OUT & ABOUT

Learning Resource

Scotland's Experience of Community Health Navigators

Who is this Resource for?

This resource is intended for Community-led health practitioners, statutory sector partners, wider 3rd sector, funders and procurement professionals who are interested in ways to support individuals who are isolated with long-term conditions. The following document describes the work of the 'Out & About' (O&A) Programme which during the delivery phase, between October 2013 and October 2015, has supported 160 isolated individuals with long-term conditions to build their confidence, skills and knowledge and reintegrate them to the wider community using the social model of health. The social model of health focuses on and attempts to address the broader influences on health (social, cultural, environmental and economic factors) rather than disease and injury. This resource provides case studies, learning from sites and practical resources to support individuals or organisations to develop their own programme for supporting individuals who are isolated with long-term conditions.

This paper describes the role of Community Health Navigators (training, practice, infrastructure, outcomes etc) and how it works in practice as a mechanism for empowering isolated individuals with long-term health conditions. Community Health Navigators (CHN) recognise the importance of working with individuals to build confidence and self-esteem and connecting people through social networks, group activities and linking people into appropriate local services. Based within long established and well respected Community-led Health Improvement CLHI organisations the work of the Navigators often complement statutory services because they have the flexibility to meet specific needs and they can work holistically with individuals. In short, these CHNs and CLHI organisations move in to fill the gaps which others would struggle to reach – they trade on trust, build their activities from first-hand experiences and maximise the local knowledge and connections available within their community. There is growing evidence relating to the benefits of recruiting local members (lay people) in promoting health based on the values of life experience and support systems which can exist within neighbourhoods. (Woodall et al: 2003)

Background

O&A supports individuals with long-term health conditions and the wider community to tackle the causes of social isolation and health inequalities. O&A involved a consortium of 5 CLHI organisations from Aberdeen to Ayrshire who are using their combined resources, experience and expertise to tackle the issues regarding social isolation and health inequalities. The O&A partnership includes Annexe Communities, Glasgow; Healthy Valleys, South Lanarkshire; yipworld, East Ayrshire; Deaf Connections, Glasgow and The Foyer, Aberdeen and is managed by Scottish Communities for Health & Wellbeing (SCHW) a national representative body for 75 Community-led health improvement organisations. Training, reporting and monitoring & evaluation support was provided by Community Health Exchange (CHEX). The project was funded through the Health and Social Care Alliance Scotland's (The Alliance) 'Impact Fund'. The Alliance recognises that in the current economic climate there is an urgent need to develop effective, economic and sustainable models in disadvantaged communities which can be used to tackle the barriers which result in individuals becoming socially isolated and, as a result, experiencing poor health and wellbeing and a poorer quality of life.

O&A created 5 part time Community Health Navigator posts and a number of volunteering opportunities (See Appendix 3: The job description for a Community Health Navigator). Each CHN spent time building a relationship with isolated individuals and developing a sense of who that person is and what is important to them. Over time these individuals were supported to share their hopes and fears and to plan and work towards personal outcomes. The CHN determined what support was needed with the participant and together they worked to enable the individual to achieve their personal outcomes.

Over three years the project has supported 160 individuals, with long-term health problems who had become socially isolated, to identify and self-manage pathways to achieve positive personal outcomes. This amounts to 7,968 hours of O&A support to the people who are most vulnerable in the community.

The outcomes for the overall programme were:

- Beneficiaries are better able to identify positive personal and social outcomes and manage the pathways to achieving them.
- Individuals in the project are better able to self-manage their long-term mental health condition/situation.
- Beneficiaries have increased skills, knowledge and confidence
- Communities have increased capacity to empower individuals with long term mental health problems who are experiencing social isolation.

Overall the project has changed lives and provided a huge increase in confidence; built a stronger relationship with partners and increased work with statutory agencies. O&A has also had a very positive impact on the wider family and community.

