Ageing Better Isle of Wight

Isle of Wight age UK

COMMUNITY FUND

CARE NAVIGATORS

report 2019

The Care Navigators project aims to help older people with health or care needs to navigate the health and social care system, connecting them to the services they need to stay living well and independent for longer.

The project helps people access support that will make living at home easier or financial support that means people can purchase additional support.

Care Navigator project

The Care Navigator project is part of an Ageing Better partnership funded by the National Lottery Community Fund's Ageing Better programme which started delivery in 2015. The project is match funded by the CCG (Clinical Commissioning Group).

The project aims to support clients in navigating the range of health and care support services available to older people on the Island.

The project includes the following elements:

• Referrals from a range of organisations (and self-referrals) are initially managed by a triage team who identify support needs and allocate clients to a Care Navigator.

• Care Navigators carry out an in-depth assessment and produce a support plan based on the individual's needs.

• Care Navigators will then make referrals to relevant services and support clients to access financial support or attend local social groups/activities.

About Care Navigators

The Care Navigator project provides 1-1 support to older people, helping them to navigate the health and social care system. Care Navigators receive referrals from health care professionals or clients themselves and develop a bespoke support plan to enable people to access a range of services which meet their needs.

A triage service at Age UKIW manages referrals and a telephone interview with the client helps identify the main needs before the Care Navigator meets with the client. Ideally each client receives up to 6 face to face visits, to develop, review and update the support plan. However, the support is flexible and clients will stay with the service for as long as needed. Living Well Support Workers provide complementary support, such as form filling or support in attending social activities.

Participants and Reach

Since April 2015 the Care Navigators have supported 5,083 clients, an average of 1,200 a year. Two-thirds (66%) are female and a third (32%) are male. Although the project supports anyone aged 50+, nearly three quarters (74%) are aged 75 or older.

Care Navigator clients have some form of long-term health condition, restricted mobility or are struggling with day to day activities;

74% are disabled

83% have mobility problems

78% are experiencing pain or discomfort

76% find it difficult to carry out normal day to day activities

54% are suffering from anxiety/ depression

45% have some problems with self-care

69% are mildly or moderately frail

52% of clients live alone and a quarter (24%) are a carer for their partner. Although many clients do have family either at home or nearby, many do not want to ask for help and families often do not realise they are experiencing difficulties.

A third of clients meet up with friends or family less frequently than once a week and 15% have social contact with someone who isn't a family member less frequently than once a week.

"It doesn't matter if families are there – if they can't get out they can still be lonely even if they live with their family." (Care Navigator).

Because of their health conditions, many clients find it difficult to leave the house and can become lonely and isolated. Even those who do have family can become lonely. On average, clients scored themselves as 2.80 on the De Jong Gierveld loneliness and isolation scale, with 0 being least lonely and 6 most lonely. This compares to a score of 1.80 across the older Island population, showing that the project is reaching people who are lonelier than the average older population on the Isle of Wight.

Wellbeing levels are also low, with an average score of 20.80 being reported for the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMBS) (7 being lowest levels of wellbeing and 35 high levels). When compared to a national dataset compiled by the New Economics Foundation, this score is in the bottom 20% of the population and is rated 'poor'.

"The main problem is they can't get out very easily. Once they start staying in they lose their confidence to go out and it spirals." (Care Navigator)

The baseline data collected shows that the project is reaching older people who are vulnerable due to their health condition, have poor wellbeing levels and many are lonely or isolated as a result.

Support provided

The Care Navigators provide access to a range of support, depending on the needs of the individual. This ranges from raising awareness and helping clients to apply for particular benefits - for example completing Attendance Allowance or Blue Badge application forms, through to accessing specific support services such as Social Services, Red Cross, Admiral Nursing, home care or befriending service, or help accessing social activities or groups.

Care Navigators find that many people are not aware of what support is available to them, and need help accessing it.

"You feel a bit like 'has it really come to this?' But you find out what you should be having and what you should be doing, and it's to your advantage. If you need help and you can get it, you should go for it. You just don't know [what's there] - we've gone a long time without any help, we never knew anything. Someone said we should be claiming for such and such, but unless you know about it you don't. We were living on the breadline for so long." (Participant)

The project helps people access support that will make living at home easier, such as aids and adaptations, or financial support through Attendance Allowance or other benefits that mean people can purchase help such as cleaning, gardening or even a taxi to take them to a local social club. The ultimate aim is to enable people to live independently, at home, for as long as they are able to and to ensure that clients are accessing the support they need to do this.

