2019-2020 COMMUNITY NAVIGATOR IMPACT REPORT

Project Name: Community Navigator

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Local authorities your project is delivered in: City of Edinburgh, North East Locality

How long has the project been running?

1 year 6 months (June 2010- December 2020)

Describe the project in no more than three sentences:

The project provides support for individuals and encourages increased community connections and in turn contributes to a reduced need for the support of statutory services.

The service achieves this by a blend of one-to-one support and advice for individuals living with complex and multiple needs/long term conditions, encouraging wider community engagement, and providing training and advice as well as one-to-one shadowing opportunities to frontline statutory colleagues.

The majority of the concerns were related to advice/social welfare/housing/practical support, psychological and emotional wellbeing/ loneliness, physical health and access to exercise and activities.

Project overview (more detailed) …

Research suggests that addressing multiple and long-term health difficulties involves an extensive holistic approach not always attainable in standard primary care. Models of social prescribing, which consider social and economic factors as well as physical and mental health, were successful for people who were offered this type of support (Moffatt S, Steer M, Lawson S, Penn L, O'Brien N. BMJ Open. 2017 Jul; https://pubmed.ncbi.nlm.nih.gov/28713072/).

Between June 2019 and December 2020, the Community Navigator working in the Edinburgh North East Locality aimed to test models of social prescribing/community navigation and delivered **one-to-one support for individuals living with long term conditions and facing multiple and complex socioeconomic barriers who do not have access to GP Link Workers** (see case studies below).

The Community Navigator also provided **advice to frontline colleagues individually** tailored to their client's needs.

Furthermore, the Navigator also **promoted wider sharing of the most common knowledge about local community resources and available services by working** collaboratively with frontline colleagues, organisations and others such as families, carers etc. The Navigator also **contributed to identifying gaps and barriers in accessing community assets and supports**, and the implementation of potential solutions and training/awareness raising/ building directories of services. **The Navigator worked closely with one of the project support**

managers at the Long Term Conditions team and provided regular contribution to the Connect Here Directory of Services.

As a part of the North East Edinburgh Innovation Team the Community Navigator implemented the Three Conversations Model (Conversation 1: Listen and Connect; Conversation 2: Work intensively with people in crisis; Conversation 3: Build a good life) and **utilised social prescribing as means to harnessing assets within the voluntary and community sectors and other non-statutory organisations with main focus on the supported individuals accessing non-clinical resources in their community** and strengthen their links with people around them to enhance their physical and mental well-being by income maximisation/ access to grants and charitable funds, addressing housing issues, encourage physical activity, and healthy lifestyle, promote access to volunteering, employment, befriending etc with the aim to reduce loneliness and isolation and increase community participation, improve confidence, sense of control and self-efficacy.

The Community Navigator was also involved in testing social prescribing models in community follow up care for patients referred from the SCARF Project (Supporting Community Recovery and Reducing Readmission Risk Following Critical Illness) https://www.ed.ac.uk/usher/acute-care-edinburgh/news/scarf-improves-community-outcomes and for specific care requirements for clients on the **Unmet Needs List** and successfully supported them to access specific services they required (see Case Study 1).

The service observed only (approximately) 2% non-engagement rate which was down to occasional cancellations and changes to appointment dates (cancellations due to illness, hospital appointments, family emergencies), however the following meetings always took place and the joint work towards agreed goals resumed. Whenever appropriate text message or telephone reminders were implemented.

The project 'in numbers'

53 overall number of individuals supported on a one-to one basis between June 2019 and December 2020 (the support lasts approximately between 3 and 9 months for each individual).

265 requests from colleagues for tailored advice on resources and services for their clients.

£13529 grants for individuals supported (Edinburgh Trust Fund, ELTF, Capital Charitable Trust, Merchant Company and others).

£56725.80 successful Attendance Allowance/ PIP/ Pension Credit claims (including backdated payments).

£2095 in items (e.g. tablet, smart phone, washing machines, cookers, supermarket vouchers, day tickets, bedding/ blankets etc.)

80 organisations (statutory and third sector) had been involved in supporting clients referred to Community Navigator.

Response to Covid-19/ Lockdown

- In additional response to **the lockdown in March** the Community Navigator has created a **database of services and community initiatives and supports** that were still offering help and rapid response in terms of food provision, medication collection, supply of white goods, tackling loneliness and offering mental wellbeing support, and other vital help. This database had been kept up to date on a daily basis updating and disseminated daily and later on weekly to all front-line colleagues in the NE Locality and across organisations. The database appeared very useful, with colleagues from other localities and even different local authorities approaching the Navigator for tips and advice on how to create similar for their areas (I received phone calls from workers not only based in Edinburgh but also for example in Argyll and Bute and London).
- The Community Navigator was also involved in delivering melas, food parcels and medication directly to client's doorstep during the lockdown.