"*She has been able to set very clear goals. She has reported a significant increase in her feelings of confidence and self-esteem and also stated that she now feels more connected in her local community. Her main goal is to find employment and she feels that she is making significant steps towards this.*" (Family member)

"*He now has a clear structure to his day and a feeling that he is doing something worthwhile. He will shortly be moving on to the REACH programme as he is keen to make further positive progress and start thinking about employment.*" (Family member)

"*He has now developed coping strategies to help him manage his fluctuating mood and confidence levels and has been able to engage with a community based organisation as a volunteer.*" (Family member)

"*Through identifying her own goals and making links within her local community she has also discovered a flair for communication and negotiation and she uses this to sources resources for others.*" (Community member)

Out & About has developed the critical role played by Community health navigators.

Scotland's first Community Health Navigators
– Left to right:
Joyce Cameron - yipworld,
Lainey Docherty - Annexe Communities,
Maureen Heddle - Aberdeen Foyer,
Mary Hastings - Healthy Valleys,
Catriona Lafferty - Deaf Connections

Getting Started

In a unique approach to funding applications Scottish Communities for Health and Wellbeing (SCHW) issued a call for expressions of interest to its 75 partner organisations. The expressions of interest were considered by the SCHW Board and a group of 5 organisations were selected to form a consortium to prepare a bid for funding. The organisations in the consortium had an interest in and experience of working with individuals who had become isolated and disconnected from family, friends and their communities often as a result of long-term conditions. The 5 organisations came together to form a Partners Group made up of managers and development workers from the consortium organisations. Over 3 days, across a few weeks, the Partners Group met to design the O&A project and produce the bid for funding. SCHW then applied to the Alliance for 3 years funding. The Alliance granted a reduced sum (based on huge demand for the fund). Following negotiations the Alliance determined that the full programme would be run over 2 years. This allowed for a lead in to the start of the programme which enabled Partners to market the approach to local partners and to employ a CHN for each area. The model was as follows:

The recruitment of the CHN happened in a number of ways. In some sites an existing part-time staff member within the organisation was identified or a post was advertised locally and a new part-time member of staff joined the particular organisation. Each organisation determined how many hours the CHN would work based on their allocation of funding and their local conditions. All Partners received equal amounts of the funding. There were some minor variations in the hours worked by CHNs based on each Partner organisation's rate of pay and management costs.

The O&A programme started off with a 2 day development workshop with Managers and CHNs from each Partner organisation present to discuss the practicalities of implementing the programme and reporting mechanisms. Key to the success of the programme was the inclusion of both the CHN and their managers at the development day and subsequent Partner Group meetings. This ensured that the people who implement the programme (CHNs) and the decision makers for the Partner organisation (Managers) were both involved in all the development, review, progress and problem solving discussions at Partner meetings.

In advance of the start of the programme marketing materials were co-produced by the Partners to make local service providers aware of what the O&A programme aimed to do and how it could support local agencies and organisations. When in post the CHNs promoted the programme through meetings with partners in schools, GP surgeries, housing associations, social work services etc. to explain the project in more detail and to encourage appropriate referrals.

One of the key discussions at the beginning of the programme was the eligibility criteria for potential participants in O&A. It was agreed that the 4 main criteria for inclusion would be:

The participants*

- must have a long-term condition (Physical/ mental) – can be a self-reported condition,
- must have been isolated for over 1 year – none or very limited contact with statutory or voluntary sector service providers,
- willing to be part of the programme (beneficiaries must be ready and able to give their time and commitment to the process),
- must meet local organisation criteria for O&A e.g. older person, young person etc.

*(*See case studies at end of this resource)*

Learning Points

Partnership working

The Partners Group met quarterly to discuss progress and agree the way forward. Sharing information across the 5 localities proved an excellent way of developing confidence of CHNs and improving practice. The Partners regularly reinforced the importance of the host organisation manager attending the Partners meetings with the CHNs. This proved to be invaluable in maintaining continuity when two of the original CHNs moved on to new posts. The discussions and exchange of ideas and experiences as well as resources at these meetings were critical and influenced practice across the project e.g. in the way LEAP records were kept; in the use of Outcome Star for personal plans; in the ways of approaching initial meetings and the pace of working with individuals.