Support plans are developed with the client and their family (if appropriate). Care Navigators use informal conversation combined with a structured assessment to identify the client's needs, explore options and offer advice about what support is available. Ultimately the client decides what actions go into their support plan, with actions for both Care Navigator and client. The intention is to empower people to make decisions and take action for themselves.

"Empowering people is about helping them make decisions themselves – supporting them to take control of their own life." (Care Navigator)

The project has high satisfaction levels, with 79% of clients agreeing that the project has met their needs.

Partnership working

The project works closely with a range of partners, including GP surgeries, social services, fire, police, a large range of health and care services and other charities. Care Navigators attend multi-disciplinary team meetings with other health and social care providers which ensures the project works closely with the sector. It also has a close link with the Community Navigator project, which helps clients access social activities in their communities once the Care Navigators have helped with their immediate care needs.

Stakeholders report that the project adds value to their services, by helping identify the most vulnerable older people on the Island, and by enabling them to access the support they need.

"It provides an additional support for GPs in providing practical advice on aspects that affect patients' health but are not medically related and therefore outside the remit of the doctors." (Assistant Practice Manager)

"The majority of people who die in fires are vulnerable and many are over 50. The Care Navigators help us to identify the most vulnerable older people on the Island and we do joint 'safe and well' visits. The Care Navigators build a rapport with people which means we can access and support them. It also means we are able to identify specific risk factors of the most vulnerable people, so if they do have a house fire we know, for example, where they sleep, whether they are immobile etc. Every GP surgery should have a Care Navigator." (Fire and Rescue Services)

"The Care Navigator project is needed because we have an elderly population on the Island and they can be very isolated as many are without the support of family. It is an invaluable service to get them the help that they need. Without the service many patients would not receive practical support in their lives."(Assistant Practice Manager)

What works

Delivering person-centred support

Being person-centred means having a flexible, client-led approach to planning and delivering support. Care Navigators do this through:

Having time to develop a relationship and build trust.

Being flexible to the needs of the individual - some people need less than 6 visits, others need much longer-term support.

"For one client it has taken nearly 18 months of support until I was able to introduce him to a Community Navigator, and last week I was also able to get a befriender in for him. Some people do need long term support to build their confidence and trust." (Care Navigator)

Listening to what the client wants and not making assumptions about their needs.

Having empathy, being personable, friendly and approachable.

"She's a lovely lady. As soon as she walked out the door [my daughter] said 'oh what a lovely lady' and my husband has been really looking forward to her coming."

Having a good sense of humour, particularly when discussing personal or sensitive topics.

Being led by a charity also helps build trust as clients don't have the same negative perceptions of Age UKIW as they can some statutory services.

Detailed knowledge

Care Navigators provide practical as well as emotional support, so need good levels of knowledge about what services are available that their clients can access. Working as a team and regular team meetings helps transfer knowledge and share experiences between team members.

"[The project works because of] the care and dedication of Care Navigators, they are very thorough and patients feel confident in their ability to help them." (Assistant Practice Manager)

Connections with other services and projects

The Care Navigator project needs to be well connected with other services; both in terms of organisations that refer clients in to the project and services the Care Navigators refer or signpost clients on to. In some areas Care Navigators are located within GP surgeries, which have helped develop close relationships with surgery staff, information and access to clients.

"Close contact with GPs is very beneficial. We have access to their database and have regular contact with the surgery staff so get lots of information from them. It's easy for us to get a foot in the door if we can say we are working with the GP surgery."

Complementary services, such as the triage system, Living Well Support Workers and Community Navigators, all help the Care Navigators to develop an effective and joined up support package.

Supporting and complementing statutory services

Care Navigators have the capacity and flexibility to provide support that statutory services are unable to. They help ensure people don't fall through the net. Many people would previously have been referred to Social Services, however stricter criteria and lack of resources means people are no longer supported. Continued reductions in health and social care budgets is a constant challenge for the project, as more people are referred with more complex needs.

"We pick them up and refer them to the appropriate services."