CASE STUDIES:

<u>Case Study 1</u>

Mr. EM is 78; he lives with severe COPD/ asthma, eczema, limited mobility and severe social anxiety. He had been referred to the Community Navigator in 2019 by the Unmet Needs Coordinator. MR EM had been recently discharged from hospital (following several previous readmissions due to falls at home, difficulties in breathing and chest infections) with an assessment from an OT requesting a twice daily package of care. Mr. EM, however, was very reluctant to accept a package of care due to his anxiety and feeling overwhelmed and he declined the help on a couple of occasions. In the meantime, the OT were concerned about his welfare as he needed help maintaining his personal care, his eczema being of particular concern. Mr. EM was also using oxygen cylinders for the majority of his waking time which affected his ability to perform his activities of daily living.

During a home visit Mr. EM advised the Community Navigator that he felt that having people in his flat was generally anxiety provoking and 2x daily visits from carers would feel too intrusive. He has acknowledged however, that he needed help caring for his skin and personal hygiene, especially that his mobility was so limited. After some discussion Mr. EM agreed that he would consent to having some help twice a week, however, such arrangement was not offered as part of standard package of care provided by the local authority. The Community Navigator suggested accessing Direct Payment or Independent Service Fund (IFS) and Mr. EM agreed to explore this. The Navigator then explained that accessing a care service independently may be more flexible and suiting Mr. EM's needs better, however, he would need to partially contribute to the cost of the service. Mr. EM stated that he would be happy to do so, however his funds are very limited and he had no savings and no family/ friends who could help financially.

It then transpired that Mr. EM's income was very limited and that despite of his care needs he was not in receipt of Attendance Allowance and his Pension and Pension Credit were quite low. The Community Navigator suggested referral to the DWP visiting service for the Attendance Allowance claim and Mr. EM agreed to this with some reluctance as he was anxious about having people visiting/ asking personal questions.

The Community Navigator consulted a colleague who was a Community Care Assistant and had a more in-depth knowledge about she visited Mr. EM to carry out and assessment towards potential Direct Payment/ IFS.

As a result of an assessment Mr EM had been found eligible to 2 hours per week help with personal care which would be funded by the local authority. He then decided to pursue the IFS route and the Community Navigator supported him to contacting suitable care providers. Mr. EM then selected a provider he felt was most suitable and started receiving the service next week. He utilised the funding provided by the local authority and combined it with the funds from Attendance Allowance and increased Pension Credit (Severe Disability Premium) to secure the support he needed and as flexible as he had wanted.

During a follow-up visit the Community Navigator Mr. EM stated that he benefited greatly from the help he received and that because he felt in control throughout the process he could manage his anxiety levels and is now receiving the care he needed. He was also very appreciative of the income maximization input as his income has increased and he could manage his finances better as a result.

Case Study 2

Mr X is 77. He lives with his wife who is 63. They reside in a top floor 2-bedroom flat provided by the City of Edinburgh Council. The local authority has recently carried out a deep clean of Mr X's property due to the couple not coping with everyday tasks because of their very limited mobility and other health conditions. Client's granddaughter (currently in local authority's care) will be moving in to live with them next month when she turns 16. His wife is awaiting a hip replacement surgery; however, this had been postponed due to Covid-19. In the meantime, both struggle with shopping, cleaning, personal care (accessing bathroom). Both clients felt strongly that they would not want to rely on external help for personal care and declined package of care suggested by their social worker. Mr X and his wife also struggle financially and need a fridge/freezer and a cooker (old appliances had broken down due to wear and tear) as well as a number of smaller items such as bedding, winter clothing etc.

Upon visiting Mr X and his wife at home the Community Navigator carried out holistic assessment of the couple's needs. Most important for them was to get a cooker so when their granddaughter moves in next month they can provide her with home cooked meals. Mr and Mrs X also needed a small chest of drawers so the granddaughter could store her belongings.