Referrals

CHNs made regular contact with referral agencies. These include GP practices, Social Work Services, Cordia Home Help Services, local schools (Guidance staff), Royal Voluntary Services, Remploy, student support services, churches, community councils, NHS Public Health teams, NHS Mental Health Teams, Plus One, managers of health centres, district nurses, carers organisations, local health visitors, sheltered housing organisations, Community Flats organisations and organisations supporting homeless individuals. Information and references to O&A has also been included in the websites of many of the organisations and on the CHEX and SCHW websites. It was considered important to ensure that regular positive progress reports on the work of the project were made to referral agencies. The CHNs organised regular follow-ups with the appropriate referring organisations to remind them of the service that O&A provides and to discuss the process for appropriate referrals to the project. As a result the number of inappropriate referrals decreased to around 1 in 4.

Despite efforts to establish new referral routes the majority of the referrals to the project have come from groups or services which already have good links with the host organisations. The range of referring organisations has increased over the 2 years as O&A has become more established in each of the 5 communities.

Progression

CHNs focused on progressing participants to positive destinations. The balance that each CHN struck was in helping people but not creating a dependency, instead providing them with the advice and information to help them make informed choices and not to ‘do it for them’ but to encourage them to do it themselves. On the other hand, in some instances CHN were surprise at the level of progress made by some participants with a relatively small input from O&A.

Training

Rather than providing one central training resource within the programme CHNs took up a number of local training opportunities including, Supporting Health Related Behaviour Change, Scottish Mental Health First Aid, Learning, Evaluation and Planning (LEAP), Assist Training, Safetalk training and Lip Reading training.

Monitoring & Evaluation

Using LEAP Online to monitor and evaluate progress provided a very effective common framework for recording and monitoring the programmes progress in different sites. The support from CHEX as a main partner was invaluable in establishing and maintaining this approach effectively. All CHNs were supported in working with LEAP Online and this was welcomed and effective. In the development of individual plans for participants many of the sites used the Outcome Star which varied depending on the theme of the organisation; for example some sites were working with young people, others were working with the deaf community and others were working with older people.

Successful methods

Having an independent chair from the SCHW Board (ie not involved with any of the Partner Group organisations) and from another community-led health improvement organisation was vital because it provided an impartial overview of the work and helped to keep partners on track in terms of service delivery and sustaining the approach.

The CLHI organisations commented that the initiative brought them national exposure for their work and allowed them to work in partnership and share practice with other organisations in other parts of the country rather than just working within their locality.

CHNs took an asset based approach to participants to identify the positives in each person's life. Working without time limits was one of the most successful ways of progressing with participants to help them manage issues and become more engaged with the wider community. (See case studies at the end of this resource)

SCHW ensured that the appointment of CHNs took place through well-established community-led health improvement organisations. This proved to be critical to the success of the programme. CHNs quickly benefitted from the reputation, credibility, integrity, structures, processes, contacts and resources of the host organisations. This enabled the O&A Programme to start up very quickly and benefit from the established close relationship with local contacts, resources and services.

Challenges

Referrals

Overall a majority of referrals have arisen from connections/ programmes/ personal contacts linked to the activities of the host organisations. The CHNs and host organisations did require to remain vigilant about responding to inappropriate referrals.

Multiple conditions

Several of the beneficiaries of the programme had complex and multiple health issues coupled with fairly chaotic home situations. These individuals, while responding positively, continued to be very challenging for the CHNs.

Local Partnerships

It has been challenging and time consuming to actively engage and sustain health professionals and other agencies in the project.

Time constraints

The nature of some family ties have been identified as an important contributory factor to an individual's isolation. This has led to a challenge to balance the time CHNs spend with beneficiaries and with family members and has also led to a review of the roles which volunteers played in the project.

