voluntary action camden

Camden age UK

Charity No. 293446
Est. 1965

Care Navigation and Social Prescribing Service Report June 2021:

Supporting Camden residents 18+

Care Navigation and Social Prescribing Service Report June 2021: Supporting Camden residents, 18+

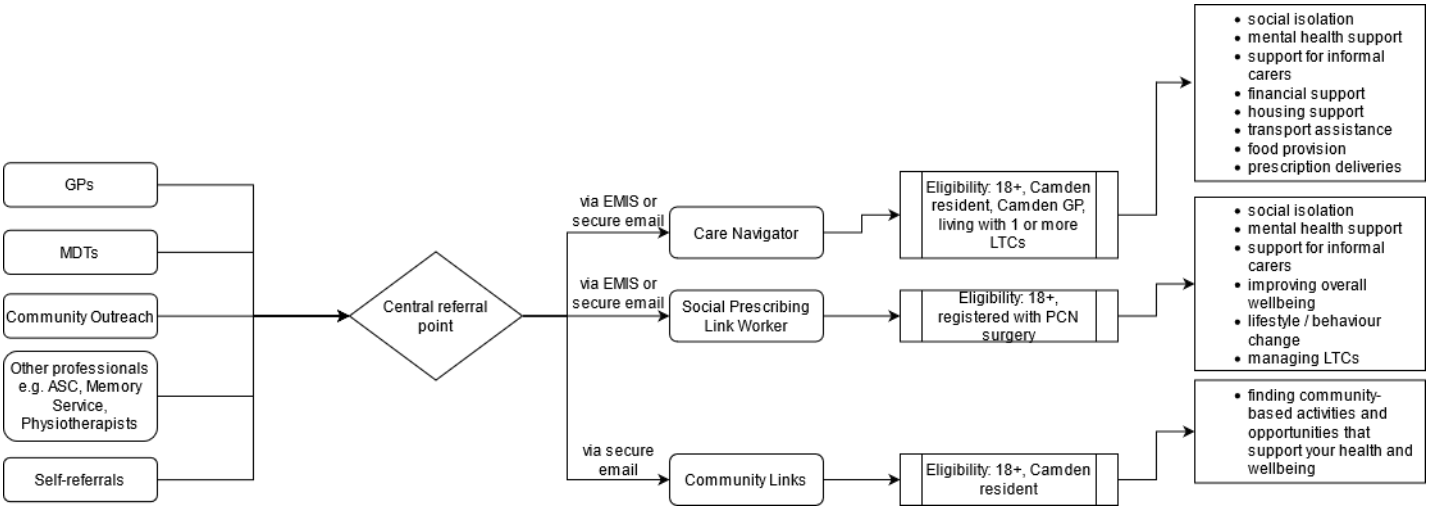
Contents:

Introduction: Age UK Camden, Voluntary Action Camden and Wish Plus who together deliver the service, have worked with Camden Council, North Central London CCG and local PCN's over the past three years to instigate, embed and develop an outstanding service that has proved efficient and effective in meeting the needs of the Community ensuring improved health and wellbeing outcomes and taking the burden off the NHS and Council. The service is agile in its response to need and proved invaluable during the pandemic helping to ensure that people had the care and support they needed during the most challenging of times. The role the service provides linking with statutory and third sector provision is invaluable in maximising the resources we have to provide a seamless service to the client.

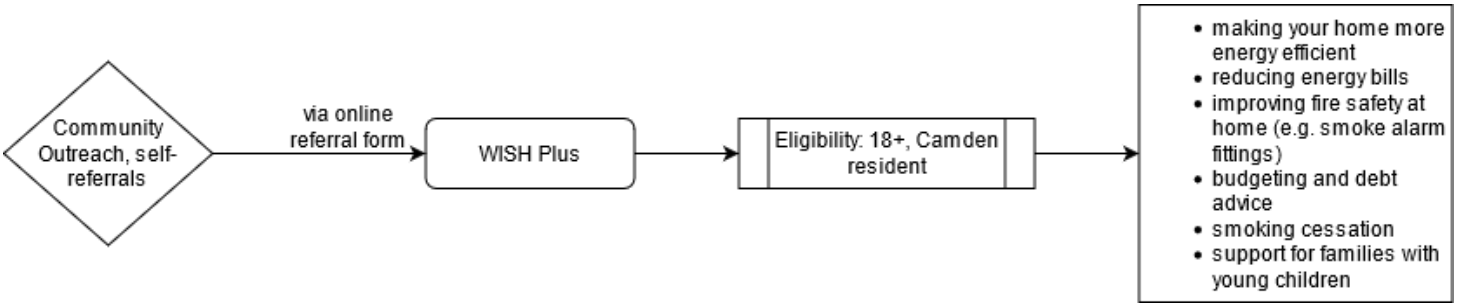
Executive Summary: This report evidences how this service continues to deliver outstanding outcomes showing effective partnership working between the Statutory and Third Sector provision at its best. The evidence shows the positive impacts both on clients and volunteers are exemplary and that the service reduces the workload burden and financial pressure on the NHS and Council with a relatively low level of investment. The service continues to be responsive and has been agile and responsive in its development to meet local need with an effective model. **The service evidence:**

