EAST SUSSEX TRAINING HUB

University of Brighton

Care Navigation Evaluation (CaNE)
Final Report

Evaluation of the NHS Hastings and Rother and NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Groups Care Navigation Initiative

Report prepared for

The East Sussex Training Hub

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Executive Summary

KEY MESSAGES

(1) By May 2019 22 GPPs were delivering care navigation out of the 29 GPPs which completed the training, a 76% implementation rate over the pilot period.

(2) The evaluation analysed care navigation data and carried out interviews with a total of 46 participants, from 4 implementing practices, one non-implementing practice and the care navigation implementation team.

(3) Over six months 10,010 navigations were accepted by patients to internal, external, other health, and self-help professionals/services.

(4) Overall, staff expressed support for care navigation. Completion of the template was one of the main challenges reported by reception staff.

(5) Patients responded positively to care navigation. Staff reported that patients' awareness and understanding of treatment options and services improved and some patients were getting quicker treatment by professionals with more specialist knowledge.

(6) 1,526 GP hours were saved during the 6-month care navigation period, equivalent to an estimated 407 GP working days per annum. GPs saw their time being used for patients in need of seeing a doctor, but they were still very busy.

(7) Care navigation is a success story which should be rolled out further.

(8) Implementing care navigation took longer and required more resources than anticipated, but the benefits, in the views of the interviewees, clearly outweigh the costs.

(9) Care navigation is likely to become a key component in the development of primary care networks and delivering integrated care, as required by the NHS Long Term Plan.

BACKGROUND AND AIMS

Care navigation is a model of active signposting used to guide patients to the health or social care service/professional who is best able to meet their needs in a timely fashion. Care navigation was piloted in GP Practices (GPP) in two neighbouring CCG areas in 2018. These are NHS Hastings and Rother (HR CCG) and NHS Eastbourne, Hailsham and Seaford (EHS CCG) Clinical Commissioning Groups. GPPs which took part in the pilot received care navigation training, a template to log and record patient navigations, and support with the implementation of care navigation. The University of Brighton were commissioned by East Sussex Training Hub to carry out an evaluation of the care navigation pilot to:

- Explore key changes the new service has made to the day to day work life in individual GP practices;
- Report on patient experiences within primary care;
- Report on the impact on GP capacity;
- Report on the impact on service providers outside the practice which are included in the care navigation template;

- Explore the impact of care navigation on services within the practice.

Care navigation will be abbreviated CN and GP practices as GPPs.

METHODS

The project utilised a mixed-methods evaluation approach. An analysis of navigation data was conducted to establish i) total number of CNs across the pilot, ii) navigation pathways, and iii) other navigation trends. Case studies of five GPPs (four which had implemented CN; one which had trained staff, but not implemented CN) were developed, combining quantitative template data and semi-structured interviews with receptionists, patient advisors, senior practice managers, and internal and external service providers. Telephone interviews were conducted with four members of the CN implementation team.

KEY FINDINGS

(1) By May 2019 22 GPPs were delivering care navigation out of the 29 GPPs which completed the training, a 76% implementation rate over the pilot period.

(2) The data shows that the CN pilot was successfully implemented in GPPs. Over six months, 10,010 navigations were accepted by patients to internal services (76%), external services (11.2%), other health services such as A&E (11.8%), and self-help professionals/services (1.1%). Out of these, 9,154 were navigations to services that did not involve the patient seeing a GP as the right person first. Based on a GP appointment of ten minutes, this represents a saving of 1,526 GP hours over a 6-month period. This would be equivalent to 407 GP working days per annum (based on a nominal working week of 37.5 hours[1]).

(3) The level of interest in CN was higher than expected at the planning stages which meant that more GPPs than planned for were involved in the pilot. This impacted on the ability of the implementation team to monitor closely CN in each GPP and to deliver the level of additional training and support they would have liked.

(4) Most managers and reception staff felt the training was adequate and did prepare them to navigate patients. Initial fears and concerns of reception staff that CN would involve significantly more responsibility and would be poorly received by patients did not materialise. Most patients contacted the GPP and see a GP because they are the right person first. Staff report few issues with the group of patients who would be better treated by other internal or external services.

(5) Reception staff reported that navigating patients they judged as 'vulnerable' and/or for social issues (compared to medical issues) was harder and more stressful.

(6) Staff reported that CN improved their awareness and understanding of local services available to treat and support patients. Staff's self-confidence in CN increased over time.

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[1] British Medical Association at https://www.bma.org.uk/advice/employment/contracts/sessional-and-locum-gp-contracts/salaried-gp-model-contract/minimum-terms-and-conditions (accessed 04/11/2019)

(7) The case studies suggest that CN worked better for GPPs in urban areas, or in places with greater availability of external services. It is more of a challenge in semi-rural areas or in places where external services are not local or easily accessible; staff reported that patients can be reluctant to travel or cannot travel, for mobility or financial reasons.

(8) Problems with the template, in particular the additional time it took to complete, was one of the main challenges of CN implementation raised by reception staff.

(9) Staff reported that patients' knowledge and understanding of treatment options and services had improved. They also felt that some patients were getting quicker treatment by health care professionals with more specialist knowledge of some complaints.

(10) Although staff from all four implementing case study GPPs reported that CN has saved GP time, GPs reported that clinics were still very busy and demand for their time remained high despite the introduction of CN. However, they reported that CN meant they saw fewer patients who did not need to see a GP and they felt better able to manage their workload efficiently.

CONCLUSIONS AND RECOMMENDATIONS

Overall Conclusions

(i) Care navigation, based on the figures and interviews contained in the report, is a considerable success, supported across staff groups (GPs themselves, practice managers and receptionists), and patient members of advisory groups also considering it beneficial. Care navigation despite some initial reservations has been adopted in many practices with benefits well outweighing changes to roles, above all the role of receptionists, and changes to working practices. The *Right Person First* initiative aimed to ensure that patients are navigated to the *right* service or professional *in good time* and thus improving patient health and wellbeing whilst also freeing GP time, for patients who needed to see them. Based on the figures and interview data, care navigation is an unmitigated success.

(ii) The interview data provide many useful pointers which can inform training, further roll-out, and fine-tuning of care navigation; these include:
   a. Further efforts to help patients understand care navigation are needed;
   b. Worries about having to pay for external services need to be addressed;
   c. Care navigation may be easier in urban areas or areas with local services; hard to reach groups may find care navigation more difficult;
   d. Patients, once they understand care navigation, may 'game the system' by finding ways of ensuring being seen by a GP even when other services might more appropriate;
   e. Implementation may be more challenging and time-consuming than anticipated, particularly when competing with other initiatives; resources need to be managed carefully.

(iii)   The limitations of this evaluation need to be kept in mind; no objective health service data, except for numbers navigated, or health outcomes were collected. A small number of case studies forms the backbone of this report.

Recommendations

Care navigation implementation and delivery

(i)   Care navigation should be promoted to GP practices which have either not adopted it or not undergone relevant training.

(ii)   Follow-on support including reflection on implementation of working practices is offered to reception teams and delivered to those who would consider it beneficial.

(iii)   Improvements to the care navigation template should be considered, informed by further consultations with receptionists who are the main staff group navigating patients.

(iv)   Care navigation may be extended to other services/professionals beyond those which are already sign-posted, but care needs to be taken to keep all staff including senior GPs on board and to not overcomplicate processes and the template. It is, however, possible that over time, both staff and patients will develop their understanding of needs, suitable/required services and professionals, mitigating this potential risk. This needs to be linked to recommendation (ii).

(v)   Promotion of care navigation should be embedded in the entire patient care pathway, within primary care; anecdotal evidence found by the researchers suggests that many practices already provide automated messages to their patients calling in by phone and highlighting to the caller that relevant services may be sign-posted to them.

Care navigation in the wider context

(vi)   Care navigation appears to be a successful innovation which has spread quickly within the pilot area.

(vii)   Care Navigation is an effective intervention supporting the integration of health and social care, within the context of the primary care networks, going forwards. Thus the sign-posting taking place as part of care navigation is an important element in delivering on *The NHS Long Term Plan* and the establishment of integrated care systems.

Evaluation and research

(viii)   Further evaluation of care navigation over an entire year would be useful; questions which should be addressed include reasons for refusal by patients to be navigated, navigation of vulnerable patients and patients who tend to not use health services, despite possibly serious health problems. Collection of objective and economic data on the effects of care navigation on GPs, other staff in practices and external services

would be highly desirable, possibly in collaboration with care navigation initiatives in other regions.

(ix)   Evaluation and research should be integral to the development and improvement of working practices within primary care, adopting a systematic and reflective approach. as e.g. based on the *quality improvement wheel* suggested in An Introduction to Quality Improvement in General Practice, published by NHS England in April 2019[2].

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[2] NHS England (2019) An Introduction to Quality Improvement in General Practice. April 2019. https://www.england.nhs.uk/wp-content/uploads/2019/03/an-introduction-to-quality-improvement-in-general-practice.pdf

Contributors

Jörg Huber was principal grant holder and has overall responsibility for the report. Nigel Sherriff was co-applicant and contributed to all phases of the project, including the final report. Carlie Goldsmith was in charge of day-to-day delivery of all aspects of the project and made substantive strategic contributions to the project. Alexandra Sawyer provided research ethics support.

Acknowledgements

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Acronyms

CCG	Clinical Commissioning Group
CN	Care Navigation
EMIS	A widely used digital clinical records system
ESLT CEPN Network[3]	The East Sussex Learning Together Community Education Provider
ESTH	East Sussex Training Hub (replaced ESLT CEPN during summer 2019)
GPP	GP Practice
PPG	Patient Participation Group
MECS	Minor Eye Conditions Service

[4]

Tables and Figures

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[3] https://news.eastsussex.gov.uk/health-and-care-news-east-sussex/wp-content/uploads/sites/10/2018/12/Governance-Pack-2018.pdf

1. Background

Care Navigation (CN) is a model of active signposting developed by West Wakefield Health and Wellbeing between 2015 and 2017 as part of a New Models of Care vanguard site (see e.g. https://westwakefield.org/our-history/). The overarching aim of care navigation is to signpost patients who have requested a GP appointment to an alternative provider who might better be able to meet their needs. CN may be carried out by a number of professions, but in the East Sussex Training Hub (ESTH) catchment area this role is primarily taken on by receptionists. To this end GP Practice (GPP) receptionists were trained to offer patients who contact primary care requesting a GP appointment, treatment with the health or social care professional or service that were best able to meet their needs. CN is one form of so-called *link-working* focused on people getting the right type of support, at the right time[5]. Since its development and pilot in West Wakefield, CN has been promoted as a model GPPs can use to manage increased patient demand by increasing patients' awareness, understanding and use of other community-based health and social care professionals and services.