Travel

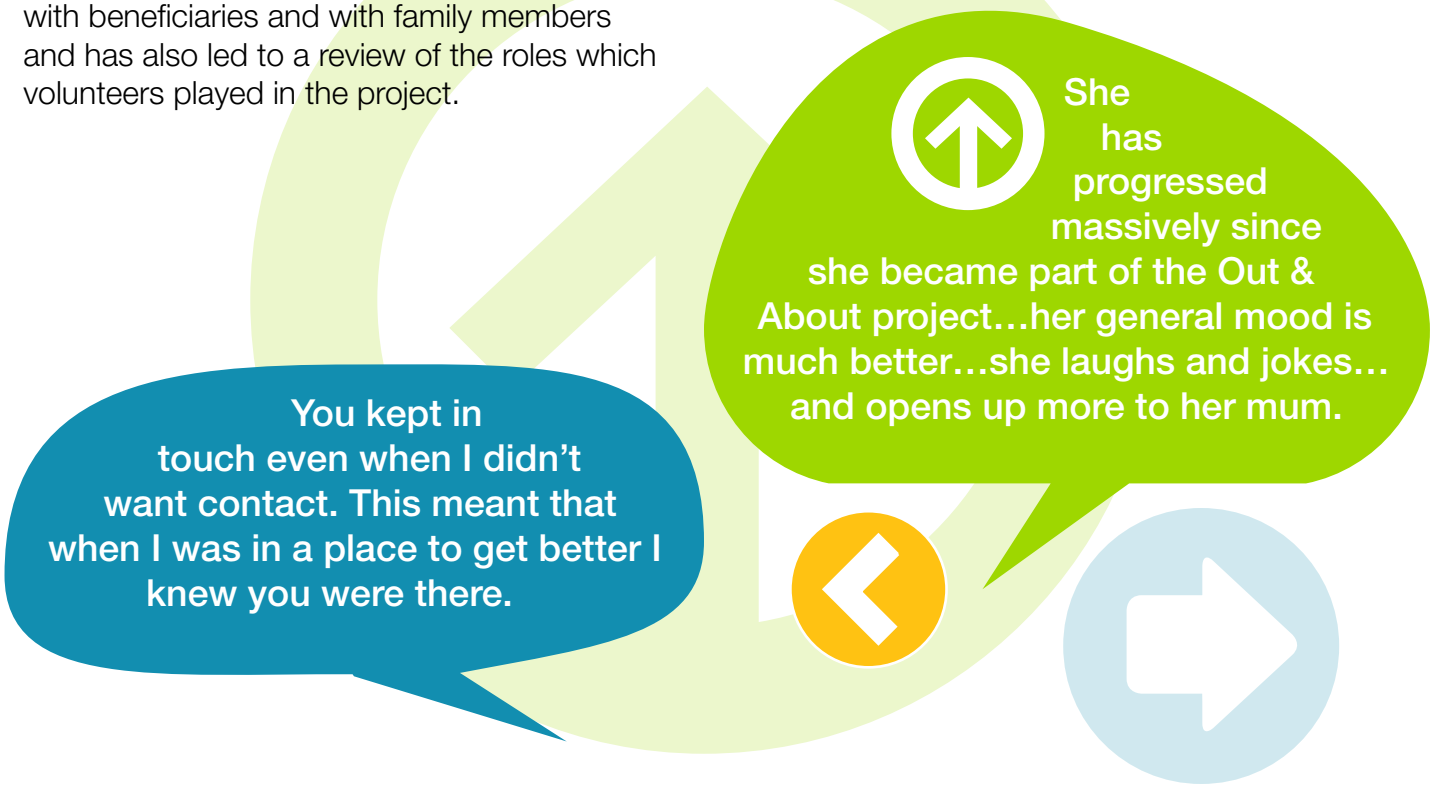
The distances/routes that some beneficiaries have to travel to access opportunities for community engagement & individual support proved challenging in some cases. This was particularly true in rural locations.

Support

Deaf Connections who work with deaf and hard of hearing people found it difficult signposting or referring to other partners as these services were not supportive to the deaf community i.e. not having BSL interpreters available. As a result Deaf Connections had to be more involved and hands on with participants. Limited funding for the programme meant that there were few resources for additional interpreter support.

Staff Churn

It was challenging at points to deal with managers or CHNs moving on to new posts. This often entailed bringing the newly appointed person up to speed quickly and to get buy in to this way of consortia working.