- **A robust model that has developed and expanded with partners over a number of years.**
- **High quality data and detailed costs.**
- **A cost-effective model which diverts pressure from statutory services saving time and money.**
- **Significant impact on health and wellbeing outcomes.**
- **It leverages existing assets in the community.**
- **Effective in reaching/supporting those who identify as coming from minority groups.**
- **100% of Camden residents volunteering within the service for professional development purposes have gone on to jobs, education or training in health and care services.**

Referral Pathway – Central Point of Access: Care Navigator, Social Prescribing Link Worker, Community Links



Referral Pathway – Central Point of Access: Wish Plus:



Service Awareness:

- Clear communication with all key stakeholders has been essential to ensure the effectiveness and embedding of the service. There are a number of studies that have shown the disparity between services nationally (Tierney et al 2019) and so a local communication plan has been implemented to ensure patients, the wider community and health and social care staff are aware of the service, how it supports patients and how to access it.

- The Care Navigators attend monthly Neighbourhood MDTs and being based across Camden in GP practices allows for regular and productive exchanges with GPs and Health care staff member. Community Links volunteers are based in GP practices which makes communication with GP staff and patients seamless. The database EMIS is used for direct communication between Care navigators and GPs.

Case Study 1 | Care Navigation |

Client: **41 years old, Female, Black-British-Somali, unemployed, main disability: mental health (ADHD, learning difficulty, PTSD, Agoraphobia, Social anxiety, anxiety, and depression), emotional trauma – emotional, physical, and sexual abuse & FGM**

Reason for referral: **support with housing and finances**

Actions:

- Care navigator followed up with DWP re PIP and UC benefits application
- Liaised with Domestic Violence Advocate to support client with acquiring adequate points to bid for properties
- Liaised with GP, TAP and Private therapist to collate medical evidence to support housing application
- Submitted supporting documents to Housing Allocations OT for medical points
- Contacted ADHD diagnostic clinic to request supporting letter for Freedom Pass application

OUTCOMES:

- Client was awarded priority points (400 points) based on medical need, domestic abuse, and MH conditions for housing
- Bidding for Council Property was put on hold due to Covid-19, however, affiliated Housing Association opened referrals and client has now signed her tenancy and has a move in date
- Client has been awarded UC and PIP benefits
- Continuing mental health support from Likewise
- Grant application approved and now has a new mattress

Case Study 2 | Care Navigation |

Client: **57 years old, Female, White-British**
Referral reason: struggling to get support for mental health, needs befriending service

Overview:

- Client was very isolated and lonely due to being housebound and not having access to the internet for online support from family.
- Client wanted to be able to have access to the outside world
- Client was struggling with GP liaison
- Client was struggling financially specifically to improve home environment and was not in receipt of all the benefits she was eligible for.

Referrals made:

