The Primary Care Navigator Programme

In West London

An Extended Summary of a Quantitative and

Qualitative Evaluation Study

Priya Davda, Peter J. Aspinall and Ken Eason

December 2015

1. Objectives, Method and Sample The objectives of this study were to undertake an evaluation of the Primary Care Navigator (PCN) programme in West London. In the summer and autumn of 2015 we conducted a quantitative analysis based on the returns the PCNs provide of the activities they have undertaken in five practices and we conducted a wide ranging interview/focus group study that included the PCNs, patients, practice staff from four GP surgeries (GPs, practice managers, nurses and receptionists) and service providers (collectively termed 'the stakeholders' in the summary below).

2. Overall Response to the PCN Programme Without exception the response of all stakeholders to the PCN programme was very positive. The patients, for example, have found it extremely helpful, sometimes life changing, because it is a personal service dealing with any issue of concern to them. The PCNs have found themselves navigating to a very wide range of services. For the practice staff, especially the GPs, the PCN programme offers a very valuable capability because it enables the surgery to deal with the non-medical needs of older patients that practice staff have neither the time nor the expertise to provide.

3. Performance Metrics The analysis of the records shows that the PCN programme has achieved and sustained a significant level of referrals, averaging 24 per practice per quarter. This level has been sustained although the PCNs are now spread across more practices and are spending less time in the 5 practices we examined. The referrals are for patients across a wide age range over 55, from many ethnic backgrounds and for many different reasons. Many of the referrals are dealt with and closed within 1 week (21% across the 5 practices) and from referral to closure may only take 1 to 2 hours of the PCNs time. However, there are many complex cases that take more time and effort. 41% of referrals take over 4 weeks to complete and 22% take over 5 hours of the PCNs time. There are wide variations in these figures across the practices. This may be a product of different patient populations, of the different ways referrals are made or the way the PCNs fulfil their roles.

Perhaps the most striking result is that, after referral to a PCN, in most practices patients attend A&E less frequently, need fewer contacts with their GPs or with the GP out-of-hours service, miss fewer appointments and have fewer outpatient appointments and inpatient admissions. This is significant evidence that the PCNs are enabling patients to manage their lives better so that they need to make less frequent use of the health services.

4. The Perceived Benefits of the Programme The qualitative evidence from the interviews gives more details of the kind of impact being achieved by the PCNs and how it is being achieved. The benefits of the PCN programme to patients as perceived by the interviewees are many and varied: they range from helping patients to attend appointments to supporting individuals achieve or sustain independent living and reduced social isolation. These are beneficial outcomes that are directly attributable to the work of the PCNs although we cannot put numbers to these achievements or represent them in financial terms. Should it become necessary to justify the work of PCNs in these terms, it may be appropriate to develop metrics for these outcomes. Some are relatively straightforward and are already in place, e.g. examining whether there is a reduction in appointments missed, but others such as social isolation and independence may be more problematic to measure but not unachievable.

The patients are not the only ones to benefit from the presence of a PCN. Both the practice staff and the service providers report that the PCN helps them by enabling them to focus on their own roles with respect to the specific needs of patients and also by sensitizing them to the broad array of needs a whole person care strategy may need to address and demonstrating how these can be addressed. The GPs in particular were keen to explain how much of their time was saved by the availability of a PCN and also said that their awareness of the significance of non-medical issues grew considerably as they saw the contribution a PCN could make.

5. Coping with the Health and Social Services The pivotal role of the PCNs is to help patients navigate the complex and confusing world of health and social services. The interview data shows how challenging this world can be for an elderly person with complex conditions and perhaps deteriorating mental faculties. A basic model of the PCN role is that it is to help the patient navigate to a specific service when it is needed, e.g. getting to a specific appointment. However, it seems the PCNs often uncover a more general need: what many patients need is an enduring support structure that can help them to navigate all of the services necessary if they are to continue to live independently in the community. The split between the short cases of navigation and longer, more time-consuming cases shows that there are many patients whose need is for an enduring and broad based support structure.

