses.
2. The themes presented could be conceptualised as part of either the vital factors in relation to capacity, approach or process, or were a perceived impact of care navigation.
3. At this point in time, no definitive causal relationships between themes can be claimed. This could be explored as part of a different study using a quantitative design.
4. Themes were considered active ingredients if they were discussed as important and related to an impact.
5. Although certainty about causal relationships is not possible, the themes presented in this framework do represent a series of qualitatively informed hypotheses. Further study could investigate these hypotheses.

6. Each theme is considered of equal weighting and contributes to the whole picture.

7. The impacts identified in the framework are considered to have occurred due to the combined value of all the active ingredients identified. Therefore, the framework proposes an absence of one or more active ingredient would result in a reduction in impact.

8. Some active ingredients may be missing from the framework as they were not/could not be elicited from participants. However, as 4 qualitative methods were used in this evaluation this issue should be minimised.

9. The barriers and lessons learnt identified are considered disruptive factors. Therefore, the removal of these barriers and action to learn from the lessons is considered an opportunity to improve the frequency and depth of identified impacts.
### Synthesised themes identified from qualitative analyses

<table>
<thead>
<tr>
<th>Higher order theme</th>
<th>Theme</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital elements of organisational capacity to support care navigation</td>
<td>Essential preparatory work for new staff</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Broad skill mix of team vital</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Physically integrated position within a GP practice</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Processes integrated within a GP practice</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Ongoing training provided</td>
<td>Staff interviews</td>
</tr>
<tr>
<td>Vital elements of approach to care navigation</td>
<td>Willingness to engage with, and be proficient with, the 90-ish types of further referral destinations</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Good organisational skills to manage referrals at different points of action</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Up for a challenge attitude</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>High level of IT competency to manage paperwork</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Ability to work in a pre-crisis role</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Ability to work in a post-crisis role</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Willingness to work in an independent manner</td>
<td>Staff interviews; R-outcomes</td>
</tr>
<tr>
<td></td>
<td>Person centred approach</td>
<td>Staff interviews; person interviews; case studies; survey; R-outcomes</td>
</tr>
<tr>
<td></td>
<td>Flexible working approach</td>
<td>Staff interviews</td>
</tr>
<tr>
<td></td>
<td>Collaborative approach</td>
<td>Staff interviews; person interviews; case studies; survey; R-outcomes</td>
</tr>
<tr>
<td></td>
<td>Prevention approach</td>
<td>Staff interviews; person interviews; case studies</td>
</tr>
<tr>
<td></td>
<td>Willingness to sustain positive relationships with health professionals</td>
<td>Staff interviews; R-outcomes</td>
</tr>
<tr>
<td></td>
<td>Persistent nature to engage/encourage those who have serious problems but unwilling to engage with options offered</td>
<td>Staff interviews</td>
</tr>
<tr>
<td>Vital processes of care navigation</td>
<td>Quick response to person’s needs</td>
<td>Staff interviews; case studies; R-outcomes</td>
</tr>
<tr>
<td></td>
<td>Engaging in problem solving</td>
<td>Staff interviews; case studies; R-outcomes</td>
</tr>
<tr>
<td></td>
<td>Providing people with the tools to self-manage</td>
<td>Staff interviews; R-outcomes</td>
</tr>
<tr>
<td></td>
<td>Managing the fine line between dependency &amp; self-management</td>
<td>Staff interviews; R-outcomes</td>
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<td></td>
<td>Working with new referral processes</td>
<td>Staff interviews; survey</td>
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<td></td>
<td>Provide tailored help that’s right for people at the time it is needed</td>
<td>Staff interviews; R-outcomes</td>
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<td>Good coordination with other teams vital</td>
<td>Staff interviews; survey; R-outcomes</td>
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<tr>
<td>Barriers to the operationalisation of</td>
<td>Willingness of people to engage</td>
<td>Staff interviews</td>
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<td>Excessive expectations of people</td>
<td>Staff interviews</td>
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<tr>
<td>care navigation</td>
<td>Patient / Carer impacts</td>
<td>Practice / Staff impacts</td>
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<tr>
<td>Poor working with other organisations</td>
<td>Improved confidence</td>
<td>Practice staff have an option for residents who frequently, and sometime inappropriately, access services</td>
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<td>Fluctuations in referral levels</td>
<td>People not falling between the cracks of existing services</td>
<td>GP surgeries have an option to refer residents whose problems fall between the cracks of existing services</td>
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<tr>
<td>High level of evaluation requirements on care navigator team</td>
<td>Better awareness of benefit of services available (health/social services/voluntary sector)</td>
<td>Care navigators are forging new working relationships with other healthcare staff (health trainers, LACs, Community Navigators)</td>
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<td>Re-referals / ongoing caseload to manage</td>
<td>Improved healthy lifestyle for those they support</td>
<td>Care navigators reported they are frequently joining up services for residents, acting as link-points and organisers of a broad holistic tailored plan for residents</td>
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<td>Short term contracting of role is stressful for care navigators</td>
<td>Improved safety in the home</td>
<td>Care navigators provide live feedback to the GP surgeries and enhance residents’ care records</td>
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<td>Balancing (triage) priorities between dealing with new referrals and ongoing cases</td>
<td>Reduction in social isolation</td>
<td>GP visits avoided</td>
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<td>Families and carers felt listened to during difficult times</td>
<td>Staff interviews; case studies; survey</td>
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<td>Quality of life improved</td>
<td>Staff interviews; Person interviews; case studies; R-outcomes</td>
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<td>Staff interviews</td>
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