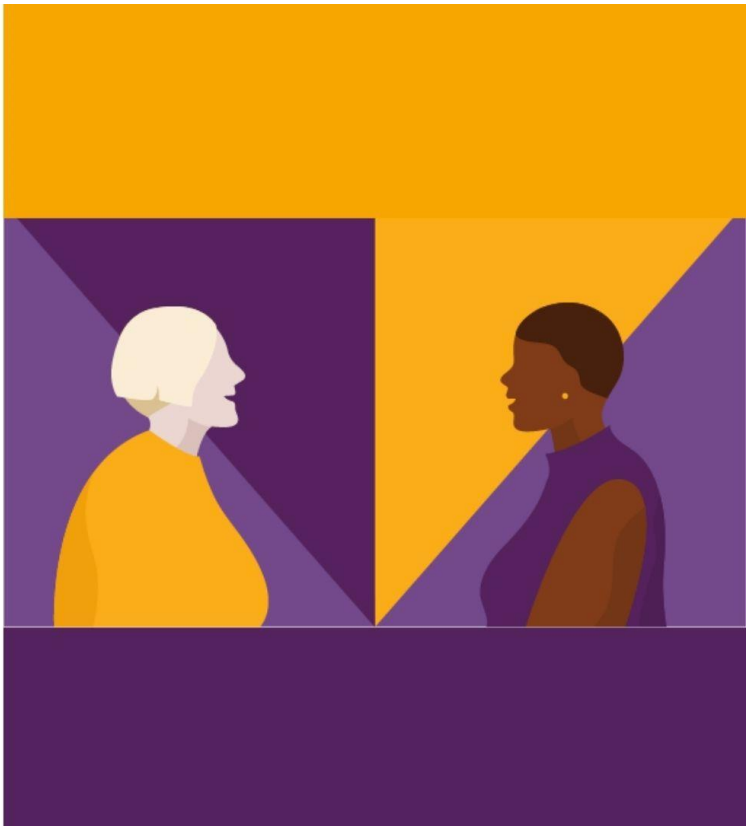
- Referral to The Reading Project for a shared reading scheme
- Referral to the Building Resilience Project to support with finances including PIP, grants to local charities to refurbish flat
- Referral to social prescribing to become a telephone volunteer
- Referral to Holborn Community Association for their digital inclusion project
- Referred to Voicability Peer Mentoring Programme

Outcomes:

- Social connections: client is slowly building their connections with groups and volunteers who are not professional increasing their social connectedness in a way that is not reliant on services. In addition to this, the client is becoming more able to connect with their family and friends with digital inclusion support.
- Client has had a better understanding of managing her relationship with her GP and advocating for her own needs.
- Financial support: client will be receiving on-going support to improve her financial situation and her home environment
- Emotional/MH support: Client is feeling more hopefully, resilient and of use to others through the social prescribing volunteering training and connections with a volunteer from Holborn Community Association.

Case studies Community Links:
Getting out again (Summer 2020)

A recent self-referral came from an elderly lady who was desperate to start going out and get some exercise. With no access to online support and no friends or family locally she has been isolated for months. She had seen her doctor about deterioration of her physical health through lockdown but needed to address her mental health after staying indoors for so long. She was not interested in walks or the lower impact exercise that is starting to emerge in socially distancing groups, she really wanted to dance. Unfortunately, we could not accommodate that just yet, so will keep her updated about local dance classes as restrictions reduce. In the meantime, she agreed to join the Third Age Project where she can start kayaking lessons. She has also been referred to Community Connectors who will help her get there and support her to get her confidence back.



Community Links Case Study:
Collaboration in emergency response (Summer 2020)

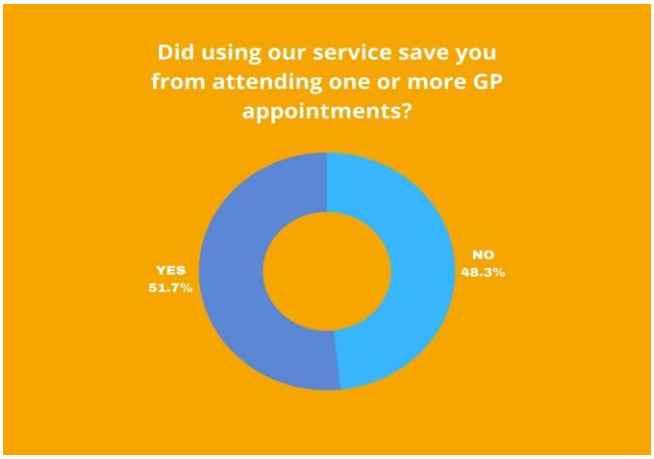
During late August one of the key food projects (The Winch) in the north of Camden closed down as the community centre began to resume it's regular activities. Winch staff contacted Social Prescribing 3 weeks before this happened to enable a smoother redistribution of residents needing food provision. The Winch provided Social Prescribing with a spreadsheet of need resulting from their project closure. This increased our inward referrals on one day to 108. Fortunately, they did not all need urgent attention, and the prewarning had enabled the frontline staff at the organisations stepping in to help to prepare.

Social Prescribing staff, working with Wish +, Age UK Camden's social prescribing link worker in north Camden, Abbey Community Centre, and Queens Crescent Community Association, managed to connect all the referred residents with appropriate food provision. The social prescribing link worker helped with food vouchers for those who qualified, Wish+ staff found a small local food supply suitable for one resident who was particularly hard to find provision for, and the two community centres took on a variety of food deliveries and supplying food parcels and hot food with Social Prescribing organising delivery by volunteers.