Mr X and his wife have also advised that their current accommodation was not suitable for their needs as they were unable to negotiate the stairs to their flat; they had also been

advised that their bathroom cannot be adapted due to the flat being located in the top floor. Community Navigator explained about housing eligibility, sheltered and mainstream housing options and suggested joining the local authority's housing waiting list by filling in an application (Edindex) which would enable the couple to move to a more suitable accommodation which the clients have agreed to. The Navigator then assisted the clients with the application and submitted it on their behalf to the housing department.

During subsequent home visit, Mr X advised that he felt he was responsible for majority of the budgeting decisions and was struggling to 'make the ends meet' due to limited income. Furthermore, Mr X stated that he also bears the burden of caring for his wife and granddaughter but 'no one cares for me'. The Community Navigator had a discussion with Mr X about his mental and emotional wellbeing and offered a listening ear so Mr X could express all his concerns and talk freely about recent stressful events (Mr X stated that the lockdown and uncertainty of the past few months had been affecting him significantly and agreed to discuss this further with his GP). Following Mr X's disclosure the Community Navigator suggested applying for Attendance Allowance and some discretionary grants to local charitable organisations and clients were both agreeable to that and happy to provide supporting evidence as required. The Navigator suggested contacting VOCAL (local carer support organisation) but Mr X advised he did not feel ready for this at this time.

Community Navigator submitted applications to local grant-giving charities and within a week Mr and Mrs X have received funds for a new cooker, fridge/freezer and a chest of drawers. It transpired that Mr X can use a computer and would be able to order the items on-line if he had access to a device. Having a suitable device would also enable him to place housing bids on-line as well as keeping in touch via email with his social worker, using online banking and requesting his and his wife's repeated prescriptions via email, shop for groceries and access information/ documentaries/ library and other on-line services and resources.

Community Navigator suggested referral to Cyrenians Digital Inclusion Service. Mr X agreed and a Digital Inclusion Key Worker has contacted Mr X offering a home visit (in line with the Government Covid-19 guidelines). Mr X received a free Chromebook (worth £300) and one-to-one coaching that was adjusted to his needs.

Upon a follow-up telephone call from the Community Navigator Mr X reported that he was able to order the white goods and furniture online (the Community Navigator submitted a successful application for a grant for Mr X and he received £750).

Shortly Mr X had also heard from the DWP regarding his Attendance Allowance claim – he completed a telephone interview and was awaiting the form being posted to him for signature. Upon receiving the form Mr X has contacted the Community Navigator with whom he had built trusting relationship and was now happy to receive support and reach out for help and advice. The Community Navigator reviewed the form and it transpired that Mr X did not mention his mental health difficulties to the DWP assessor due to his perceived stigma around mental health as well as his perception of gender roles/ attributes. Community Navigator encouraged Mr X to talk openly about all aspects of his health and

include the additional information in the form. Mr X consented to that and the Community Navigator amended form accordingly and posted back to the DWP.

Within four weeks Mr X received a letter stating he had been awarded higher rate of Attendance Allowance as well as his Pension Credit had been increased (Severe Disability Premium applied). He also received backdated payment of £2539.15 for the time he had been waiting for his assessment.

Mr X has also received another grant of £175 for winter clothing and bedding for his granddaughter, and a few food parcels and supermarket vouchers as a result of various funding applications to charitable organisations made on his behalf by the Community Navigator.

As a result, Mr X's financial situation has improved significantly – he is now in a position to pay for a cleaning, shopping and garden maintenance services, and can afford a taxi to travel to medical appointments or local shops. Thanks to the support he received from the Digital Inclusion Key Worker Mr X can now place on-line bids for sheltered housing, access on-line shopping and banking and feels much more confident and better prepared to cope with the Covid-19 restrictions and what's more important, he knows that there are people in the community that he can turn to for help and support.

Case Study 3

BJ is a 72 years old woman, who had been referred in July 2019 by her OT following a fall and a hospital admission and identified as being at risk of isolation due to her poor mobility and living alone. She also suffered from low mood, anxiety and poor sleep patterns due to limited social contact and experiencing pain symptoms as a result of arthritis and brittle bones prone to fractures. When discussed her social network and activities BJ advised that she would like to try an art or photography group but she does not have sufficient funds to pay for the classes and travel. As part of the holistic service assessment the Community Navigator learned that the client was receiving relatively low pension with no additional income in place; she had to pay monthly rent on her 1-bedroom flat which she rented from a housing association. Having worked her entire life and being self-sufficient she was not aware that she may be entitled to additional financial supports such as Attendance Allowance, Pension Credit, Housing Benefit and Council Tax Benefit or charitable grants and was constantly worried about how she will pay her rent and could not afford heating etc. The Community Navigator provided advice on income maximisation, carried out an online eligibility check and suggested applying for Housing Benefit and Attendance Allowance to which BJ agreed. A referral had been made on BJ's behalf to a dedicated team at the DWP who could visit BJ at home and help filling in the Attendance Allowance claim form and process her claim further. The Community Navigator also assisted BJ with Housing Benefit claim form and submitting the supporting evidence required (bank statements, proof of ID, proof of pension, tenancy agreement). Furthermore, an application had been made for a small grant towards purchasing comfortable clothing and shoes so BJ could join a community run lunch club which would help BJ to gradually overcome isolation and encourage better

