Bristol Ageing Better Community Navigators

Summary of evaluation findings from UWE Bristol and Community Researchers

This document provides a **summary of the evaluation findings relating to the BAB Community Navigators** social prescribing service. Click here to read the full report.

Background

BAB funded the Community Navigators service from April 2017 – March 2020.

It was a **city-wide social prescribing service** which involved trained Community Navigators working **one-to-one with people aged 50+** on a short-term basis, **visiting them in their homes** or via phone appointments. Community Navigators provided **free information, signposting and support in order to improve confidence, boost wellbeing and tackle loneliness & isolation.** This support was tailored around the individual's interests and personal situation.

The Community Navigators service was delivered by **two lead delivery agencies** (North Bristol Advice Centre and Bristol Community Health), in partnership with **seven other local organisations.**

UWE Bristol and a team of Community Researchers evaluated the Community Navigators service.

The evaluation explored the explicit service aims, what worked well within the Community Navigator service, what was challenging, what changed within the service and any unintended consequences.

To do this **the evaluation explored five key questions** (detailed analysis of each question can be found in the full report):

- Were the **right referrals** received?
- Is the Community Navigator service **useful to clients**?
- What **sustains** the client to reduce loneliness?
- How useful is the service to the **stakeholders**?
- To what extent has **partnership building** occurred to ensure that future services in Bristol are better planned and more effective in reducing loneliness and isolation?

Impact on participants

Between 1st July 2017 and 31st March 2020 the Community Navigators supported **1,769 individuals.**

Of these, 1,080 provided their demographic details. **63%** were female and **92%** were White [White British or other White ethnic background]. The **largest age group was clients aged 80-89** (27%), although age was relatively evenly distributed among those aged 50+.

363 clients provided further information. At the start of their involvement with the Community Navigators service **almost 80% lived alone** and **77% had high levels of loneliness**. On average clients had **higher levels of loneliness and lower levels of health and wellbeing** than the UK average for older people.

Following support from the service, evaluation questionnaires showed **statistically significant improvements in:**

- **Social and emotional loneliness** [De Jong Gierveld and UCLA scales]
- **Social participation in clubs, groups and societies**
- **Wellbeing** [SWEMWBS scale]
- **Health** [EQ5D and EQVAS]

Key aspects of success

1. Home visiting

This made the service **accessible** to people who had physical or psychological **difficulties getting out of the home**, or experienced hearing difficulties when communicating on the phone.

It enabled the Community Navigators to **gain a better understanding of clients' day-to-day lives** and often revealed practical and physical issues such as hoarding, damp, lack of handrails and ability to cope with domestic tasks. Moreover, Community Navigators found that people could be **more willing to reveal other, often sensitive matters,** such as debt or benefit problems, when they were in their own home.

In particular referrers to the service, especially from health and social care services, whose remit did not necessarily include home visits, recognised the **value of people having face-to-face interaction with the Community Navigator at home.**

> **"Home visits are key...it's massively preventative - it's a really positive intervention, person-centred, based on supportive interaction rather than telling someone what to do."** Housing Association Tenancy Impact Officer

2. Open to referrals from any source

Community Navigators were 'free-standing'; they were **open to referrals from anywhere and were not attached to a GP practice.** They received referrals from a wide range of sources in addition to health professionals, including social services, housing workers, voluntary organisations, the individual themselves and family members. **While GPs have a good understanding of who is lonely and isolated, they should not be the only referrer.**

3. Able to accompany people to groups and events

Clients, referrers and Navigators all felt the **accompanying aspect of the service was very beneficial for anxious or under-confident clients,** such as those recently bereaved, and believed it could **make all the difference in whether someone would carry through** and attend a new activity.

> **"I'd only just come out of hospital and still couldn't drive and I'd lost a lot of confidence, so it was brilliant that my Navigator could come with me. I found that really helpful, that's crucial, especially to start with."** Client aged 81

4. Navigator skills and support

The role required a **person-centred** approach, use of **high-level communication** skills, **empathy** and **patience**; people may be reluctant to engage and there are often complex issues to resolve. Navigators needed a **wide knowledge base** and the **ability to source up-to-date information** about local activities, groups, entitlements and specific agencies. Having appropriate and motivational **training** was very important, as well as **adequate support, reflective practice and debriefing.**

5. Combination of staff and volunteers

The Community Navigator needed to be **highly skilled in assessing** the appropriateness for the service, the level of support needed and whether a referral to another agency was required in order to resolve a particular barrier first before a home visit occurred. This **enabled volunteer Community Navigators to take on the less complex cases, leaving paid Community Navigators to manage the more complicated ones.** Volunteer Community Navigators have reported benefits for themselves of this type of role.