Right Person First

The Right Person First initiative, implemented by East Sussex Better Together (ESBT), aimed to raise awareness amongst patients of the services provided by allied healthcare professionals and other services available in GPPs and in the local area to treat and resolve health and social care issues.

A major component of the Right Person First initiative was to pilot CN in GPPs across the East Sussex Better Together alliance region which has aimed to improve population health and wellbeing and reduce health inequalities, and break down barriers between health and social care[6]. 'Care Navigation' (also referred to as 'active sign-posting) was one of the ten 'high impact actions' in the Time for Care Programme – one of the outcomes of the GPFV initiative.

 It was identified as a model that could:

- Help GPPs manage patient demand and release more GP time so patients whose immediate needs can only be met by a GP get to see one;
- Streamline care by directing patients to the Right Person First;
- Enhance the role of receptionists in GP practices.

To judge whether CN would be acceptable, 200 patients at Shaping Health and Care events, focus groups, an online survey, and PPG events across the footprint were asked for their views on their ability to access appropriate care. This consultation found that the majority of people wanted the right care *quickly* and that seeing a named GP was not their main

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[5] On link-working, see e.g. https://www.connectlink.org/2018/06/24/why-social-prescribing-is-different-from-active-signposting-care-navigation-and-mecc/ (accessed 17/10/2019)
[6] ESBT includes the following organisations: East Sussex County Council, East Sussex Healthcare NHS Trust, Sussex Partnership NHS Foundation Trust, Sussex Community NHS Foundation Trust, Eastbourne Hailsham and Seaford Clinical Commissioning Group (CCG), Hastings and Rother CCG, High Weald Lewes Havens CCG. Link at https://news.eastsussex.gov.uk/health-and-care-news-east-sussex/

priority, as evidenced by comments during meetings. Confident that patients would engage with CN, a gold package which included six days of training support and 150 care navigator licences was purchased from West Wakefield Health and Wellbeing. The package included an implementation strategy and access to CN training and support. Funding for the project came from two sources: ESTH submitted a paper to the GPFV management group requesting funding to run the pilot. Further funding was provided from monies allocated to ESTH by Health Education England (HEE). The initially purchased 'gold' package was upgraded to the 'platinum' package on realising the number of practices which wanted to be involved; this package included 300 care navigators licences, ten days of training support and two days of business intelligence support.

Care navigation has to be seen against a background of the ongoing development of primary care networks[7,8]. These groupings of GP practices are an important element in delivering *The NHS long term plan*[9]. As the primary care networks mature, it is intended that they will deliver personalised care to patients through integrated health and social care resources in the community. Being able to navigate patients to the right services in a seamless fashion will be crucial to the success of the PCNs.

A CN planning group oversaw the delivery of the pilot programme at a strategic level and a CN implementation team was established to focus on the ground level operation. The CN implementation team included seven members, representing key stakeholders with a range of relevant skills (management, GP representative, digital and training expertise) to aid delivery of CN. Activities involved:

- Members of the team attending CCG locality meetings to inform GPPs about the pilot and promote it;
- Running two events in Eastbourne and Hastings for GPs, practice managers and patient advisers that were designed to inform attendees about CN, promote the pilot and register GPPs;
- One full and one-half day event where senior staff from GPPs and patient advisors identified how they would use their internal services and what external services could be navigated to, thus avoiding a GP referral (Footnote[10] provides further

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[7] NHS England, Primary Care Networks. Accessed 04/11/2019 at https://www.england.nhs.uk/primary-care/primary-care-networks/

[8] Rebecca Fisher, Ruth Thorlby and Hugh Alderwick (2019) Understanding primary care networks. Context, benefits and risks. The Health Foundation. Accessed 21/10/2019 at: https://www.health.org.uk/publications/reports/understanding-primary-care-networks

[9] NHS England (2019) The NHS Long Term Plan. Jan 2019, Version 1.2 with corrections, August 2019. Accessed 04/11/2019 at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[10] Patients in this pilot were navigated to one of seventeen **NHS services** which included: other GP service, accident and emergency service, emergency care practitioner, general practice extended hours service, general practitioner out of hours service, minor injuries unit, general practice based pharmacist, health care assistant, nurse, mental health nurse, nurse practitioner, general practice based physiotherapist, health trainer, smoking cessation service, health and wellbeing worker, home visiting service, general practice administration team and five external services, a community pharmacy, dental services, health and social care connect, minor eye conditions clinic, Health in Mind. Where appropriate, patients could also be referred to one of thirteen **other organisations and services that could provide 'self-help' type support**. These were

details of services). Representatives from external service providers involved in the pilot also attended including, One You East Sussex, Southdown Community Connectors, Health and Social Care Connect, Minor Eye Conditions Service, British Pregnancy Advisory Service and physiotherapy;

- Development of the CN template for the EMIS system that receptionists use to log and record patient navigations. The template was piloted by two GPPs and has been reviewed and revised over the pilot period;
- Development and distribution of a communications toolkit to be used by GPPs involved in the pilot to inform patients about CN. The toolkit included examples of banners for reception screens and posters plus copy for a GPP answerphone message, GPP newsletter and text message;
- Providing additional support to GPPs where required, for example answering queries and questions from pilot GPPs and reassuring GPPs who were finding implementation a struggle;
- Commissioning the CN pilot evaluation and sharing information about evaluation with key GPP staff.

The pilot was funded initially by General Practice Forward View (GPFV[11]) funds allocated to NHS Hastings and Rother CCG and NHS Eastbourne Hailsham and Seaford CCG; further funding came from ESTH received form Health Education England via ESTH. GPPs who took part in the pilot received the CN training, template and support at no additional cost to them.

In return, GPPs were required to commit to:

i)   release staff for training;
ii)   use the template;
iii) agree that the CCG/ESTH could extract template data from EMIS for monitoring and evaluation purposes.

2.   Evaluation Aims

The evaluation of the CN pilot aimed to:

- Explore key changes the new service has made to the day to day work life in individual GP practices;
- Report on patient experiences within primary care;
- Report on the impact on GP capacity;
- Report on the impact on service providers outside the practice which are included in the CN template;
- Explore the impact of CN on services within the practice.

Cont'd Footnote 10

benefits advice, parenting support, parenting skills training, British Pregnancy Advisory Service, Citizens Advice, Age UK, NHS Health Check, Alzheimer's Society, contraception and sexual health service, Midwife, health and wellbeing worker, substance misuse service and support service for carers.

[11] General Practice Forward View, see https://www.england.nhs.uk/gp/gpfv/, accessed 13/11/2019.

Recruitment challenges and the associated time constraints (discussed further in Section 3 of this report) mean this evaluation report focuses mainly on the impact of CN on receptionists, managerial and other staff within GPPs and the impact of CN on GP capacity.

3.   Methods

Approach

The evaluation utilised quantitative and qualitative methods.

Quantitative: an analysis of the template data provided by the ESTH was conducted to establish (i) total number of CNs across the pilot, (ii) navigation pathways, and (iii) other general navigation trends.

Qualitative: case studies of five GPPs who had been involved in the CN pilot – 4 who had trained staff and implemented CN and 1 who had trained staff and not implemented CN by the time of the evaluation, plus semi-structured telephone interviews with members of the CN implementation team.

The case studies for implementing GPPs were developed from a combination of quantitative template data with semi-structured qualitative interviews and focus groups with receptionists, patient advisors, senior practice managers and staff and internal (Health Care Assistants, Senior Nurse Practitioners and GPs, for example) and external service providers (such as Community Pharmacists and staff delivering the Minor Eye Conditions Service) gathered at each GPP. All but two of these interviews and focus groups were conducted face-to-face. The case study for the non-implementing GPP was developed from a semi-structured telephone interview with the practice manager.

Recruitment

Details of GPPs involved in the CN pilot were shared with the evaluation team. A named member of staff at all GPPs were contacted and asked if the GPP would agree to take part in the evaluation.

An email was sent to all members of the CN implementation team asking if they would be willing to be interviewed. Staff who agreed contacted the evaluation team and a telephone interview was arranged.

Participants

Full details of participating practices and participants can be found in Table 1. Four participating GPPs and one non-implementing GPP took part. Interviews or group discussions involved a total of 41 participants, plus 4 members of the CN implementation team.

Table 1. Number of participants involved in CN evaluation, by group

	Receptionists	Patient Advisors	Senior Managers	Internal Service Providers	External Service Providers	Total
South Medical Centre	3	10	1	2	0	16
North Medical Practice	4	0	1	3	1	9
West Town	2	1	1	1	2	7
Eastern Road Practice	6	0	1	1	0	8
Greenview (non-implementing GPP)	0	0	1	0	0	1
Total GPP participants	**15**	**11**	**5**	**7**	**3**	**41**
CN implementation team	-	-	-	-	-	4
Total participants						**45**

Data analysis

All interviews were recorded, and a summary of each interview was produced. Data from each case study GPP was grouped together and analysed thematically. Data from the telephone interviews with the CN implementation team staff were analysed thematically. A descriptive statistical analysis was conducted on the quantitative template data.

Research ethics

An application for ethical approval was submitted to the Life, Health and Physical Sciences Centre Research Ethics Committee and approved in April 2019. In practice this meant that:

- Informed consent was obtained from all participants;
- Participants could take part in the evaluation confidentially, unless they disclosed information about behaviour that was potentially harmful to them or others;
- GPP case studies have been renamed and all features that could potentially identify them have been omitted from this report;
- All data was securely stored.

Reflections on the approach

- Participating in an evaluation was not a requirement for GPPs who took part in the CN pilot. Recruiting GPPs to this evaluation was a challenge. Many, even those who had given an earlier indication to the CN implementation team that they would be willing to participate, declined. Time pressure and staffing issues were the most often cited reasons for not taking part.
- At the start, it was planned that a named link person in the GPPs participating as case studies would share participant information sheets with receptionists, patient advisors and internal and external service providers and those individuals would contact the

research team if they were willing to take part in a focus group (receptionists and patient advisors) or telephone interview (internal and external service providers). None of our participants were recruited using this strategy. Instead a member of the research team spent a day in each GPP and interviewed or conducted focus groups with participants that the link person/s (always a member of the management team) had pre-arranged. Opportunistic interviews were also conducted with other staff where possible but time pressure on staff meant few were able to engage.