6. Definition of the Role The PCNs are achieving their impact as a result of becoming an established part of the GP practice team although this process has involved a complex process of role negotiation. The PCN role is initially an unfamiliar addition to GP surgeries but the practice of using a PCN has become more firmly established as everybody has become familiar with what a PCN can and cannot contribute. The interviews revealed many different perspectives on the role that suggests

there are more elements to it than might initially have been supposed. At the heart of the role definition is, of course, that the role is to navigate patients who are over 55 years of age to services to meet non-medical needs. But in pursuing this goal, the PCNs go beyond mere 'navigating': they build relationships with patients; they hold the various strands of service input together to facilitate an integrated service; they persevere over time to ensure there is continuity of care and, when necessary, they provide limited services themselves. Respondents spoke of the PCNs occupying a special niche in the provision of care. In essence this niche is that they can play a patient-centred role that enables them to work on the needs of patients without reference to a particular service remit. Whereas other care providers are limited by their particular role to a specific kind of patient or client care, the PCNs can navigate anywhere. They have additional advantages that others do not: time to work with patients and a trusted route, via the GP surgery, to reach the patients. For some patients the PCNs become the general-purpose agent that provides a conduit between them and the bewildering world of health and social care providers. It could be argued that, in a care world made up of many different special service providers, any whole-person strategy is going to need some agent to hold it together and 'plug any gaps'. For many patients the PCN is just the person who 'navigated' them to a particular service but for others the PCN *is 'their'* agent making things happen for them across many different services.

7. Role 'Boundary' Issues. The PCN role is unusual and the PCNs are engaged in a continuous process of explaining themselves and what they can and cannot do. They speak of having to manage a number of 'role boundary' issues if they are not to be diverted from their main purpose. The 'boundary' issues include:

- Ensuring referrals are appropriate, i.e. ensuring they are non-medical in nature and the patient is in the 55+ category.
- Navigating to services rather than delivering services. There is sometimes a fine distinction between navigating and providing a service, especially when the service is easy to provide and is required urgently, in a time period where it would take too long to engage a service provider. A related issue is that it can take considerable time and patience to establish a trusting relationship with a patient and it can then sometimes be difficult to hand that patient on to a service provider.
- Enhancing rather than duplicating the service to the patient. Some other service providers, e.g. social workers and community matrons, also provide some coordination for patients and they can perceive the PCN to be overlapping with their own roles. However, the PCNs tend to have a wider remit than other service providers and, by working together with these colleagues, issues about potential duplication tend to be resolved at a local level.

8. Integration into Practices. Practice staff report that the PCNs have become 'part of the practice team'. They attend practice meetings, especially multidisciplinary team (MDT) meetings. They tend to work by making home visits and they have the time to gain a fuller appreciation of the patient's home circumstances than other members of the primary healthcare team and, as a result they are often able to provide a valuable and different perspective in discussions about patients. They are also given access to practice computer systems and they add reports of their work with patients to

the electronic records held by the surgery to ensure that all staff are fully appraised of the relevant but non-health related issues of significance in the patients' lives.

9. The Development of the Programme. Many aspects of the programme have developed significantly since its inception. Selection and training processes are widely regarded as successful and the team of PCNs are regarded by other stakeholders as committed and resourceful individuals very well suited to their roles. Although the PCNs come from diverse backgrounds, the selection process succeeded in identifying very good candidates for the role. The qualities that stakeholders identified as important for the role include having a caring and compassionate disposition, being trustworthy, resourceful and self-starting and very well organised. They also have to become extremely knowledgeable about local services and how to access them, and be capable of sustaining good relations with all the other agencies that they come into contact with. The PCNs praised the training they received and especially the opportunity to shadow experienced PCNs because this provided early insights into the techniques needed to offer support to patients. All the PCNs referred to the continuous learning they have undergone in fulfilling the role and together they have developed a significant 'community of practice' about how to be an effective PCN. Although they work independently of one another, they greatly value existing opportunities to share problems and experiences with one another and as a result shared approaches to fulfilling the role are emerging. This includes the development of shared views on how to encourage referrals, how to engage with patients to encourage them to take up services, how to understand and access the many services available (including mastery of the conditions and timescales for access to services) and how to monitor and facilitate the take-up of services by patients.