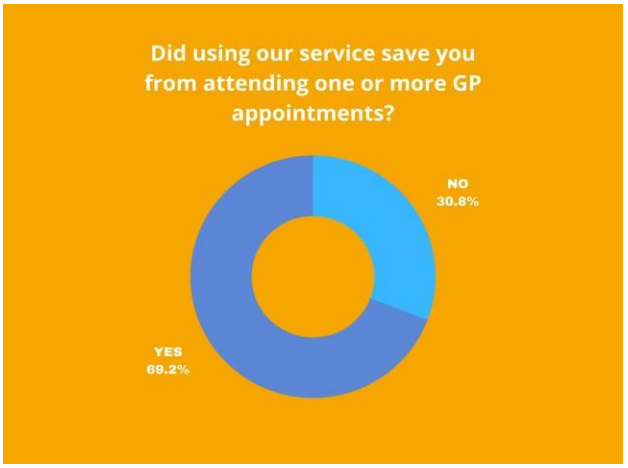
Health/Social Economics:

We undertook a questionnaire of patients which showed **People self-reported using fewer health and social services:**

Care Navigation:



Community Links



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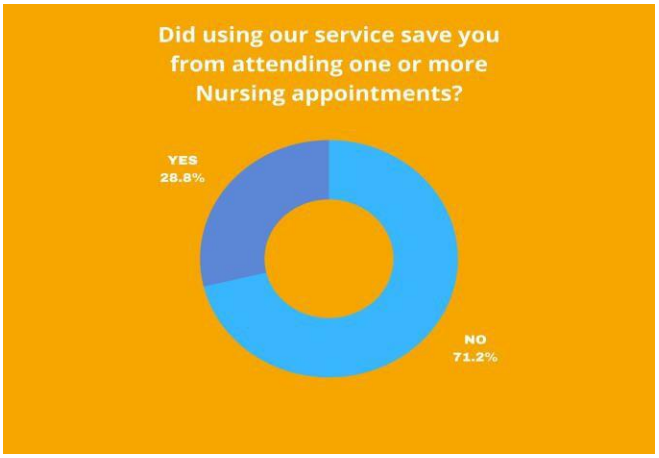
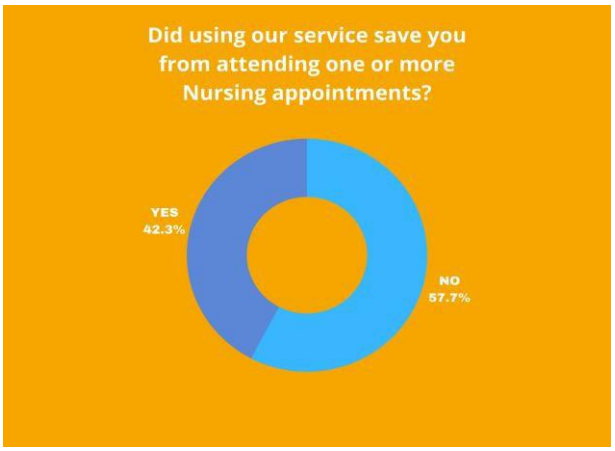
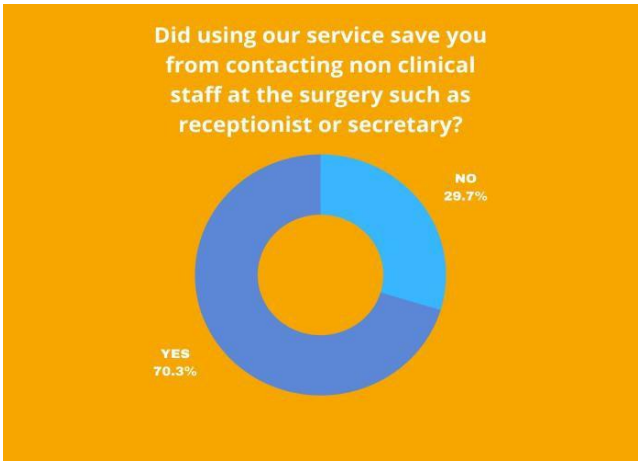