- Patient advisors from each case study GPP were invited to take part in a focus group at the practice by the evaluation link person. The response from patient advisors was low. This reflects the limited role patient advisors have played in the CN pilot. The 10 patient advisors who took part in a focus group at South Medical Centre were already at the practice for the advisory group meeting and had little knowledge of the CN pilot. Most insights this evaluation offers about the impact of CN on patients has therefore been drawn from the perspective of GPP staff and service providers.

- At the start, we wanted to include the top three external services that patients were navigated to from each GPP in the evaluation. In the end, involvement from external service providers was limited to those the link person had some relationship with and who agreed after being invited to take part by them. Two community pharmacists and an optician from a MECS were the three external service providers who participated in the evaluation. Only a very limited understanding of how CN has impacted on external services can be offered in this evaluation.

4.   Findings

4.1 Implementation of the CN pilot

Views of the project and its getting off the ground were very positive.

> *'I think it's been a great project and I hope it gets renewed and reviewed for the benefit of practices and patients.'* (CN implementation team member)

Overall, the data shows that the implementation of the CN went well. In particular:

- CN implementation team members felt that the effort and time that was put into informing GPPs about the CN and promoting the pilot paid off and did result in a high level of interest from GPPs;
- Events were well received and successful in their aim to promote CN and get GPPs to sign up to the pilot. Senior GPP staff involved in this evaluation found the input from the care navigation programme manager from West Wakefield particularly helpful to them. Originally, the ESTH has planned that the CN pilot would involve 10 GPPs but across the two waves of implementation that had taken place since Spring 2018, 359 staff from 29 GPPs across the footprint were trained as Care Navigators;
- By May 2019 22 GPPs were delivering care navigation out of the 29 GPPs who complete the training, a 76% retention rate over the pilot period.

- There were concerns from GPPs about CN, for example some reception staff felt that CN would change their role from administrative to clinical and some were concerned about the additional time CN would take. The CN implementation team arranged for staff from GPPs that had embedded CN successfully to support GPPs that were finding the process more difficult. This process was considered helpful by the GPPs involved in this evaluation;
- The implementation team felt the events that were held to identify the Top 6 external services to be included on the template were very positive. Staff from the GPPs who participated in this evaluation agreed and reported that this made them feel more invested in the pilot and gave them a greater understanding of the external services they could refer patients to and what they offered;
- The CN implementation team recognised and accepted that GPPs would customise the CN model to meet their particular needs, for example not navigating at the reception desk. In practice, this has caused some issues, which are discussed later in this report. However it does reflect the fact that GPPs are independent and serve different patients with often different needs;
- The CN template was tested by two GPPs before it was rolled out, but not all issues with the template and how it is being used were successfully addressed (see section 4.3);
- The GPPs involved in this evaluation who implemented CN had all used the communications toolkit provided by the CN implementation team to promote CN to patients;
- Senior staff from GPPs involved in the pilot reported that the support received from the CN implementation team met their needs. GPPs could contact the CN implementation team with questions or queries, request refresher training or other forms of support where required. As of May 2019, 22 GPPS of the 29 who were trained were still using CN – a take-up/implementation rate of 76%.

Reflecting on the implementation, members of the CN implementation team also highlighted some challenges.

A. **Shared and agreed understanding and expectations**: GPPs involved in the pilot did agree to use the template, release staff for training and share template data with the ESTH and CCGs. On reflection, however, it was felt that GPPs should have been asked to sign a Memorandum of Understanding or other type of agreement which set out more clearly other requirements and expectations. For example, how GPPs would use the template, setting a minimum requirement for GPPs to communicate with the implementation team or a requirement to take part in any evaluation. Members of the implementation team acknowledged that this could have resulted in some GPPs deciding not to be involved in the pilot but it was recognised that not doing this has made it harder to judge how well the pilot has met its main aim, to offer patients more appropriate help for conditions better served by other professionals enabling GPs to have more time for those who needed their expertise and has meant that

some GPPs disengaged from the pilot process quite quickly, even though they have continued to use CN.

> *'The big lesson is the need to be much clearer about what you expect from GPPs at the very beginning.' (*CN implementation team member*)*

B. **CN pilot size**: The CN implementation team were surprised by the level of enthusiasm and interest GPPs showed in the CN pilot and were keen to capitalise on this as much as possible and so did not limit the number of practices to ten, as originally planned. On the one hand, this means that more GPPs have navigated patients over the pilot period, but it also meant that there was less time to work with GPPs because the team were stretched and not able to conduct the in-depth preparation and systematic follow-up work they had planned. For example, the implementation team could have gone into GPPs to explain more about the pilot and CN and provide more information early in the process, which might have allayed staff fears about CN. They could also have had systems in place to receive staff feedback on what was working and not working and conducted refresher training and provided additional support.

> *'Feedback was more stumbled about. How it was being used and more information about what was useful, what wasn't and what could be done next time, would have been useful because that would help us with all our work, not just this project.'* (CN implementation team member)

It was acknowledged by the team that whilst some of the GPPs involved have established a relationship with ESTH, this has not been the case for many which has made it more difficult to understand the impact of CN over the pilot period. As this extract above highlights, this feedback would have had value that reached beyond this pilot and so this was a missed opportunity.

C. **Not a quick win:** Originally, CN was an attractive model because it was identified as a 'quick win' for GPPs wanting to better manage GP time. The experience of this pilot, however, is that implementing CN is not a quick win. The pre-pilot preparation and implementation took approximately two years and this was longer than planned.

> *'The time it took to implement was long, long, long.'* (CN implementation team member)

several factors were identified as contributing to this: CCG governance processes; organisational and structural change within the CCG; the 'bolt on' nature of ESTH; limited staff capacity; and large pilot size. It was reported that this led to some of the momentum built at the early stages of the pilot being lost and leading to a very small number of people driving through the process. It needs to be noted that the involvement of practices in the set-up was time limited; introductory meeting in

December 2017 and training and implementation starting in June 2018, the process stretching to about 6 months.

Despite the challenges, members of the implementation team felt that CN delivers for patients who present to GPPs with different needs.

> *'CN meets a variety of needs of patients from varying backgrounds for different reasons. So for example if you phoned up with a muscular-skeletal problem then you could be care navigated straight to see a physio. It makes much more sense; you don't need to see a GP and have the right professional there. On the other hand you can have a frequent flier who comes in with this ailment and that ailment and spends time talking about their social problems and their depression and a ten minute appointment turns into a thirty minute discussion. CN is really helpful because if you unpick it the problem might be that they haven't got any food or they can't pay their rent and there is a social prescriber they can be navigated to and you can ask, 'do you want to go and speak to them first and if you still feel you need to see someone come back to us.'* (CN implementation team member)

And whilst they acknowledged that CN remains a 'work in progress', they feel there are signs that the model is becoming embedded in the practice and culture of primary care of the GPPs involved in the pilot.

> *'It's interesting what the language is now it's just embedded. 'Oh, we can just care navigate into that or we could use the care navigators to do that,' so it's just becoming par for the course.'* (CN implementation team member)

This shows that CN has had a longer-term impact on staff and GPPs.

4.2 Evaluation of CN pilot outcomes for Dec 2018 – May 2019

Saving GP time for those most appropriate for their care was a quantifiable aim of the CN. The template data included numbers of completed navigations and navigation destinations for the four CN implementing case studies and totals for all 22 navigating GPPs between December 2018 and May 2019 – half of the 12-month implementation period.

The findings presented here do not represent the total numbers of CNs that have taken place because i) data was not provided for the whole 12-month implementation period and ii) the case studies show that the CN template was used differently by GPPs and were not consistently recorded by receptionists.

Number of CNs

Our analysis shows that between December 2018 and May 2019 (for full details see Fig 1):

- A total of 10,650 internal, external, other health, and self-help CNs were attempted and recorded by reception staff. Navigations to GPs were not counted towards these figures, but were very small (n=73; 0.7%).

- Of these, 10,010 (94%) care navigations were accepted and 640 (6%) were rejected by patients.
- Figures for January and February are higher, indicating a possible seasonal effect.

Figure 1. Number of accepted and rejected CNs in implementing GPPs between December 2018 – May 2019[12]
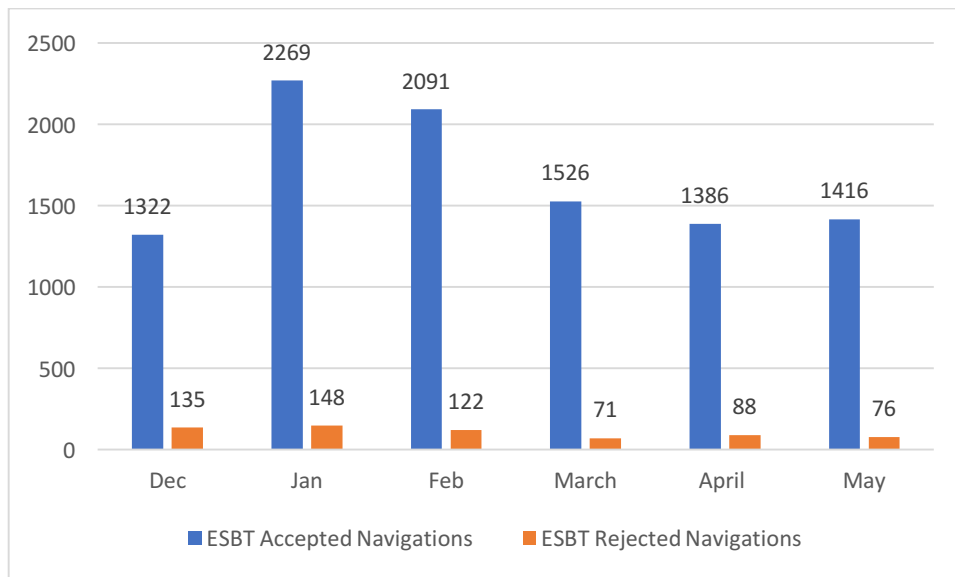
GP appointments saved

- 9,154 navigations took place to services that did not involve the patient seeing a GP as the right person first. This excludes GP out of hours and extended hours services.
- If each GP appointment is ten minutes long, this represents a saving of 91,540 minutes or 1,525.6 GP hours over a 6-month period (Dec to May). This would be equivalent to 407 GP working days per annum (based on a nominal working week of 37.5 hours[13]).