Learning for the Future

Partnership agreement

In order to maintain consistency as staff move on it was decided that O&A should develop a letter of understanding or partnership agreement which indicates the importance of service delivery and Partner Group meetings with dates of meetings allocated in advance.

National Programme

Marketing the programme as a national approach was useful to demonstrate that local CLHI organisations are working at a national level, it helps raise the profile of local projects to national status.

Volunteering

The volunteer role did not work as planned in all the locations. However local variations in the roles of volunteers contributed to the effective delivery of the programme. In future the volunteering role will be an optional choice for locations to make.

Demand

Statutory agencies appear to be very keen to have a trusted social prescribing model that they can work with (See quotes below from referral agencies). We need to agree on a more formal referral process to manage inappropriate referrals.

I have regained confidence and been educated about other useful resources in my community. I also learned to follow my action plan but at small steps at a time…I got there in the end. They have given me my life back again.

O&A as a community resource

"The Out & About Project has been a very valuable resource. This project has changed people's lives. Many users had not been out and are now actively going out and look forward to it. I have also noticed an improvement in their mental health and confidence." (GAMH Team)

"Out & About is needed as there are very limited resources for older people in this area. There are many service users that had not been out for years which has had a very negative impact on their mental health." (Social Services Team)

"Out & About offers an additional service to support clinical teams. This project supported several of our patients to become more involved in local activities." (GP Practice)

Impact of O&A

"Each individual is now going out and have their independence back and improved mental health and well-being. It has been positive and life changing for the individuals." (GAMH Team)

"Out & About reaches people that other services don't." (Housing Association)

"There are not enough organisations like Out & About which have local knowledge and the fact that they support clients over a long period of time." (CPN)

"Out & About has had a positive impact on individuals. It has made regular commitments to clients who have been difficult to engage. All of our patients have had a positive experience from being involved." (Social Services Team)

Strengths of O&A

"Out & About staff are willing to really try to see if they can find an activity that interests the client. They persevere with patients that other services have given up on. They continue to keep in touch. They see all our referrals in the first instance." (GP Practice)

"The Out & About project encourages independence. Each individual feels empowered. This project works on increasing people's confidence. It positively changes mental health and wellbeing." (Later Life Matters Team)

Other comments

"It would be great to see the project expand as there are many people outwith the area requiring support." (Housing Associations)

"The age group supported by Out & About should be expanded." (Social Services Team)

"Out & About gives people their lives back." (GAMH Team)

"Like to see it funded long term." (CPN)

Appendix 1

Case studies

Case Study 1

A young person aged 21 yrs was referred to the Out & About project from the Job Centre's disability team. He had been socially isolated for over two years, won't go out on his own and suffers from anxiety and depression. He also has slight learning difficulties and a foot impairment causing him problems when walking for any length of time.

I met with him on several occasions to build up a relationship with him before arranging any other appointments with him. I escorted him to doctor's appointments but found the doctor did not show any interest in him, he received a lot of different medication which led to him taking side effects such as hallucinating and thinking people were in his house. Due to lack of interest from the doctor I arranged for him to register with another GP's surgery. The new doctor listens to the young person and has arranged a variety of tests to be carried out resulting in his health improving. He was sent for x-rays and has also been referred to a specialist for his foot. I also arranged for his medication to be made up and collected on a weekly basis due to him getting mixed up with some of his pills and taking the wrong dose.

I referred him to the mental health disability team who are now arranging services such as physiotherapists, psychiatrists, occupational health and for him to attend some group work for him to assist with his daily living skills.

I took the young person to visit an organisation based in Kilmarnock that works with people with disabilities where they get real work experiences but need to be referred through social work. The young person is really keen to participate in this so I have now been able to secure a social worker for him and hopefully he will now get funding to allow him to attend this service. This service could also lead to him gaining some employment opportunities within the organisation. He will also be meeting like minded people with the same interests and will hopefully make some good friendships there too.

I took him for an eye test and referred him to the essential skills team and he is now engaging with them to enhance his reading, writing and numeracy work.

There will be ongoing input for this young person from a wide range of organisations so we will now begin an exit strategy. We will contact him periodically to ensure he is still maintaining a better lifestyle.