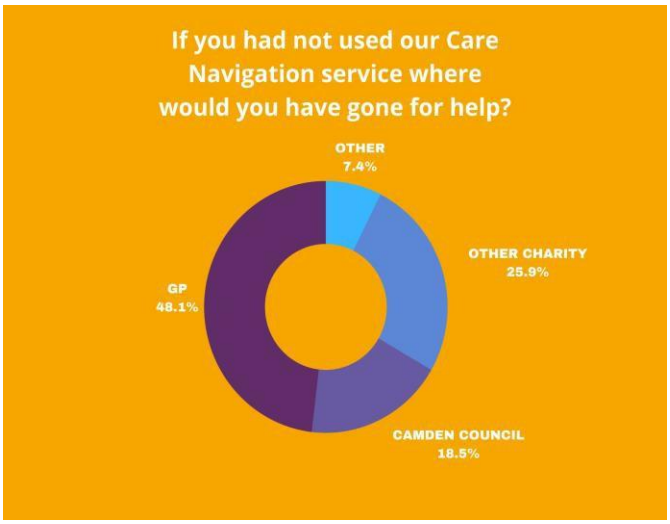
Community Links



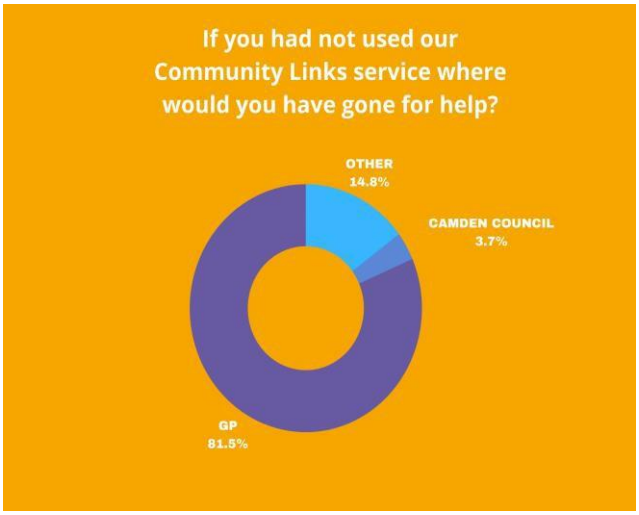


Care Navigation and Community Links

Care Navigation:



Community Links



Service	Average Cost per Individual	Average Cost per Intervention
Care Navigation	£125	£21
Community Links	£56	£9.50
Social Worker		£213*

Taken from: Care Navigation Competency Framework (2016)

Using Unit Costs of Health and Social Care 2020 | PSSRU, Hobbs et al (2016) and the Care Navigation Competency Framework (2016) we can conclude the following minimum savings for the NHS:

- Based on saving one GP appointment for 51.7% of CNS and 69.2% of CL patients the service saved the NHS £56,745 and 223.6 hours of GP time.
- Based on saving one nurse appointment for 28.8% of CNS and 42.3% of CL patients the service saved the NHS £5,478 and 130 hours of Practice Nurse time.
- £192 per saved Social Worker intervention – 18.5% of CNS patients and 3.7% of CL patients said they would have contacted Adult Social Services for support if they had not accessed this service.
- Time and cost for reception time at GP Surgeries and Camden Council.

In addition, 100% of the Camden residents volunteering within the service for professional development purposes have gone on to jobs, education or training in health and care services further supporting the local economy.

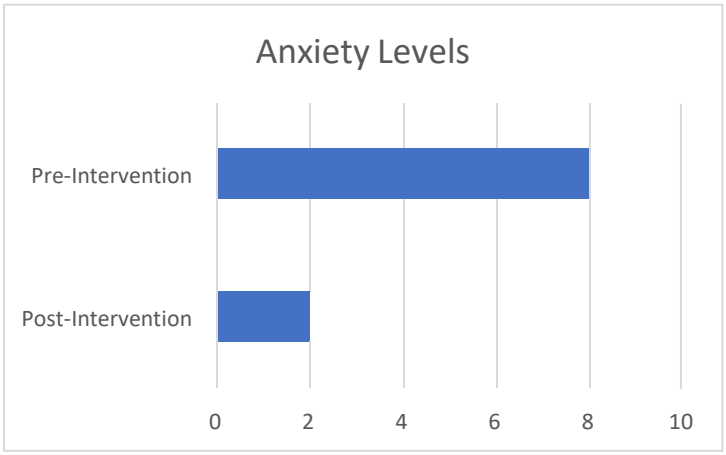
Impact Data: We have developed an AUC approach to the self-measuring/self-reporting of impact based on the MYCaW approach. We undertook this activity at the point of referral to the CNS and at the time of discharge from the service.