"They talk to people who maybe don't quite need to go to the doctor, and hopefully, stop them. It's much more social than medical but doing that you help people and stop their problems becoming crises. It benefits the surgery because if the problems don't become a crisis then you don't become ill." (GP surgery)

Care Navigators - the difference it makes

Improving health and wellbeing

Data from the Ageing Better national evaluation survey and Age UK's own wellbeing and frailty scales demonstrate how the project is helping to improve clients' health and wellbeing, or prevent further decline:

50% of participants have self-reported an improvement in their overall quality of life (using the EQ-5d-EL quality of life index)

65% have seen an improvement or no further decline (using the EQ-5d-EL quality of life index)

55% self-report an overall improvement in their health

66% report either an improvement or no further decline

63% report an improvement in their wellbeing (SWEMWBS)

74% report an improvement or no further decline (SWEMWBS)

67% report an increase in their overall wellbeing score (Age UK wellbeing scale)

46% report a decrease in the use of health and social care services

61% feel they have been supported to 'live well'

85% of clients' frailty scores have stayed the same

9% have improved, showing that the project is preventing decline

"It helps reduce anxiety and stress; many clients access the service because they need support with completing DWP or benefit forms which they find challenging, as most of this is online and they are not." (Assistant Practice Manager)

"I live on my own [and] I find looking at four walls all day monotonous. Having support from the Care Navigator project has pulled me out of depression. I don't feel stressed like I was. I used to get up and turn on the TV and there could be something on the news and I'd get wound up about it. Now I don't feel so tense."(Participant)

By improving clients' health and wellbeing the project is helping people to be more independent and live at home for longer.

"She made it possible for me to stay in my home."

"I have stopped agonising about what would happen to him [husband] if something happened to me. I've had sleepless nights over it."

A referral was made from a client's friend who had concerns after they suffered a recent fall and live alone. The client wanted to remain independent however their family lived on the mainland. Following the needs assessment the client received help in completing an application for Attendance Allowance and received a Wight Care button. Further to this a referral was made to Action on Hearing Loss and the Age UK Befriender Service. The client was awarded Higher Rate Attendance Allowance to help them pay for additional services which has made them feel more confident living alone.

A client referred by their GP struggling with hip pain and poor mobility was bed bound. Feeling low in mood and isolated, suffering with low confidence as immobile and worried about potential falls hazards. Following a needs assessment Care Navigators made referrals to occupational therapist for a care assessment and ordered a leg lifter from the Red Cross. The Adelaide Centre was contacted and a referral made for day care. Because of this intervention the client is now able to get in and out of bed, they have been awarded a Blue Badge and are awaiting a disabled bay outside their property. They have also started attending day care and have been able to reconnect with friends again. This intervention has increased the client's health and wellbeing and has given them back their confidence and lifted their mood.

Improving access to information and support

The project is helping increase clients' knowledge about what support is available as well as supporting people to access support, by helping complete forms or make referrals to relevant services or activities.

"It's made a difference. The pressure has been taken off. If I need information or need something I know where to go. Where else would I go for this? It's a great comfort." (Participant)

"She's helped me with everything - Council Tax, Attendance Allowance, Blue Badge. It's been more than I expected - I knew that there was Attendance Allowance but I didn't think I'd qualify for it. I want to join a walking group and yoga but I didn't know where to go. I need to get out, I haven't been to anything since I moved here - I used to go dancing but I can't do that now. I can't concentrate to fill out the forms [due to a brain injury], my memory is bad." (Participant)

"I wouldn't have applied for the attendance allowance without [Care Navigator]. It's quite dispiriting and lots of red tape. I want more help from a personal assistant - I wish I didn't need them. If I had more help I'd be less stressed and I'd have a bit more time for myself, which I don't get at the moment as I'm looking after my husband all the time."

"The referrals should be really helpful, and when she said she would come and help me fill out the forms that was really helpful. Knowing that support is out there is beneficial, even if you don't take it up. It's there if we want it. If we get the Blue Badge [our son] can take [my husband] out. It'll make things much easier. It's making sure we have a good quality of life and are able to look after each other for as long as possible - it will be difficult but we can tick along and it'll make things easier." (Participant)

Increasing connections and reducing isolation and loneliness

The project is also helping to increase social connectivity and reduce loneliness and isolation, or is preventing isolation levels from decreasing further:

33%

of clients report an increase in social contact with family or friends

39%

report an increase in contact with non-family members

25%

of clients are less isolated

"We are getting a person back on their feet and that needs doing before they are ready for the social side." (Care Navigator)