Destination of CNs

- Figure 2 shows that 7603 accepted care navigations (76%) were to internal GPP services; 1182 (11.8%) were to other health; 1124 (11.2%) to external services; and 101 (1.1%) to self-help services.
- The top three internal accepted navigations made across implementing GPPs were to nurse practitioners (3146 CNs), health care assistants (1549 CNs) and nurses (983 CNs); these figures and those below refer the 6-month period Dec 2018 to May 2019.
- The top three other health navigations made across implementing GPPs were signposts to GP extended hours services (769 CNs), signposts to Accident and

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[12] Excel spreadsheets with full, aggregate data listings can be made available.
[13] British Medical Association at https://www.bma.org.uk/advice/employment/contracts/sessional-and-locum-gp-contracts/salaried-gp-model-contract/minimum-terms-and-conditions (accessed 04/11/2019)

Emergency services (170 CNs) and advised to attend GP out of hours services (87 CNs).

Figure 2. Destination of accepted CNs, December 2018 – May 2019
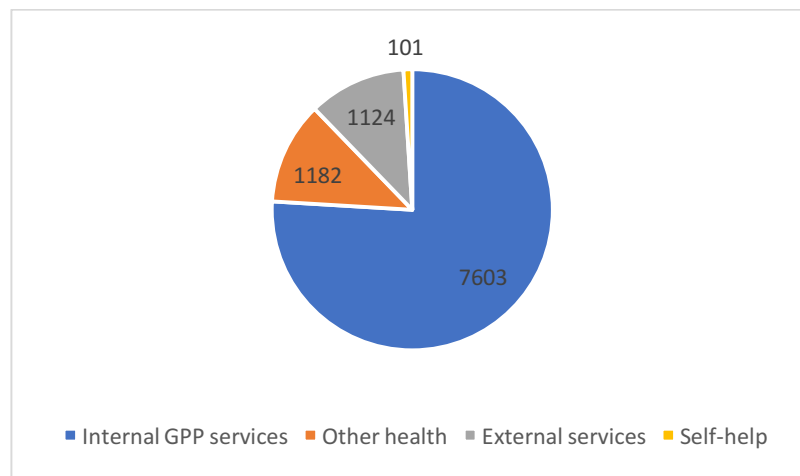
- The top three of external services CNs were to community pharmacies (606 CNs), opticians (345 CNs) and Improving Access to Psychological Therapies (IAPT) services (78 CNs).
- The top three self-help navigations were to the midwife (37 CNs), contraception and sexual health services (14 CNs) and health and wellbeing worker (13 CNs).

Case Study A - South Medical Centre (16 participants including 10 Patient Advisors)

South Medical Centre (SMC) has just under 11,000 patients, a large percentage of whom are elderly and live independently in their own homes. The area the practice serves is settled and many of its patients have been registered at SMC for a long time. Patients are used to seeing a GP when they contact the practice and have historically had relatively easy access to appointments. In recent years, however, demand for GP appointments has increased and the practice had outgrown the space available. To manage this, reception staff were asking what patients needed to see the GP for when they contacted the practice for an appointment, but it was felt that implementing CN might better help them manage demand. SMC became involved with the CN pilot in 2018. The office manager attended the events run by the ESTH and heard about the experiences of West Wakefield Health and Wellbeing and was involved in the discussions about what external services would be included in the CN template. The office manager felt the sessions provided her with a clear road map of how to implement CN in the practice.

> *'It was good. I got back to the practice and I could literally say;*
> *this is how we're going to do this.'* (Office Manager, SMC)

When reception staff were informed about CN some were positive.

> *'I thought it was a great idea because it would help the practice with appointments and getting patients to go elsewhere.'* (Receptionist, SMC)

Others were more apprehensive because they were concerned that patients would not agree to be navigated. Some receptionists were also concerned that CN made them more responsible for patients and therefore more vulnerable if something was to go wrong.

> *'I thought it was going to be difficult. I thought it would be hard to persuade patients to accept it because they're used to having access to the doctor as and when they wanted it.'* (Receptionist, SMC)

In the autumn of 2018 CN was implemented at SMC. Staff completed online training in preparation for CN. Posters advertising CN were displayed in the practice and the telephone answer message was changed to inform patients that the GPs had asked reception staff to ask additional questions. At that point, all receptionists were expected to view all contacts with patients seeking a GP appointment as a potential navigation and to log every interaction on the template.

Reception staff felt that overall the online training did prepare them for CN, although it was recognised that some members of the team struggled with the online delivery and may have benefitted from face-to-face engagement. They also reported that the support they received from managers and each other was enough to implement CN. Despite this, it was acknowledged that not all receptionist fully engaged with CN in the beginning and that it has taken time to achieve consistency across the team. Initially, some reception staff saw CN as a big change to their role and were reluctant to take on what they considered to be additional responsibility. Others reported a lack of confidence and were worried about asking patients additional questions. Over time, as receptionists have seen CN in action and had support from other members of the reception team this has changed. Now, some receptionists are still navigating more than others, but the view from managers is that all staff are now on 'on the same page' with CN. A staff incentive scheme is being used to further encourage staff to navigate where possible.

SMC has benefitted from using CN. Reception staff and managers feel that it has saved appointments.

> *'There were so many wasted appointments with things that GPs didn't need to see but could be better dealt with elsewhere, like the pharmacy. There's not a lot of wasted appointments now. Now we can give numbers out and they can self-refer. There's a lot of things patients can do to help themselves and it's really saving appointments.'* (Receptionist, SMC)

100 accepted CNs were recorded by receptionists at SMC between December 2018 and May 2019. Clinical staff have not seen a reduction in their workload but feel that CN means they are seeing patients who do need the services of a GP because more issues are being dealt with elsewhere.

In addition, GPs feel that the additional information gathered by reception staff is enabling them to run clinics more effectively and improving patient outcomes as a result.

> *'I can hover over a name and see why they are coming in to see me so I will often look through my clinic and I'll call through to [Office Manager] and say can you get Mr X to come in now rather than the end of surgery because I don't want him waiting two and a half hours with what's written on there or I'll say we need to call an ambulance. The patients aren't aware that this is happening but we are looking at the details given to the reception staff before clinic starts.'* (GP, SMC)

Reception staff, managers and clinicians felt that navigated patients had benefitted from CN because they had a better knowledge of the services that were available to them locally, got treated faster and had greater access to more specialist care.

> *'A lot of people have spoken very highly about the minor eye clinics in the area and before they wouldn't even have known they were there. They are seeing the right person first time and they are getting a far better assessment of the condition of their eyes than they do from me so it's far better.'* (GP, SMC)

Internal service providers did not feel their services had been disrupted by CN and did not report that they were overwhelmed with navigated patients. There was, however, a general lack of awareness about CN amongst internal service providers, who reported seeing mention of CN on emails but little other formal communication about the strategy and pilot.

Patient advisors had very limited awareness of CN; they were told about it being introduced to the practice at the last Patient Participation Group (PPG) meeting, but this was the first-time information about CN was shared with them as no SMC advisor followed the invitation to attend the training sessions. At the most recent PPG meeting, patients were given more information about CN and shown the latest practice newsletter due to be distributed to patients, which featured CN. Members of the PPG who had been navigated felt the process had been simple and straightforward and did not feel intrusive. Patient advisors were clear that in their experience reception staff at the practice were professional, efficient and helpful. The introduction of CN had not altered this view.

Reception staff felt that CN had made the job of receptionist easier as they have more options to help patients, had made them more knowledgeable about patient care and had given them confidence.

> *'I'm more confident and more secure that I have more possibilities to help, to navigate.'* (Receptionist, SMC)

They do, however, still identify as receptionists and CN has not precipitated a fundamental change in how they see themselves in the role.

SMC will continue to use CN. They have embedded it into training for all new reception staff and current receptionists, now see it as rooted in their role despite being hesitant in the beginning.

> *'It's just second nature. It's just what we do.'* (Receptionist, SMC)

There does however, remain some challenges for the practice. It was suggested that between 10-20% of patients are still very reluctant to engage in navigation. Some practice staff felt that GPs should be doing more to encourage reluctant patients to support CN, for example, identifying patients who have refused and reassuring them that the advice and information provided by reception staff was correct. Practice staff felt that there also needed to be a campaign to raise awareness amongst the general public about the role of CN in primary care.

Reception staff felt that some patients also struggled to access external services because there is not many located in the immediate area and mobility issues and financial constraints make it had to travel. There is also limited communication between practice staff and external services.

Reception staff and internal service staff felt that some patients are reluctant to be navigated because they are concerned about whether they will be required to pay for services or purchase treatments that they are used to getting free or cannot afford.

Although the practice is working hard to ensure that all patients who can be are being navigated, some reception staff are still less likely to navigate than others and so some opportunities to direct patients to the right person are being missed. Reception staff are also struggling to complete the navigation template, especially during busy times because of a lack of time and pressure to answer calls.

Case Study B – North Medical Practice (9 participants including 0 Patient Advisors)

North Medical Practice (NMP) has just under 15,000 registered patients and is in the centre of an urban area. Although the patient population is varied, a high percentage of the practice's patients face significant social and economic challenges and as a result present with high levels of physical and mental ill health that is often compounded by homelessness, drug and alcohol misuse, criminal justice involvement and poor educational outcomes. Over the past nine years, central government has reformed the out of work benefit system and reduced the local authority budget. At the same time, the social and medical needs patients present with at NMP have increased, placing further pressure on GP time.

This reality forced senior leaders and managers at NMP to be creative in the ways it manages patient demand. Prior to the introduction of CN, NMP already employed an informal navigation process that saw reception staff routinely enquiring what a patient's issue was and seeking, where possible, to find a treatment solution that avoided GP involvement altogether or minimised the amount of GP time. In this informal system, reception staff were limited to referring patients to internal practice services and a limited

number of services located nearby, the community pharmacy and sexual health services. NMP wanted to implement CN because it formalised a process they had already deployed, the template provided a way to record this work, it gave practice staff access to training and increased the number and type of external services available to navigate to.

> *'We were, unbeknownst to us, care navigating anyway so when it came along, we had a lightbulb moment. This is what we've been doing but great there's an actual template for it and actual guidance for it, so the transfer of skills wasn't that difficult for us.'* (Office Manager, NMP)

NMP became involved with the CN pilot in 2018. Managers from NMP attended CN events and training and this was cascaded back to the reception team, who also completed online CN training and went through the template in meetings. Receptionists felt the training was 'clear' and mostly prepared them for navigating patients. Some felt that more opportunity to role play would have helped them feel more confident about managing patients who were reluctant to be navigated or who were more challenging.

> *'We didn't get much training on role play and how you speak to patients because some of my colleagues didn't feel very confident, and I felt that maybe if they did a role play it would have worked quite well.'* (Receptionist, NMP)

NMP fully implemented CN from the start and reception staff deploy navigation where appropriate with all patients who contact the practice to make a GP appointment. NMP publicised to patients on the reception area video screens, by posters in the practice and through changing the practice answer machine message. The PAG were informed of CN and the practice's involvement in the pilot.