6. Collaboration

The two lead delivery agencies and in particular the Community Navigator Coordinators **worked well together from the start developing a common brand across the city.** Resources were shared and issues relating to geographical boundaries were quickly resolved.

Learning and recommendations for future funders

1. More complex issues than originally anticipated

One Community Navigator estimated there to be **complex issues for 40% of people.** There were often **practical issues** such as debt, benefits, housing problems, continence management and transport difficulties (e.g. bus pass) that **needed to be resolved first, before any progress could be made regarding loneliness and isolation**. A referral to an appropriate agency sometimes also required advocacy and follow-up. Staff **training and support** to manage the complexity of these barriers to social engagement is a necessity.

2. Levels of poor mental health

Prevalence of **poor mental health was higher than expected**, particularly regarding more complex forms of anxiety and depression. Sometimes a referral to specialist mental health services was needed first, before any progress could be made on the issues of loneliness and isolation.

> **Roughly 10% of referrals have mental health issues more complex than mild depression. They need phone counselling, have memory issues, high levels of anxiety...** Community Navigator

3. Home visits

Any new social prescribing service should **include the option of home visiting.** This element allows for a **more tailored assessment of needs**, which may include referrals to other agencies. **Lack of home visits risks exclusion of some of the most lonely and isolated people,** including those with hearing, sight or mobility impairments, or people with high levels of anxiety and a lack of confidence.

4. Transport is a real challenge

Transport is a significant barrier which social prescribing services and referrers alone are unable to address. Bristol bus services **do not cover the whole city** and are **expensive**. Even those who could use local buses find themselves unable to do so if there is **no bus shelter** where they can sit while waiting. There have been many complaints about the **unreliability of community transport,** for example failing to arrive at all or arriving too early so that individuals need to leave social events before they finish. Taxis or individual specialist transport for those with mobility problems can be **prohibitively expensive.**

5. Lack of befriending services in Bristol

Not everyone wants or is able to go out to social activities and prefer to have someone to visit them regularly. In such cases, Community Navigators referred to one or more of the well-established befriending organisations in the city but were aware that the **demand for volunteer befrienders exceeded supply,** particularly for **face-to-face befrienders** or those who can also **accompany the individual outside of the home.**

6. Adequate and realistic resourcing

Funders should be realistic about the money needed for travel, telephone calls, management costs and the time taken for this type of work (which often involves a lot of information gathering, liaison and arranging of transport prior to referral to an activity). Budget provision should also be made for **confidential non-managerial support** in addition to **regular work supervision** for Community Navigators

> **“Effects of cuts really impinges on Community Navigator work, for example lack of social work involvement can mean Community Navigators are left holding worrying, vulnerable clients who have no other advocate, this is very frustrating as it's not in their remit but no-one else is acting for the client.”** Community Navigator Coordinator

7. Planning appropriate monitoring and evaluation

From the outset, **appropriate outcome measures need to be planned, agreed, budgeted and incorporated into service delivery.** This may require new social prescribers to be trained in the rationale of collecting outcome data and to assist in devising realistic outcome measures. Similarly, both **referrers and ‘end organisations’ wanted more feedback from the Community Navigators** about people’s experience of the service. This **feedback mechanism** should be made available from the outset.

8. Partnership working

When there are multi-partnership arrangements, there needs to be a **single clear management structure** with accountabilities for tasks made clear from the beginning. There also needs to be a **consistency for social prescribers across different partner organisations,** for example regarding annual leave. A feedback mechanism between referrers and ‘end organisations’ as outlined above would help to aid partnership working.

9. Investment in the social infrastructure; the service is only as good as the 'end organisations' to which it can refer

There are an impressive range of opportunities available in Bristol but they are **not evenly distributed across all areas** and there are **gaps in what is available**. Most are run by voluntary organisations and respondents recorded **concerns about funding cuts,** a disappearance of organisations and a **lack of resource to stimulate further new activities.**

Consideration needs to be given to the availability of local 'end organisations'. Is there sufficient resource? Is it appropriate? **Resources need to be made available** to enable community resources to be developed and enhanced in accordance with the need discovered from people accessing social prescribing services.

> **"...[there are a] lack of resources directed to end organisations who are expected to take on extra, unforeseen capacity."** CEO Voluntary Sector Organisation

Further BAB learning resources including the full Community Navigators evaluation report can be found at:

http://bristolageingbetter.org.uk/learning-and-evaluation-hub/

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