Number of respondents: 20 with 23 issues.

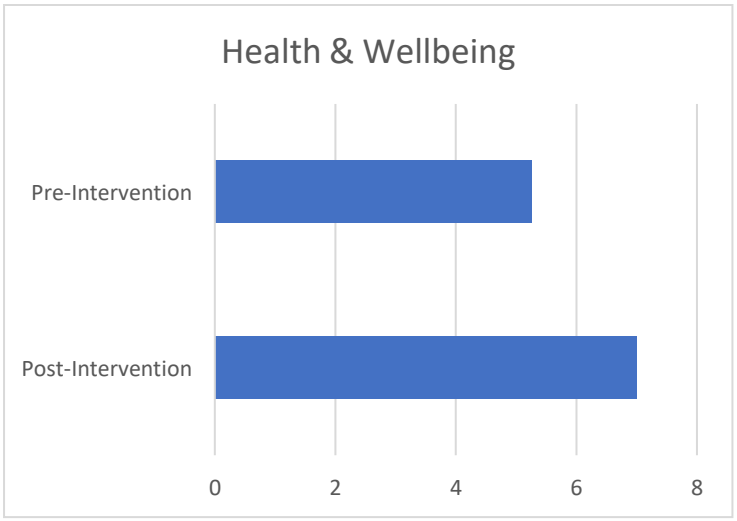
Age Group	Number of respondents
20-30	2
30-40	1
40-50	4
50-65	3
65-75	2
75-85	4
85+	4

Using a Likert scale of 0-10 to self-report:

- **on average clients reported their anxiety levels before the intervention as 8 (10 being highest anxiety) and after the intervention as 2.1. The service therefore reduced on average anxiety levels by 5.9. All but 1 client recorded a decrease in anxiety, one recorded no difference in their anxiety level.**



- **On average clients reported that the service increased their health and wellbeing by an average of 1.75 (on a Likert scale of 0-10 – 10 being the highest level of positive wellbeing). Reporting at the start of the intervention their health and wellbeing an average of 5.25 and after the intervention an average of 7.**



Outputs:

	CARE NAVIGATION		Community Links	
	2019/20	2020/21	2019/20	2020/21
Referrals received (IN)	1087	1446	1794	1022
of those, BAME	366 / 33.7%	599 / 41.4%	1224 / 68.2%	718 / 70.3%
Referrals made (OUT)	893	2034	1563	1605
of those, BAME	364 / 40.8%	785 / 38.6%	1057 / 67.6%	1178 / 73.4%
Number of clients supported / case managed each year	1150	2929	551	704
Average number of unique clients supported each month	96	244	149	85
Number of clients supported under 55	184	295	482	476

Reasons for referral

	2019/20	2020/21	Definitions and notes
Care Navigation – top 5 referral reasons	1. Self-Management 2. Home Management 3. Social Isolation 4. Financial Support 5. Support for Informal Carers	1. Self-Management 2. Home Management 3. Social Isolation 4. Financial Support 5. Housing Support*	**Self-Management:** appointment support (e.g., remembering appointments), support booking hearing/vision tests, podiatry & nailcare referrals. Help with care packages – referring to/follow up with ASC. Liaising with health & social care departments. **Home Management:** Help to access services related to cooking, cleaning, looking after pets, hoarding / decluttering, and accessing mobility aids and home adaptations. *'housing support' not included as a separate referral reason in 2019/20 and housing-related referrals are included under 'home management' for this period
Community Links – top 5 referral reasons	1. Social and community activity / social isolation 2. Complex needs for Care Navigation 3. Fitness and exercise 4. Welfare / housing 5. Assistance with home management	1. Signposting and information 2. Access to food 3. Prescription and medical deliveries 4. Social isolation / social activity 5. Assistance with home management	**High numbers of referrals / self-referrals for connecting people with** local community provision, Mutual Aid and statutory health and care services, shielding lists etc. Includes food banks, food parcels, help with shopping and deliveries. The service was the medicines pathway for Camden and organised pick-up delivery of prescriptions, medication, sample pots etc. Social isolation mainly addressed through volunteer support and connecting residents with online arts and cultural activities.