Reception staff acknowledged that because they had already been sending patients elsewhere for treatment, CN was a formalisation and development of and not a radical change to their usual working roles.

> *'It wasn't a massive change for us, but it gave us the authority of the GP.'* (Receptionist, NMP)

Despite this, some reception staff reported that at the start of the process they had concerns about the time it would take to complete the template, especially during the busiest hours on the telephones in the morning, and how patients would react to being asked additional questions.

> *'I cringed when I first heard [about CN]. For the simple reason that our phones are so busy from 8 o'clock onwards we thought it was going to impact on us a lot more until we knew what was going to happen.'* (Receptionist, NMP)

Receptionists report that most patients have been open to CN and that completing the template has become quicker with practice, although some report that the tension to

answer calls quickly and to navigate and record navigation means the template is not consistently completed.

Now CN is considered an integral part of the role of a receptionist, and some reported that it had improved their level of knowledge and confidence but had not resulted in a fundamental change in professional identity. In contrast, senior practice staff felt that CN had impacted on the receptionists' role. Reception staff, they felt, were empowered, more confident, had better levels of knowledge and now occupied a more responsible and central role in the practice system.

> *'They are more empowered and have a much more interesting role to play in the life of the practice. They are no longer 'just' a receptionist. They are more involved, and this brings extra satisfaction, learning and developing in their job.'* (GP, NMP)

Internal service providers reported that CN had given reception staff a better understanding of what they do.

CN has saved GP time and meant that GPs are not seeing people who could be successfully treated elsewhere. 312 accepted CNs were recorded by receptionists between December 2018 and May 2019 at NMP.

> *'To be honest, navigation has made our lives [GP] much easier because some of the things that would have come to us before are now being dealt with by our team. So, in many ways it has been a very successful project.'* (GP, NMP)

GPs also felt CN had resulted in patients being treated faster and more proficiently.

> *'Patients are not having to wait for a GP appointment and so their needs are being met much more quickly, much more efficiently and with less hassle.'* (GP, NMP)

Navigating patients away from GPs has not had negative consequences for internal services providers, who were fully aware of CN and its implementation at NMP. Senior nursing staff said that CN had led to the nursing team seeing some patients they may not have seen before, but this had not disrupted their service. Health care staff felt that CN had relieved some pressure on their clinic time as patients with very minor issues are being navigated out of the practice.

As well as being beneficial to the practice, staff at NMP feel that CN benefits patients. It has improved their knowledge of what services they can self-refer to, resulted in quicker treatment by the right person and therefore also saved the patient time.

> *'It's beneficial to the patients because they are being treated quicker, it's beneficial to the staff because their time is being utilised properly.'* (Internal Service Provider, NMP)

There are signs that CN has started to impact on how some patients are thinking about primary care and seeking treatment.

> *'I had someone in the other day for a blood pressure check. She said she had itchy eyes and when it had happened before she'd gone to the pharmacist and got drops and it had solved the problem. She asked if I thought she should do that again rather than see the GP because she wouldn't have to phone first thing, come in for the appointment but could go to the pharmacy and have the drops in a few minutes. I said yes. [Interviewer] Would you have had that conversation before CN? No, it would have been the doctor doesn't want to see me, they're not bothered, they don't care.'* (Internal Service Provider, NMP)

NMP had a working relationship with some external service providers before CN was introduced because some are located in the same building and were receiving informally navigated patients before the introduction of CN. These relationships have continued and now some of the new external service providers operate in NMP because there is a shortage of space in the town where services could be based. CN has resulted in NMP having working relationships with more external services.

Furthermore, managers at NMP reported that CN had increased communication between themselves and external service providers and that this enabled the practice to be more proactive in its care. For example, since the introduction of CN they had more instances of external services contacting the practice with concerns about patients because they presented in a way that suggested their physical or mental state had deteriorated. Staff at the practice then contacted the patient and invited them in for a review or to see a GP and potentially avoided a crisis for the patient.

Another advantage is that for NMP CN has made the healthcare system more joined up.

> *'This formalisation makes everyone aware of it so when you send a patient to the community pharmacist to have a look at an insect bite they're aware that they should be looking at that insect bite and advising the patient well actually here's an over the counter something or actually that looks infected you need to go and see your GP. If they come to us, we know the pharmacist has seen it and the patient needs an appointment.''* (Office Manager, NMP)

The community pharmacist nearest to NMP confirmed that since the introduction of CN they had become busier and noticed an increase in the number of people saying they had been referred to them by their GP, although they could not say that this was solely down to CN as a campaign to encourage people to buy basic medication over the counter instead of getting a prescription from the GP was also being run. The pharmacist reported that they had always had a good relationship with NMP and that CN had not changed this. The pharmacy were supportive of CN continuing as they felt it raised the profile of the

community pharmacy amongst the population and increased patients' awareness of the full extent of the services provided by pharmacists.

CN is a normal part of practice life at NMP and managers felt the investment in staff time and training had paid off. None of the staff, however, felt that they had spare time on their hands. Patient need meant that the practice was as busy as ever; however, senior staff felt without CN they would be even busier. CN has been very valuable to NMP and they plan to continue to use and develop it at the practice.

> *'This is the best system at the moment that can be used to help us meet patient demand. It's an invaluable thing to be implemented at a GP surgery and I think if it continues to be developed it'll carry on being invaluable.'* (Office Manager, NMP)

Staff acknowledged that CN was not a magic bullet and that there were still challenges to overcome. The percentage of patients at NMP that could be navigated is quite low because of the high level of medical and social need in the patient population. CN helps them manage existing demand, but practice staff felt that the needs in the population are still growing whilst other forms of social support are becoming scarcer creating a very challenging climate for primary care.

Vulnerable patients, by whom staff meant the elderly, the homeless, those with drug and alcohol abuse issues and those with mental issues need continuity of care and to establish relationships with care providers.

> *'Anyone who comes under the vulnerable banner, they need to know who they're seeing really. They need relationships with people.'* (Internal Service Provider, NMP)

People who are time poor and who are confident enough to follow instructions do well with CN. Reception staff and internal service providers expressed concern that navigating vulnerable patients to services that are not familiar to them and not having a routine mechanism to follow-up on these patients may result in people not accessing the treatment they need and falling through the cracks. Receptionists felt it was harder to navigate patients with social issues because this was a more complicated task that was made harder by their lack of knowledge about what exactly services that focused on this area did with patients.

Many patients at NMP survive on low-incomes or live in poverty. They are reluctant to be navigated because they are concerned about how much it will cost and are used to getting medicines free on prescription.

Receptionists and internal service providers felt that a campaign to educate the general public on the best ways to use primary care was needed. Current lack of awareness meant that people still turn to the GP first to solve their medical and social needs.

Case Study C – West Town (7 participants including 1 Patient Advisor)

West Town is in a relatively affluent and settled medium sized town. It has 18,000 registered patients, approximately half of whom are older and has been involved in the CN pilot since 2018. Senior practice staff wanted to implement CN to see if it would help them better manage patient demand for GP time. For the past couple of years receptionists have asked patients what the issue is when they contact the practice for a GP appointment, and in some circumstances, they may have advised to go to the community pharmacy located a short walk away from the practice, but patients have not been routinely asked to seek treatment elsewhere prior to the introduction of CN.

When the idea of CN was first introduced to managers at West Town, they were positive about it in principle but worried about how it might be implemented in practice because it required a change in how reception staff engaged with patients.

> *My initial thoughts were, good idea but this is going to be hard to implement. People, especially receptionists don't like change, so it was going to be an uphill battle, definitely.* (Manager, West Town)

The concerns of managers were reflected in the initial response of reception staff to CN. Receptionists understood what CN was trying to achieve and saw that better managing the demand on GP time was an important goal but nevertheless felt a bit overwhelmed by what it meant for them. Specifically, they reported being concerned about how patients would react to CN and whether patients would agree to be navigated. They also said that some members of the team felt daunted by the prospect of asking patients additional questions and lacked the confidence to do so.

Reception staff at West Town were trained in CN. Some attended events and/or completed the online training and were shown the template by managers, others completed the online training and were shown the template and others could not recall completing the online training but remembered being shown the template. Those with the most training felt that it prepared them as much as anything could to care navigate but that the opportunity to role play was missing. Receptionists who received less training did not feel prepared to navigate.

> *'I don't think we were really trained, we were told and then given the template. It wasn't a full training. It wasn't, if the patient says this this way then you can say that. I felt thrown into it to be honest.'* (Receptionist, West Town)

A phased approach was used to implement CN at West Town. A script for receptionists was developed and for the first month, three receptionists only navigated all patients who contacted the practice for an appointment with the GP. Managers felt that this would give other reception staff the opportunity to see the reality of CN and hear from the receptionists involved that it was a more straightforward process than they initially might have thought. CN was also advertised on the practice website and on the screens in waiting rooms. After this, another group of reception staff were told to begin navigating and this

process was repeated until all reception staff were navigating. Now all receptionists are expected to navigate patients who contact the practice for a GP appointment.

CN has been deployed at West Town for over a year and staff have gotten used to the system and grown in confidence. It was acknowledged by managers and receptionists, however, that it still presents a challenge and is not consistently applied to all contact with patients.

> *'Can I say it's completely embedded? They forget, they forget because it's retraining them. It's ask for the name first, not who is your GP. But they have definitely improved.'* (Manager, West Town)

Between December 2018 and May 2019 341 accepted CNs were recorded by reception staff at West Town.

Receptionists reported that they do still sometimes forget to navigate (or follow the navigation script) or struggle with how CN has changed the way they communicate with patients.

> *'We are trying to change our way of thinking but when you've been doing the phones for like five years and that's your way and you're now trying to slip other things in, and you don't always ask the right questions.'* (Receptionist, West Town)

In addition, receptionists felt that more support from other practice staff might have made CN easier to embed. For example, they feel that GPs could support CN more by talking to patients who have refused to be navigated and reassuring them that they were given the right advice by reception staff. Also, there was a long delay in changing the holding message on the answerphone to a GP informing patients that they have asked reception staff to ask patients additional questions, so they are directed to the right person first. Managers felt that the delay affected the implementation of CN, a view that was supported by receptionists who felt that without it they did not have the authority to CN and that patients were more resistant.

> *'I didn't feel comfortable to care navigate anything when we didn't have the backing from the doctors. Even though we verbally did but the patients didn't know we had permission to ask and I think the mind-set of the patients has slightly changed since the message, which has gone on to help us.'* (Receptionist, West Town)

The message was changed three months ago, and this has made CN easier for receptionists to do. Their perception is that it has also made CN more acceptable to patients, who now seem more willing to engage in the process.