Although these elements of the programme have received significant attention, less emphasis has been placed on developing appropriate 'tools for the trade'. The PCNs tend to use other peoples systems. They are well served by SystmOne to enable them to share patient information in practices but they do not have similar access to information systems in social services and in AgeUK. The PCNs also have a complex task to perform in managing their caseload, i.e. recording the details of patient visits, setting appropriate priorities and ensuring referrals to other services have been effective. At the moment the PCNs use 'home grown' systems to keep their records and it may be that they could be significantly improved. Similarly, the methods by which the work of the PCNs are monitored are relatively underdeveloped and better systems could make it possible to continually improve understanding of where the PCNs can make the biggest impact.

10. Views of the Future Stakeholders ventured a number of views on the future of the programme:

- All of the stakeholders, but especially the practice staff, were very keen for the PCN programme to continue. Indeed they would like to see it extended so that (a) all GP practices could offer the service and (b) patients from other categories, e.g. younger patients with long-term conditions, those with mental illnesses and families with sick children, could benefit from the PCNs' navigational expertise.

- There were concerns about how many practices a PCN could support. Over the life of the programme, the PCNs have gradually extended their cover so that they now support up to 4 or 5 practices each. There is concern, particularly in the practices, that they may now be spread too thin. This concern is on two grounds. The number of referrals in each practice is growing so that the workload could become unmanageable. However, the other issue is that there is a general view that PCNs need to be 'seen' in a practice to be effective, e.g. to remind practice staff to discuss patients with them and to be involved in practice meetings.
- The PCNs have had a considerable degree of latitude in the way they interpret their role and for many stakeholders this is regarded as very important because of the requirement to respond to whatever the patient need turned out to be. There was some concern that as the PCN programme is further developed the role might be more tightly defined and preclude many of the activities the PCNs found to be necessary in practice.
- At the time of the study some of the PCNs were being considered for roles within the whole systems strategy and there were sharply divergent views about this development amongst the stakeholders, especially amongst GPs and other practice staff. Some felt this was a very good development because it enabled the PCNs to include basic healthcare in their repertoire of capabilities. Others however were fearful that it would dilute the capacity of the PCNs to deliver non-medical navigational support to a much bigger population of patients that also had significant needs.

11. Recommendations The main recommendation of this study is perhaps obvious. There is a wide and growing need for navigation to the bewildering world of available services and the PCNs based in GP practices are able to serve this need. We recommend the service is sustained and extended elsewhere whenever possible.

Our other recommendations are specific ways of enhancing and protecting the effectiveness of the service. It could be enhanced, for example, by looking for ways to share patient and client information with other providers, by developing tools to help PCNs manage their case load and by ensuring that the mentoring arrangements and opportunities to share learning with colleagues are enhanced in order that the community of practice can continue to grow. One of the dangers to the effectiveness of the PCNs is that they are being spread over a greater number of practices. We recommend the inclusion of a criterion about the necessary 'presence' in a practice to be effective in any mechanism for establishing the number of practices a PCN can serve. As the programme matures there are also other dangers that the properties that have enabled the early success of the programme might be lost. There is a danger, for example, that the programme might become more formalised with tight definitions of the role. This could rob the PCNs of the discretion they currently have to be patient-centred and to follow wherever the patient need takes them. There are many possible variations of the navigator role, including being within a whole systems strategy, and each will have an impact on the target population the navigator can serve and what they can and cannot do for the patient. We see a three way on-going tension that will need careful attention in any debate about future developments: a tension between specifying the scope of a programme, of enabling the navigator to be patient-centred (and therefore able to do whatever is necessary to see that a patient's needs are met) and of selecting the patients that the navigator can serve. Whatever the strategic plan for future

developments, the reality they have to deal with means any navigator is going to need a considerable degree of discretion.