Supporting clients discharged home from hospital

	07/04/20 – 03/09/20	**04/09/20 – 31/03/21**	
Referrals received (IN)	71 Referrals received from UCH, Royal Free and St Pancras Hospitals	55 Referrals received from hospitals and Adult Social Care	Figures were recorded differently for the period 04/09/20-31/03/21, meaning there is less data available.
Of those, BME	25 / 35.2%	26 / 47.3%	
Referrals made (OUT)	115	72 (average of 1.3 external referrals per inwards referral)	
Top 5 referral reasons	1. Food provision 2. Wellbeing phone calls 3. General amenities 4. Prescription collection 5. Information and advice	1. Financial support 2. ASC referrals 3. Housing support 4. Home management 5. Support for informal carers	

WISH+

	2019/20	**2020/21**
Referrals received (IN)	2851	1025
of those, BAME	16.6%	45.3%
Referrals made (OUT)	5371	1537
of those, BAME	No data provided	19.3%

Social Prescribing Link Workers

	NORTH CAMDEN PCN ***2 full-time Social Prescribing Link Workers**		**SOUTH CAMDEN PCN** ***1 full-time Social Prescribing Link Worker**	
	2019/20 *service began on 16/03/20	2020/21	2019/20 *service began on 01/01/20	2020/21
Referrals received (IN)	12	307	45	274
of those, BME	1 / 8.3%	161 / 52.4%	11 / 24.4%	95 / 34.7%
Referrals made (OUT)	11	884	2	282
Number of clients supported under 55	9 / 75%	79 / 25.7%	8 / 17.8%	113 / 41.2%
Top 5 referral reasons	*not available on database until April 2020	1. Social isolation 87 2. Improve overall wellbeing 57 3. Group support for LTCs 41 4. Managing LTCs 24 5. Mental health support 23	*not available on database until April 2020	1. Social isolation 74 2. Improve overall wellbeing 64 3. Managing LTCs 40 4. Lifestyle/behaviour change 41 5. Self-Management (OOB clients) 13*

***Self-Management:** appointment support (e.g., remembering appointments), support booking hearing / vision tests, podiatry and nailcare referrals. Help with care packages – referring to or following up with ASC. Liaising with health and social care departments. Only for clients living outside Camden who are therefore not eligible to see a Care Navigator.

References:

Care Navigation Competency Framework (2016): https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

Hobbs R, Bankhead D, Mukhtar T et al (2016) Clinical Workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-2014 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00620-6/fulltext

Tierney, S. Wong, G. and Mahtani, K. Stevens S., Perera-Salazar R., Holt, T. et al (2019) Current understanding and implementation of 'care navigation' across England: a cross-sectional study of NHS clinical commissioning groups; British Journal of General Practice; 69 (687): e675-e681. DOI: https://bjgp.org/content/69/687/e675

Unit Costs of Health and Social Care 2020 | PSSRU - https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2020/#sections

Appendices:

Appendix 1 – Service Descriptors:

Care Navigation

Care Navigators provide (up to) 6 weeks of personalised case management support for Camden residents who are aged 18+, are registered with a Camden GP, and living with one or more long term health conditions. Service users receive personalised support and assessment, often in their own home, from a named care navigator in order to help identifying needs and to support navigation through the local care systems. The Care Navigator Service provides dedicated support for multi-disciplinary teams (practice, neighbourhood, frailty and high intensity users (HIU), providing advice, information, and co-ordination across clinicians and voluntary sector/ community services.