Reception staff felt that additional in-house CN training, which they would like to include visits from external service providers so they had more knowledge about what patients they could navigate to them would be beneficial. They also suggested that regular feedback

from the GPs on what worked and what needed to improvement when it came to CN would boost confidence amongst the reception team. Managers have introduced a CN incentive scheme and plan to implement a programme of one-to-one coaching to support the reception team.

CN has not changed the way receptionists feel about their role, although they report that it has made it a bit more stressful. Managers and internal service providers hoped that CN had empowered the reception team. At this stage, there is little to support such a fundamental change but there are signs that reception staff feel more knowledgeable, are building confidence in their abilities to CN and supporting each other with the change.

> *'We bring our knowledge in together and we work as a team to help each other.'* (Receptionist, West Town)

Reception staff also feel that CN has not changed the patient experience. Primarily because most patients who contact them are not navigated, and so do not experience a change in the service received. A member of the PPG supported this view by saying that 'ordinary' patients, those who are not members of the PPG, would not necessarily have contacted the practice in the year that CN has been deployed and that the practice had not sent a communication to patients informing them that CN had been introduced.

Despite the challenges, West Town plans to keep CN because it has navigated some patients to alternative services and saved GP time.

> *'It absolutely benefits us. Yes. It is definitely affecting our workload. We have numbers to show that 5-10% are being navigated away. It's a significant number. Here it's all about marginal gains. That's what we're after.'* (GP, West Town)

Receptionists also report that patient time has been saved when navigated and that some have given positive feedback about their experience.

> *'I sent someone to the MECS and they came back and said, 'oh my god, it's amazing!'* (Receptionist, West Town)

The ability of CN to save patient time was echoed by the MECS. They have noticed a significant increase in the number of people saying they have been referred to the opticians by their GP. For them, CN works because it improves diagnosis as patients are treated by those with specific expertise.

> *'It's a brilliant thing because we can cut straight to the chase. The training GPs have in eyes is very very basic so it stops a lot of the guesswork and speeds up treatment. It also stops the whole bouncing around from pillar to post. It takes ages to get an appointment with the GP. We are contractually obliged to give them an appointment within a week. So, there's a shorter lead time, there's more accurate diagnosis and treatment goes on and the 'poor old souls' who really need to see a GP for*

something are more likely to get an appointment.' (External Service Provider)

The local community pharmacist was also aware that more people were being referred to the pharmacy by their GP practice. To him, CN did not feel revolutionary insomuch as it is another in a long line of initiatives to direct people to the pharmacy first, however it does represent a more systematic, planned and joined-up approach. The missing jigsaw piece was how the pharmacy might better understand the impact CN has had on them.

> *'What's nice is that the practices are trying to do this in a more structured way but it's not quite there yet. You get a lot of people going to the doctor and they say right go to the pharmacy. That part of it is working. But I can't quantify how much of a difference that is making – we are very busy, but I don't feel busier.'* (External Service Provider)

West Town does face some challenges with their continued efforts to embed CN. The local town is relatively small and under-served by external services and so options for navigation are limited as patients, many of whom are elderly, have mobility issues. The limited availability means that the services that are local can get booked up very quickly and some patients have returned to the practice when they have been unable to get appointments quickly. It was felt that this undermined the legitimacy of CN.

People who are time poor are easier to navigate as they can easily see the benefits of it to them. Patients who are older, in their 80s and 90s, struggle to understand navigation and are harder to navigate.

> *'Some people are more comfortable being redirected because they are busy, and they want to get treated quickly. For some people seeing the doctor isn't about being ill. They've got ten minutes with someone.'* (PPG member, West Town)

Receptionists reported being reluctant to navigate people with mental health issues because of the risks and possible consequences for the patient if they do not receive treatment.

There are patients who refuse to be navigated and some patients are finding ways around CN by, for example, saying they have been to the community pharmacy when they have not. This is undermining CN and could negatively impact the trust between GPs and reception staff. Staff and patients felt that this could be effectively tackled if the public were educated and made more aware that receptionist staff are no longer just booking appointments but are now trained to navigate patients. As suggested by a PPG member this would make patients more likely to engage in CN.

> *'Patients need to feel that CN is being done for them, not to them. This will increase support for it.'* (PPG member, West Town)

Case Study D – Eastern Road Practice (8 participants including 0 Patient Advisors)

Eastern Road Practice (ERP) operates across two sites – Eastern Road and Compass Hill and has 17,000 registered patients. Although the patient profile at ERP is varied, patients who attend the Eastern Road site are more likely to be older and more affluent and those at Compass Hill are more likely to be younger and include people living in areas of socio-economic deprivation. ERP operates a personal list system, which means that every patient has a named GP who they will see at each appointment, unless the GP is away from the practice. Patients like this system as it gives them continuity of care. It does, however, mean that a GP is responsible for all the care of their listed patients and so workload is high. As a result, ERP is always looking for ways to help protect GP time and had implemented an informal navigation process some years before. In this system, receptionists routinely asked patients why they were calling, and where possible directed them to an internal service provider for treatment rather than the GP. Senior staff and managers implemented CN to see what, if any, extra GP time it could save.

> *'We thought it was a good idea but wondered how much extra time could be saved given that they already navigated informally.'* (Practice Manager, ERP)

Staff were told about CN at a practice meeting and were consulted on their views about CN. Receptionists' initial views on CN varied. Some were positive about it and were keen to take on the challenge. Others were less certain because they were concerned about what it would mean for their role and how patients would react. There were also worries about the time CN would take.

> *'I thought, oh my god what's this going to entail and what are patients going to make of it?'* (Receptionist, Eastern Road site, ERP)

To help allay some of these fears, the practice manager visited West Wakefield and saw CN in action. She reassured the staff that once CN was in place, it could be done simply and would not take up much extra time.

Managers and receptionists from both sites attended events run by the ESTH and completed the online CN training. At this point, managers at ERP decided to implement their own in-house CN training to ensure that reception staff were fully prepared and confident enough to navigate patients. The in-house training involved practice with the CN template, run-throughs with dummy patients and role play. The addition of the in-house training delayed the start of CN by approximately four to five months but managers at the practice felt it was vital that patient confidence in the practice was maintained.

> *'We made sure staff were really confident in what they were doing before we started because if they weren't confident then that gets passed on to the patients and they lose confidence.'* (Practice Manager, ERP)

One year later, the practice manager thinks this was the right decision and reported that from her perspective ERP has had fewer issues with CN than other practices involved in the pilot.

CN is partially implemented at ERP. All patients who telephone into the practice for a GP appointment are considered for CN. CN is not done at the reception desk at either site because of concerns about confidentiality. Initially, receptionists completed the CN template for all patients who telephone the practice, but after a few weeks it was decided that this was taking up too much time and duplicating work. Now the template is only completed for patients who telephone the practice for an appointment and who are then navigated an internal or external service for treatment. Between December 2018 and May 2019 49 accepted CNs were recorded by receptionists at ERP.

CN was advertised on the practice Facebook page and the web site. Posters were displayed in the reception areas at both sites and the holding answerphone message was changed to inform patients that GPs had asked receptionists to ask patients additional questions so they could direct them to the right person first.

Initially, there was some backlash from patients on social media who did not feel it was appropriate for receptionists to ask the additional questions CN requires to function as a GP demand management tool. Managers at ERP responded to the complaints and these have reduced over time.

The overall view is that CN has not resulted in a radical change at ERP. Internal service providers are busy and possibly a bit busier than they were before the introduction of CN but this cannot be attributed to CN as the practice has also been registering new patients. There has been no increase in communication between staff internally and life at the practice mainly continues as it did prior to CN. CN has however resulted in some change. For example, conversations between reception staff and patients have changed in tone and become less adversarial.

> *'Answering the phone and saying, 'my name is [name] how can*
> *I help you.' That brought down a barrier and made patients less*
> *rude [laughs] because you've personalised the call.'*
> (Receptionist, Eastern Road site, ERP)

Some receptionists feel that CN has not changed their role, but others do feel that it has. Some receptionists reported feeling more empowered as a result of being able to help patients access the right treatment for them.

> *'[Interviewer] Has it changed the role? I think so. For the better*
> *because you can give them a bit of guidance and you can help*
> *them.'* (Receptionist, Compass Hill site, ERP)

Others felt, however, that the additional responsibility of CN has made the role more difficult.

> *'It's made it more difficult really and sometimes the
> responsibility can weigh heavily, especially if you care deeply
> about what you do.'* (Receptionist, Eastern Road site, ERP)

For reception staff recruited after the introduction of CN it is less complicated. All new reception posts at ERP are advertised as receptionist/care navigator and all the training they receive reflects this.

Receptionists reported that most patients need to see a GP and some patients refuse to engage with CN. Patient attitudes have, however, changed over time and some patients are now more open to CN. ERP staff felt that patients willing to be navigated save time, are able to access treatment quicker because they see the right person first and do have better access to specialist treatment.

> *'We do smoking cessation here but the nurses are busy and I
> say to them if you want to give up now you are going to get
> seen quicker and not have to wait three months to get a slot
> with a nurse because it's a half hour appointment and it can be
> quite tricky to find a half hour appointment. It's much better.'*
> (Receptionist, Compass Hill site, ERP)

Patients willing to be navigated also benefit the rest of the patient population as the appointments CN saves means that access to a GP is easier for those who require that level of care.

Receptionists felt that CN had saved GP time and appointments. Senior staff, however, were less clear about this. Managers' view was that some appointments had been saved but not as many as they had initially hoped because there was not enough supply or capacity in local external services.

> *'It has helped. It hasn't saved as many GP appointments as we
> thought it would but the problem we have in this area is that
> there aren't very many outside services and those that are local
> get booked up quickly.'* (Practice Manager, ERP)

This has resulted in some external services feeling overwhelmed and requesting that the practice stop navigating patients to them. Attempts were made to resolve this but have been unsuccessful. The practice feel that this has the potential to undermine patients' faith in CN.

GPs reported that initially CN was a big success and did make a noticeable different to their workload. This, however, tapered off over time as more patients came into the practice to book appointments, possibly deliberately to avoid CN.

> *'Lots of appointments are now booked at desk and this is an
> issue. I went through my list today and all of the appointments
> were booked at desk. This is a big problem for us.'* (GP, ERP)

Management want to implement CN at reception desks at Eastern Road and Compass Hill and are currently looking at possible technological solutions to the problem.