"We are empowering people to do something - they say they can't, but you do little steps and show them they can. I supported an 80 year old man who wanted to move to the mainland to be nearer his daughter, but he never thought it would be possible. When I met him he was unsteady on his feet, having dizzy spells and was very lonely. I encouraged his neighbours to go round and have a coffee and a chat with him. We took him to the GP about the dizziness and it was an ear infection and easily solved. It just took little steps to build his confidence - he's now on the mainland and is really happy." (Care Navigator)

A client who recently moved to the Island with their son and is recovering from a stroke felt anxious and lonely and unable to use their shower. Following the Care Navigator's intervention a referral was made to The Adelaide Centre for day care as well referrals to Community Navigators and the Lynx Trust. The client expressed that they would like to go gliding and staff took them to Sandown Airport to have a coffee and watch the planes. Since the Care Navigator's involvement the client is feeling less anxious and is starting to connect with new people.

Key Findings

Reaching vulnerable people

The Care Navigator project has reached a large number of older, vulnerable people experiencing some form of health condition or support need. In addition to poor health, clients have low levels of wellbeing and many are lonely or isolated.

Person-centred approach

By employing knowledgeable, empathic, friendly and approachable Care Navigators, the project is able to tailor a flexible service which meets the needs of clients. Care Navigators build trust through guided conversation, they listen to what clients want and offer a range of options, empowering people to make decisions and take action for themselves.

Preventing decline

The project has helped improve health and wellbeing levels for around half to two-thirds of clients and improved levels of social contact and reduced isolation for between a quarter and a third of clients. For a greater proportion of clients the project has seen either improvements or no reduction in health and wellbeing levels.

It is clear from the impact data that the project is helping prevent decline for the majority of clients, by providing support to improve their immediate health and care needs. The long-term impact of what this support has enabled clients to do as a result will be explored in the final year of the project through follow-up calls and interviews with clients.

Crucially, the project is also providing people with information about what services are available and what support people are entitled to, information that many people did not have before accessing the project. Ultimately the project is helping to maintain older people's independence for longer; helping them to look after themselves and each other in their own homes.

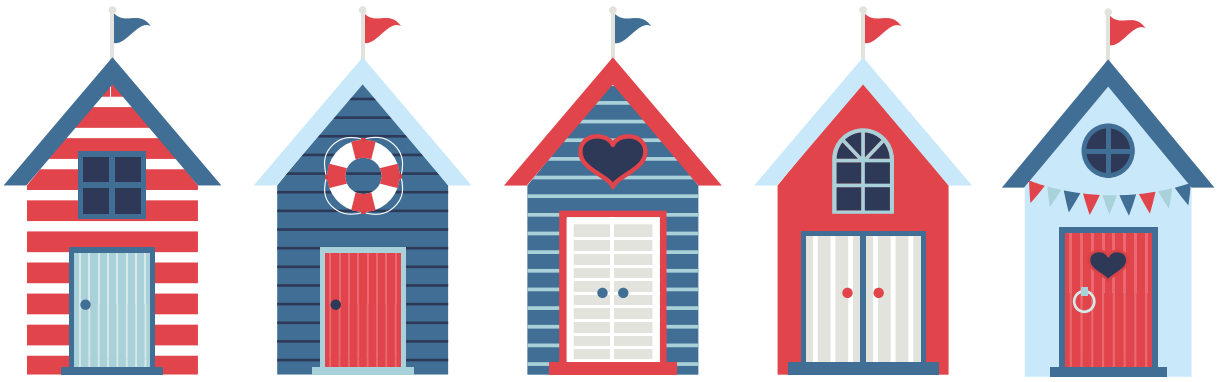
Complementing, not replacing, statutory services

By working in partnership with a range of health and social care services, Care Navigators can help ensure that vulnerable older people receive the support they need from the right agency. Care Navigators have the time to explore people's needs and identify options, complete necessary paperwork and advocate on a client's behalf.

The Care Navigators project is welcomed by statutory partners and provides complementary support.

That said, continued reductions in health and social care budgets will represent a significant challenge for the project. The Care Navigators can only help clients understand and access health and social care services; if these are significantly reduced the project will be less effective.

"GPs and social services just don't have the capacity to support people in the way Care Navigators can. I don't know of any statutory service that has the capacity - it's a vital service and needs to continue to receive funding."(Fire and Rescue Services)



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Data up to March 2019