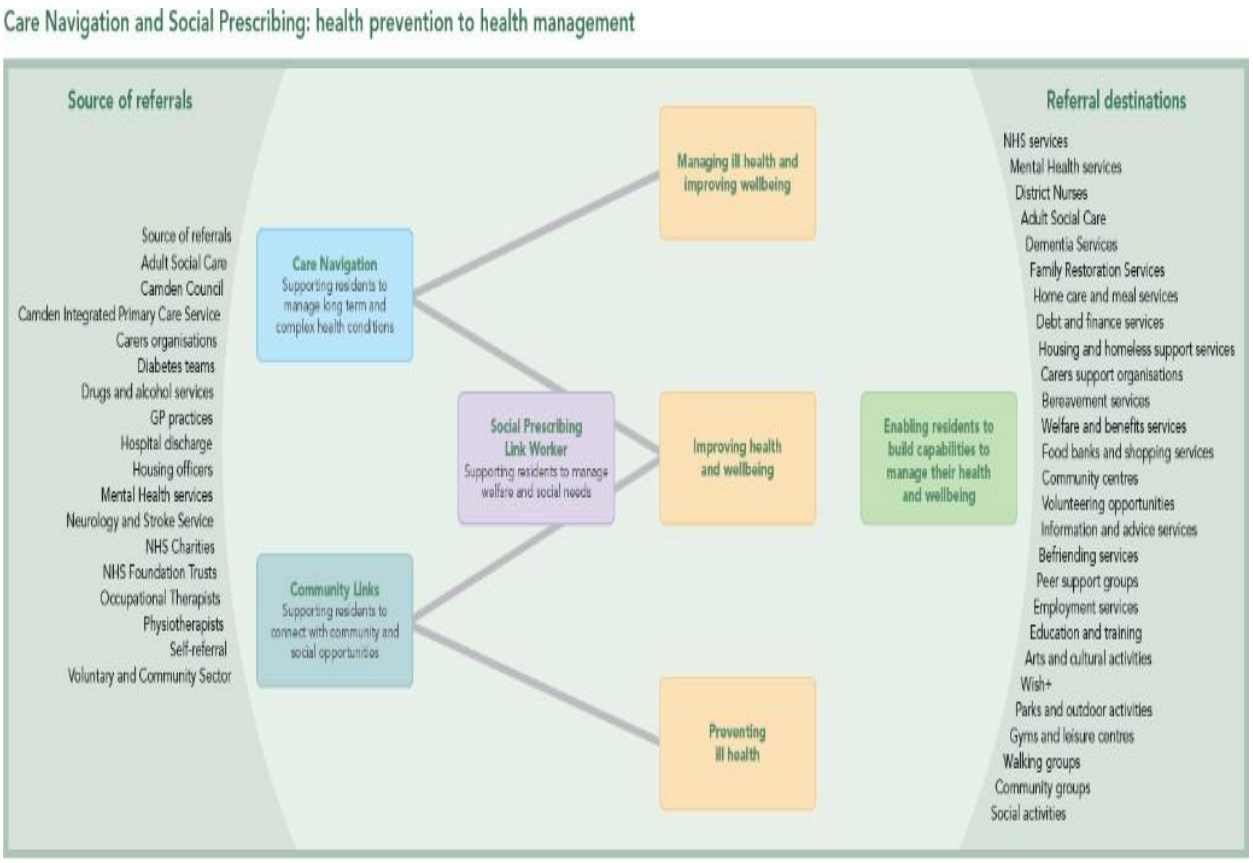
The Care Navigators support with the following:
SELF-MANAGEMENT - food provision , prescription delivery, arranging POC, Falls team, Physiotherapy, District nurses, community opticians, podiatry, dentist, pendant alarm, carers, appointment support, employment support
HOME MANAGEMEENT - OT assessment- home adaptation, energy saving, keeping warm, and home repair issues, gas/electric keys top ups, hoarding, looking after pets, cleaning, cooking
HOUSING - support with homeless applications, liaising with housing officers/departments, home swap, getting on the social housing list
SOCIAL ISOLATION - Referrals to befriending, Social Prescribing - activity classes, social support groups , online support groups and activity classes, day centres
MENTAL HEALTH – liaising with secondary services and GP, referrals to Likewise and Mid, CBT, Befriending, Counselling, therapeutic services- art therapy, pet therapy etc.
FINANCE - Benefit assessment, Debt Advice, Information Advice, PIP claim, Attendance allowance, Grant applications
TRANSPORT - Arranging hospital transport, blue badge and taxi card applications

Community Links staff and volunteers The Community Links staff manages the single access point for the service. They triage referrals and support residents who require referral into community based activity and social opportunities. Community Links volunteers provide an outreach element to social prescribing, by providing sessions in GP practices and in other community settings, including, but not limited to, libraries, community centres and faith groups, speaking to service users directly and offering support with accessing community activity provision, support, information and advice. The volunteers can also provide a 'chat and link' service for residents who need more time to connect with community activities. The Community Links volunteers aims to improve the service user's overall quality of life by supporting, signposting and connecting them with community groups and activities and events in their local area.

WISH Plus

Wish Plus provides support and signposting to statutory, local authority and VCS organisations and makes referrals to agencies offering warmth, income, safety and health advice and information. The service enables Community Links and Care Navigators to access multiple related services through one platform, and liaise with Wish+ staff to speed up referrals.

Appendix 2: Diagram showing role in Health Prevention, Maintenance, Improvement, Management



Appendix 3: List of organisations and services clients have been referred to / connected with in the past financial year:

Care Navigation

(Please note this is not exhaustive but provides a snapshot of services the Care Navigation Service liaise with.)

Appendix 4: List of organisations and services clients have been referred to / connected with in the past financial year:

Community Links:

(Please note this is not exhaustive but provides a snapshot of services the Community Links Service liaise with.)