Not being able to navigate patients at reception is not the only challenge ERP faces. Staff felt that there were still patients who refuse to engage with navigation because they have a strong sense of entitlement and unreasonable expectations.

> *'The dynamics of this surgery is that we have the wealthy elderly. We don't have many troublesome patients, but they want a private service out of the NHS. When they want treatment, they want it now and that's an unrealistic expectation. I don't know how you can change those expectations really.'* (Receptionist, Eastern Road site, ERP)

Staff at Compass Hill felt that patients registered there sometimes displayed limited understanding of the everyday demands on primary care.

> *'There are a lot of people who really have no clue of the pressure the GP are under for these appointments. They just think I need to see a GP: ' I need to see them now and they really don't appreciate that that really doesn't need an appointment'. There are a lot of people still like that.'* (Receptionist, Compass Hill site, ERP)

All staff said this could not be tackled by GPPs alone and there needed to be a public awareness campaign about CN and how to use primary care. This, they felt, might educate the public and make them more likely to be open to CN when they contact the practice. Reception staff felt that GPs also needed additional input on CN as they are so used to doing everything for patients they can sometimes undermine attempts to navigate them by giving prescriptions or running tests that should have been done elsewhere.

Other issues raised by the staff were: patients being unwilling or unable to pay for medications in external services they are navigated to; lack of capacity in external services, particularly the MECS, and the length of the wait locally for treatment; staff not as confident about navigating for social needs as they are for medical needs; and concerns that the current template is not enabling them to capture all of the CN they are doing.

Case Study E – Greenview (non-implementing GPP; 1 Senior Manager participating)

Greenview is a small practice with 4,800 registered patients. Up until the last couple of years patients at Greenview have had relatively easy access to a GP but the practice is growing, and this is changing. Practice partners were very keen for Greenview to be involved in the CN pilot because they wanted to see whether it would help better manage patient demand. In 2018, reception staff did complete the training but despite this a formal process of CN is not yet operating at Greenview.

The main reason for this was high staff turnover. Greenview had four practice managers in a year before the recruitment of the current member of staff and CN was side-lined because of this. It was not, however, just high staff turnover that impacted on the implementation of CN.

To manage patient demand receptionists at Greenview ask patients what the problem is when they contact the practice for an appointment and navigate to internal and external services where appropriate. This informal process is, however, inconsistent insomuch as some reception staff navigate and others do not. Also, navigations are not logged on the template and so there is no record that they have taken place.

GPs are getting busier and want a formal CN process to be put in place at Greenview. The practice now has a full complement of staff and there are no obvious barriers to implementation. The practice manager has asked ESTH for additional support, which they have agreed to provide. Receptionists will be asked in the next few weeks to begin formally care navigating in their role. Initially, the expectation is that they will do it over the telephone only and outside the busiest hours. The plan is to expand this until CN is fully implemented at Greenview and all patients who contact the practice for an appointment on the telephone and at reception will be care navigated if the GP is not the right person first.

There are some challenges to this. Some reception staff feel comfortable with this plan but others are expressing more concern. Primarily, this is that formal navigation means that reception staff are being asked to make clinical decisions, which they are not trained for and do not want the responsibility of.

> *'Some of our guys think they are being asked to make a clinical decision. We've spoken about this and it's not. You're just asking the patient and if the patient doesn't want to be sent elsewhere that's fine. You're not forcing them and you're not making a clinical decision yourself.'* (Practice Manager, Greenview)

Some reception staff are worried that formalising the process might result in negative feedback from patients, something that they have not seen with the informal approach. The practice manager feels confident that receptionists will realise that there is not much of a difference between what they are doing now and what they are being required to do once the process starts. She believes that over time the fears and concerns some reception staff have will be allayed.

The practice manager feels that more CN education for patients would have done a lot to help the implementation.

> *'What I think would have been better was as well as the education for practices there should have been education for patients. We do have CCG wide patient participation groups. Coming from the patients' side as well might start knocking*

> *down the resistance from patients.'* (Practice Manager,
> Greenview)

She is hopeful that with a concerted effort CN will be embedded into the practice within the next few months.

4.3 Common themes and issues derived from case studies

CN saved GP time over the pilot period: staff from all four implementing case study GPPs reported that CN has saved GP time for patients who benefited from signposting to services that better met their needs. In some instances, managers were using reports from EMIS as evidence of this but generally staff awareness came from their role navigating patients. This did not mean workloads dramatically reduced because for most of the GPPs involved in this evaluation demand for GP appointments was high and most patients seeking an appointment did require a consultation. It did mean, however, that patients who needed to see a GP were more likely to get an appointment because patients who could be treated elsewhere were being directed to an external or internal service. CN had not always, however, saved as many appointments as expected or anticipated. This was the case when CN was not fully implemented, for example, when not all staff were yet navigating routinely or when navigation was happening through one method of contact but not all. Or when there was a lack of available external local services patients could be navigated to, barriers for patients to navigation (such as having mobility issues) or lack of capacity in external services. If these issues were addressed, then CN could free GP time for other appointments which require a medically trained professional.

CN will continue in all case study GPPs: At the end of the CN pilot GPPs involved in this evaluation were at different places on a spectrum of implementation. At one end, Greenview were just starting to CN formally as the pilot ended whilst at the other, North Medical Practice had fully implemented and embedded CN into practice policies and processes. Despite this difference, no case study GPPs had plans to stop navigating patients at the end of the pilot. Rather, the data shows that going forward GPPs plan to do more to ensure that CN is used in ways that optimises its potential to manage demand. West Town is establishing a coaching programme for receptionists, for example. Eastern Road Practice want to find a way to care navigate in reception that protects patient confidentiality. South Medical Centre is going to expand the staff incentive scheme and North Medical Practice wants to explore how CN can be built into online service delivery. Furthermore, all GPPs involved in this evaluation want access to more services they can navigate to, for GPPs located in smaller towns or in places with a lack of local services this is considered particularly important. Primary Care Networks were identified as a potential solution to the problem of a lack of services but importantly for this evaluation the fact that they are thinking about how to develop CN shows that the model is considered useful.

Staff support CN: Many reception staff who took part in this evaluation said that they were initially either apprehensive, concerned or in some cases hostile to the introduction of CN in their workplace. By the time this evaluation took place, however, in all but a single case

reception staff said that given the choice they would continue to use CN because it saved GP time, patient time and in many cases resulted in quicker treatment. Reception staff reported that many of the concerns they had either did not turn out to be issues and that they had grown more confident and less worried as they became more experienced and their own knowledge and understanding of the model developed. All other internal and external service staff, including GPs, expressed support for CN.

Patient engagement and understanding: Some patients refuse to be care navigated. Putting this group to one side, however, the case studies show that whilst there may have been some initial resistance to CN amongst patients there have very few instances where attempts to navigate a patient has resulted in a complaint to the GPP. All GPPs involved in this evaluation indicated that a very small number of patients had submitted a complaint, although exact figures were not provided. Patients have responded more positively to CN than staff initially feared. Furthermore, some have been very complimentary about CN, reporting back to GPPs about the speed and quality of the treatment they received. Staff also feel that CN has led to patients having a better understanding of the range of health care professionals and services available to them and are showing an increased willingness to access alternative treatment. It is important to note, however, that all case study practices felt that CN would work better and be more effective if a campaign that aimed to inform and educate the general public about CN could be run. A lot of the resistance to CN they felt was the result of the general public's lack of understanding of primary care and the pressures it is facing combined with a cultural expectation that GPs should see everything first.

Patient advisors, patients who support a GPP by volunteering their time to attend meetings and giving their feedback and that of other patients to the practice, were informed about CN at PPG meetings but otherwise seem to have had little or no involvement with the CN pilot. This finding is surprising, given that PPG representatives were invited to training sessions and some attended and were involved with the selection of the top 6 external referrals.

Training and support: Most reception staff and managers felt the training was adequate and did prepare them to navigate patients. Likewise, they felt that the support they received from managers and team members within the GPPs whilst implementing and delivering the pilot met their needs. Staff felt they had someone to turn to if they were uncertain or unsure about a navigation and reported that other reception staff had been very helpful in this regard. There were, however, some issues to note. Not all staff in every GPP had completed the online training. Generally, staff who had the basic CN training supplemented with in-house support reported less concerns or issues than those that had not. Reception staff reported that the training was process driven and there was little scope for role-play or other opportunities to work through the types of conversations they might have with patients when navigating. Staff who felt more confident than they did at the beginning of the pilot, but who still reported some doubts about CN said they would like the opportunity to have more or refresher training. Several reception staff said they would benefit from having external services come to talk to them about the services they offered

to improve their levels of knowledge and understanding. A small number said that regular feedback from GPs about what was going well with CN and what could be improved would be very beneficial to them and make them feel like CN was more of a whole systems approach.

Professional identity: Overall, receptionists did not feel that CN had led to a fundamental change to their professional identity. CN was a part of the reception role and not the other way around. It was evident, however, that many receptionists did feel they had gained new knowledge and understanding of the services available to patients, allied healthcare professionals and referral pathways. Many reported feeling more confident in their job and finding the role more interesting because of CN. Internal staff in GPPs were more likely than receptionists to report that CN had led to a change in the reception role. For them, reception staff were now more integrated into GPPs efforts to provide person-centred care and less straightforward administrative staff. Some GPs felt that the knowledge some reception staff had gained of external services had given them an expertise that they themselves did not have and that this was of real value to them.

Navigating 'vulnerable' patients: Reception staff were clear that patients who were time poor, who had the ability to understand and access health related information and who had the money to pay for over the counter medicines were easiest to navigate. Navigating patients they judged as 'vulnerable' was harder and more stressful. When asked what made a patient vulnerable, reception staff highlighted a range of things including: being poor; lack of education; English not their first language; having mobility issues; being over 80 years old; having learning difficulties. The most commonly identified 'vulnerable' group, and the one considered to carry the most risk to staff were patients with mental health conditions. They were concerned for three key reasons i) that a patient with mental health issues could be suicidal or self-harming and that they might make an attempt to take their own life or seriously injure themselves if incorrectly navigated and they did not want to hold that level of responsibility or risk; ii) waiting times for the mental health services patients were being navigated to could be long and this increased staff anxiety; iii) staff had no way of ensuring that patients with mental health issues did access the service they were navigated to.

CN template: Problems with the template was one of the main issues reception staff raised when asked about the challenges they faced implementing CN. This mainly focused on the additional time it took to complete the template and the tension they experience, particularly during busy periods, between answering calls and speaking to patients and spending an extra few minutes filling in the template. Other template issues were highlighted including: some reception staff found having to click through to another screen to access the template frustrating; some felt the template was not tailored enough to the specific circumstances of the GPP and so a lot of CN was going undocumented; some reported that the template was difficult to navigate; some reported that the template required them to duplicate work; and some felt that the template needed to be more streamlined and quicker to use.