Case Study 2

MT contacted O&A as she had a relative who had participated in another project. An initial home visit was held and MT's cousin who also required support attended. Both had chaotic personal lives and long standing mental health issues. Goals were to get out and meet people.

Identification of individual's personal circumstances and related issues

MT is in her 40's, lives in a small village, has 4 children and her ex -partner had a drug problem. She is a carer for her son who had turned to drugs and alcohol because of issues relating to his ADHD and mental health issues. MT previously worked with young people however a family death and complex family circumstances led to her depression and drinking. She previously had support from many agencies however she felt they didn't understand her. Although she no longer takes alcohol, she lacked confidence and self- esteem and just sat in the house smoking and drinking coffee as she felt people were judging her. Her cousin was her only friend and they met daily. MT wanted to change and no longer wanted to continue in this way.

Initial activity with the individual and their response

Initial contact and engagement was sporadic with many cancellations or failure to attend, however eventually we managed a walk with her cousin. We arranged complementary therapies and despite a shaky start MT attended and in time was able to travel on her own to her appointments. MT was introduced to Hope Café which she enjoyed. She joined a sugar craft class and again despite a few setbacks managed to complete the course which was a major achievement. Unfortunately MT's cousin died in an accident. This was a major setback and MT started to drink again with some serious consequences and withdrew from the project. We remained in contact by text and some greetings cards which she appreciated and she eventually asked to come back to the project.

Current Position

Re-engagement with the project focused primarily just on talking, however eventually MT revisited Hope Café and this time continued to attend. MT has found support, a new circle of friends and initially volunteered for the Cafe. She has also lost weight through the walking group. She is attending courses to improve her confidence and self-esteem and also has a new relationship which is going well.

This has not been an easy journey for MT and despite having some major setbacks she found the courage to recover and no longer requires support from the programme. Volunteering has increased her confidence and she is looking to the future and has now gained a part time paid position helping others in the café. She is interested in beauty or reiki and looking to take courses. The son she cares for has also benefited. He no longer takes drugs, also volunteers with Hope Café, gives talks on his journey and has written 'his story'. He said that if it wasn't for O&A helping his mum he wouldn't be where he is today.

Case Study 3

A single elderly lady in her 80's who has had on going poor mobility and was involved in a car accident with another vehicle and suffered a broken arm, and trauma to her leg.

She was referred internally within the Annexe by the Connects project which works with older people and adult carers. She was previously able to do her own shopping and cleaning and had a suitable social life, getting out when she needed to visit friends etc.

The main obstacle was actually getting anywhere as she was so used to having and using the car. She had been given a walking aid with wheels to get around as she couldn't use both sticks because of her broken arm. The individual was scared to go onto public transport with the walker as she had never been on a bus for a lot of years and didn't know how to manoeuver the walker onto the bus.

After the referral the CHN called her and arranged a meeting. The CHN met with the lady and she was very open to receiving help from the O&A programme as she was missing her friends. The CHN took the lady on a short walk to get her used to the new walking aid. After a few meetings, the CHN felt confident to arrange a bus trip to Clydebank - offering full support. Once there the lady had a cup of tea and she was happy.

The following week, she surprised the CHN by turning up at the Annexe on her own! She got the bus along to the Annexe with her walker. What an achievement for her. She's now slowly coming back to classes and meeting with friends again. She's no longer scared to go on the bus and that's opened up new opportunities for her. The CHN will continue to meet with her until she regains her confidence fully.

Appendix 2

Project Partners

Project Partners/delivery

Healthy Valleys	www.healthyvalleys.org.uk
yipworld Aim for Success	www.yipworld.org
Annexe Communities	www.annexecommunities.org.uk
aberdeen foyer	www.aberdeenfoyer.com
Deaf connections	www.deafconnections.co.uk

Coordination & Research

SCHW Scottish Communities for Health + Wellbeing	chex community health exchange	scdc scottish community development centre
www.schw.co.uk	www.chex.org.uk	www.scdc.org.uk

Funded by

ALLIANCE HEALTH AND SOCIAL CARE ALLIANCE SCOTLAND people at the centre	www.alliance-scotland.org.uk

Appendix 3

Community Health Navigator: Job Description

JOB TITLE:	Community Health Navigator Part Time X hours
SALARY:	£XXXXX Pro rata
RESPONSIBLE TO:	Health Team Manager
JOB PURPOSE:	To support the Development and Co-ordinate the design and delivery of the Out & About Project

Main Responsibilities

1. To gather knowledge of, and engage with local communities to develop effective partnerships with health and social services, public services, individuals, local third-sector organsiations and community groups to identify individuals who are suffering from long term conditions and are isolated in (disengaged from) their community
2. To employ a range of approaches to make contact with individuals experiencing social isolation and to recognise the indicators of social isolation.
3. To provide identified individuals with the opportunity to undertake person centred assessment, planning and support to enable them to take control over their daily life and enhance their motivation to self-mange their situation and support community engagement and reduced isolation
4. To work with individuals to recognise their skills and aspirations, and use these to identify positive personal outcomes and develop personal pathways to developing stronger personal support networks including encouraging individuals to volunteer as mentors for other socially isolated and lonely peers.
5. To assess and record the progress of individuals in completing their pathways and in achieving their personal outcomes and moving to self-management of their quality of life.
6. To work with participants to identify solutions and address barriers to community engagement and improve uptake of opportunities and engagement in activities that increase their physical activity and improve their mental health and wellbeing
7. To effectively liaise with relevant community organisations to identify opportunities for engagement for the project client group
8. To be aware of the range of effective interventions to promote and support (individuals') emotional well being and positive mental health
9. To advocate on behalf of, signpost and support access to professional help where necessary to appropriate support organisations
10. Represent the project client group at relevant local and national meetings and forums
11. Ensure the positive promotion of the Out & About project
12. Support the recruitment, selection process, support and supervision of the Community Researchers
13. Ensure the health, safety and welfare of the participants at all times.

14. Ensure effective records are maintained and individual performance and progress recorded.
15. Contribute to the management of the project by participating in staff meetings – including planning reviewing and evaluating work.
16. Develop a knowledge of internal and external programmes, agencies and support networks likely to benefit the support, development and progression of project participants.
17. Undertake training and continued professional development as relevant to the project and as defined by your Line Manager
18. Other such duties as are necessary for the maintenance and development of the Out & About Programme and as defined by your Line Manager

Person Specification

Criteria	Essential	Desirable
Qualifications / Training		
• SVQ level 2 or equivalent in a training development, health, community learning discipline or related field.	√	√
• Relevant professional and/or personal experience		
Relevant Experience		
• Previous experience of working with and supporting individuals, in particular, skills to motivate, encourage, support and challenge people	√	
• Previous experience of positive interactive teamwork		√
• Experience of and commitment to developing the potential of people and an understanding of issues those with a long term mental health condition may be experiencing	√	
Knowledge and Skills		
• Have an understanding and knowledge of long term mental health conditions, community engagement and healthy lifestyle practices.	√	
• Ability to challenge behaviour but also engender a sense of belonging.	√	
• Ability to develop trust and positive relationships	√	
• Ability to be able to deal with a crisis situation	√	
• Good ICT skills	√	
• Proven written skills	√	
• Great communication and interpersonal skills	√	
• Strong presentational ability	√	
• Proven ability to meet operational deadlines	√	
• Ability to liaise effectively with external agencies and to represent and promote the Out & About project and 'host organisation' positively.	√	
Disposition		
• Demonstrates enthusiasm, stamina, creativity and initiative	√	
• Ability to work collaboratively with others at all levels and provide a positive role model	√	
• Full driving licence		√
• Has own transport		√

References

LEAP Online
www.planandevaluate.com

SCHW
www.schw.co.uk

Outcome Star
www.staronline.org.uk

Reference
Woodall, J. White, J. South, J.
Improving health and well-being through community health champions: a thematic evaluation of a programme in Yorkshire and Humber. Perspectives in Public Health March 2013 Vol 133 No2 SAGE Publications