Availability and capacity of external services: The case studies developed for this evaluation suggest that CN worked better for GPPs in urban areas, or in places where there

was greater availability of external services. It is more of a challenge in semi-rural areas or in places where external services are not local or easily accessible because staff reported that patients can be reluctant to travel or cannot travel, for mobility or financial reasons. Furthermore, external services need to have the capacity to cope with patients navigated from GPPs. If there are waiting lists or external services have to stop seeing patients navigated to them this can undermine CN in the eyes of staff and patients.

Patients navigating the navigation: Reception staff reported being aware that some patients are trying to navigate the navigation. At Eastern Road Practice, for example, it was noted by GPs that a disproportionate number of appointments appear now to be booked at reception and not over the telephone, where navigation is applied. At other GPPs, staff reported that patients sometimes gave misleading information about the reason for the appointment or the steps they had already taken to seek treatment. The data suggests this involves a small number of patients, however, it is an issue to note because GPPs reported that the percentage of patients who could successfully be navigated were potentially marginal given the needs of the patient population. If a larger number of those patients engage in behaviours that enables them to avoid navigation, then the marginal gains CN can offer to GPPs could reduce.

Capacity and culture of GPPs: GPPs did not start from the same place at the beginning of the CN pilot. North Medical Practice, for example, had been using an informal navigation process for at least a couple of years before they became part of the CN pilot. Others, like South Medical Centre, routinely asked patients the reason they wanted to see the GP but apart from identifying when an issue was best addressed by a nurse or GP did little in the way of navigation. This difference reflects several things. The size of the GPP, the need of need and type of patient population, staff retention and recruitment, gap between demand and availability of appointments and the cultural willingness and capacity to try new things and change practice. Understanding the differences and how this might affect GPPs implementing CN, or other models or strategies in primary care, could be a way to tailor support to GPPs that maximise the chance of successful change. In addition, GPPs reported that they were being asked or required to implement other initiatives which competed with CN implementation.

CN for social, not medical issues: Although the levels of confidence between staff at different GPPs varied, overall receptionists felt that navigating patients with medical needs was a well-defined and straightforward process because patients shared their symptoms and it was easy for receptionists to understand the issue. Receptionists felt much less confident when navigating for social issues. Firstly, it was not always obvious to them whether an issue they were presented with by a patient was a medical or social issue, or both; and in those circumstances what 'treatment' should look like and who would be the right person first. Secondly, receptionists felt they had less of an understanding of what happened to patients who they navigated for social reasons which made them more reluctant to navigate. It was not the case that staff in GPPs who had patient populations with obviously higher levels of social need, felt they had a much better understanding of this.

Paying for treatment: Patients being unwilling, unable, or worried about being asked to pay for treatment or medicines was highlighted as a barrier to CN.

Impact on external services: The external service providers who participated in this evaluation supported CN. They had noticed an increase in the number of people accessing their service who had been referred there by the GPP. There was some concern about lack of capacity in some services patients were being navigated into. Delays in patients accessing treatment at external services concerned GPPs as they felt it undermined patients' confidence in the model. By contrast, the external services involved in the evaluation felt that they were able to match patients' needs and had not been overwhelmed by the introduction of CN.

5.   Discussion

Overall, the CN pilot was successfully implemented across the footprint area. GPPs were informed about the pilot and it was successfully promoted to GPs and senior staff. The pilot promotion events were helpful for GPPs and the training included in the Platinum West Wakefield Care Navigation package was considered simple and straightforward and led most reception staff to report they were prepared to care navigate at the start of the process.

The level of interest in CN was higher than expected at the planning stages. As a result, more GPPs were involved in the pilot. This is positive insomuch as more CN was done over the pilot period but it did also impact on the ability of the implementation team to:

(i)   closely monitor CN and gather feedback on what was and was not working through the process and

(ii)   deliver the level of additional training and support they wanted.

GPPs were only required to make a minimum level of commitment to the pilot in return for accessing the CN training and resources. Some GPPs developed strong relationships with the implementation team, which have been useful for this pilot and other subsequent work, but others disconnected from the process quite quickly, although they continued to use CN.

Senior leaders and managers felt prepared to implement CN as a result of the events and training held by the implementation team. Initial fears and concerns of reception staff that CN would involve significantly more responsibility and would be poorly received by patients have not been fully realised. Most patients contact the GPP and see a GP because they are the right person first. Staff report few major issues with the group of patients who would be better treated by other internal or external services. Whilst there are patients who continue to refuse to provide additional information to receptionists, and who are booked in to see a GP as a result, many others, and what appears to be an overwhelming majority, are willing to listen and be directed to the right person first.

Over the CN evaluation period of six months 10,010 navigations were accepted by patients to internal, external, other health and self-help professionals and services. Out of these, 9,154 were navigations to services that did not involve the patient seeing a GP as the right person first, so excludes GP out of hours and extended hours services. If each GP appointment is ten minutes long, this represents a saving of 91,540 minutes or 1,525.6 GP hours for a 6-month period. This would be equivalent to 407 GP working days per annum. The figures suggest a possible seasonal effect with higher numbers of navigations found for January and February.

Staff reported that CN improved their knowledge and understanding of local services available to treat and support patients. Levels of confidence in their ability to care navigate improved with experience and attitudes towards CN became more positive over time for most reception staff. However, not all receptionists are care navigating at every possible contact and this means some patients are accessing GP appointments when they could be treated elsewhere.

Staff reported that patients' knowledge and understanding of treatment options and services has improved. They also felt that some patients were getting quicker treatment by health care professionals with more specialist knowledge of some complaints.

GPs stated that their clinics were still very busy and demand for their time remained high despite the introduction of CN. They reported, however, that CN meant they saw fewer patients who did not need to see a GP, felt better able to manage their workload efficiently because of the additional information gathered by receptionists and could provide more timely care for some patients, particularly those with symptoms that required immediate emergency treatment.

The positive evaluation of CN, on the basis of a wide range of inputs from the care navigation implementation team, four implementing and one non-implementing GPP, has to be seen as a considerable success, even more so in the face of some challenges. The latter includes the fact that the initiative to some extent became the 'victim' of its own success; the level of interest led to accelerated roll-out, stretching the resources of the implementation team.

Care navigation is likely to be an essential underpinning of the *NHS Long term plan[14]* and may form the lynch pin for the effective development of primary care networks (PCN), integrated care systems (ICS) and the establishment of integrated care providers (ICP). Multidisciplinary working, personalised and timely care, and integration of health and social care may all benefit from a workforce engaged in effective care navigation. Future ways of working are likely to depend on effective care navigation, something which this small-scale evaluation indicates is possible to achieve although possibly with slightly more input than originally anticipated and provided.

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[14] NHS England (2019) The NHS Long Term Plan. Jan 2019, Version 1.2 with corrections, August 2019.

6. Conclusions and Recommendations

6.1 Overall Conclusions

(i)   Care navigation, based on the figures and interviews reported here, is a considerable success, with support across staff groups (GPs themselves, practice managers and receptionists) and patient members of advisory groups considering it beneficial. Care navigation despite some initial reservations has been adopted in many practices with benefits well outweighing any preliminary concerns regarding changes to roles, above all the role of receptionists, and changes to working practices. The *Right Person First* initiative aimed to ensure that patients are navigated to the *right* service or professional *in good time* and therefore improve patient health and wellbeing whilst also freeing up GP time to see patients in need of a GP appointment.

(ii) The interview data provide many useful pointers which can inform training, further roll-out, and fine-tuning of care navigation. These include:
   a. Further efforts to help patients understand care navigation are needed;
   b. Worries about having to pay for external services should be addressed;
   c. Care navigation may be easier in urban areas or areas with local services;
   d. Hard to reach groups may find care navigation more difficult;
   e. Patients, once they understand care navigation, may 'game the system' by finding ways of ensuring being seen by a GP even when other services might be more appropriate;
   f. Implementation may be more challenging and time-consuming than anticipated, particularly when competing with other initiatives; resources need to be managed carefully.

(iii) The limitations of this evaluation need to be kept in mind; no objective health service data (except for numbers navigated) or health outcomes were collected. A small number of informative case studies forms the backbone of this report.

6.2 Recommendations

Care navigation implementation and delivery

(i)   Care navigation should be promoted to GP practices which have either not adopted it or not undergone relevant training.

(ii) Follow-on support including reflection on implementation of working practices is offered to reception teams and delivered to those who would consider it beneficial.

(iii) Improvements to the care navigation template should be considered, informed by further consultations with receptionists who are the primary patient-facing navigators.

(iv) Care navigation may be extended to other services/professionals beyond those which are already sign-posted, but care needs to be taken to keep all staff including senior GPs on board and to not overcomplicate processes including the template. It is, however, possible that over time, both staff and patients will develop their

understanding of needs, suitable/required services and professionals, mitigating this potential risk. This needs to be considered in combination with recommendation (ii).

(v) Promotion of care navigation should be embedded in the entire patient care pathway, within primary care; anecdotal evidence found by the researchers suggests that many practices already provide automated messages to their patients calling in by phone and highlighting to the caller that relevant services may be sign-posted to them.

Care navigation in the wider context

(vi) Care navigation appears to be a successful innovation which has spread quickly within the pilot area.

Efforts to integrate health and social care, and the introduction of primary care networks, concurrent with the care navigation pilot, will make care navigation a central component to support these developments. Thus the sign-posting taking place during care navigation is an important element in delivering on *The NHS Long Term Plan* and the establishment of integrated care systems.

Evaluation and research

(vii) Further evaluation of care navigation over an entire year would be useful; questions which should be addressed include reasons for refusal by patients to be navigated, navigation of vulnerable patients and patients who tend to not use health services, despite possibly serious health problems. Collection of objective and economic data on the effects of care navigation on GPs, other staff in practices and external services would be highly desirable, possibly in collaboration with care navigation initiatives in other regions.

(viii) Evaluation and research should be integral to the development and improvement of working practices within primary care, adopting a systematic and reflective approach as e.g. based on the *quality improvement wheel* suggested in An Introduction to Quality Improvement in General Practice, published by NHS England in April 2019[15].

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[15] NHS England (2019) An Introduction to Quality Improvement in General Practice. April 2019. https://www.england.nhs.uk/wp-content/uploads/2019/03/an-introduction-to-quality-improvement-in-general-practice.pdf

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