emotional and general wellbeing by engaging in the activities they offered and hopefully making new friends in preparation of starting the art classes.

In December 2019, BJ had been awarded Attendance Allowance, Housing Benefit and Council Tax Benefit and received backdated payments for the joint sum of £3000. She also received £140 Winter Fuel Payment towards the heating costs and a clothing grant of £150.

At the start of the year BJ had joined art/photography classes at her local community centre as she felt confident enough to be around people and could afford the weekly costs of the course, transport and a small contribution to the costs of lunch.

BJ phoned to let the Community Navigator know how her life has changed and said: 'I could not imagine that I could lead such a worry-free life. It has made a tremendous difference that I could talk about my health, social circumstances, finances and all my worries to someone I could trust'.

Case Study 4

MC had been referred in June 2019 due to being unsuitably housed and experiencing mental health difficulties (suicidal ideations, low mood and anxiety) as well as needing advice on income maximisation. MC is 80, she's a wheelchair user (due to severe arthritis) with no residual mobility, very limited function in both hands and reliant on all transfers, personal and continence care, food preparation and other activities of daily living on her team of carers (package of care provided by local authority). For the past 20 years MC lived in a first-floor property with no lift access and two flights of stairs leading to her flat. MC reported only being able to leave her flat to attend medical appointments or hospital admissions and this had been organised by the NHS with specialist transport being provided with two workers assisting and using specialist device to negotiate the stairs with a wheelchair.

MC reported feeling increasingly isolated despite receiving social support at home form a volunteer befriender from Golden Years; she frequently reported feeling 'trapped' in her flat and expressed anger and frustration at being unable to participate in activities outside of her flat. On the other hand, MC felt very attached and familiar with the area she had been living for over 20 years and had good knowledge of, as well as good relationship with her GP Practice, local chemist, shops, cafés and libraries. An Occupational Therapist had been involved in assessing MC's needs but MC reported that this was a difficult relationship due to some trust issues (MC worried that her Housing Association refused to adapt another property for her basing on the OT's advice which was not consistent with the OT's actual report and recommendations seen by the Community Navigator).

MC had also been estranged from her family so she felt she had no access to any informal source of support and advice as to whether she should move house and enjoy more independence or stay in her accommodation which is familiar and would not involve experiencing a life changing event such as moving to sheltered accommodation, organising the move, packing, re-establishing welfare benefits in her new tenancy, joining different GP Practice, changing correspondence addresses with her bank and energy providers and so on.

Upon a home visit to MC the Community Navigator felt that MC would benefit from receiving more information about sheltered housing and the application process in general and some step-by-step action planning with realistic goals and timescales as well as learning that there were actually sheltered housing complexes very close to her current address (so she could stay with the same GP and chemist and could enjoy accessing local amenities more independently) and what would moving house actually involve.

After several home visits from the Community Navigator MC felt increasingly confident in her ability to follow the agreed plan and was happy to take on a number of duties involved in planning and following the next steps leading to her move. MC kept a diary of all the phone calls she's made with dates and outcomes noted down as well so she could track the progress of her goals.

It is important to note that when the moving day finally arrived and despite the fact that MC was fully involved in planning and preparations and extensively supported during the whole process she felt very emotional and tearful. When the specialist workers arrived and offered MC their assistance with transfer from her wheelchair to the specialist piece of equipment allowing MC to be carried downstairs, MC reacted angrily and was quite vocal in her anxiety about their ability to support her need securely and swiftly. The Community Navigator asked the workers to slow down a little and provided verbal reassurance to MC and a slight touch to her forearm which was enough for MC to relax and feel encouraged to carry on with the task. This brief difficulty acted as a cathartic moment for MC and she was able to release the build-up emotions and anxiety and overcome the feeling of being vulnerable and to accept help.

Following the move MC manged to settle in her new environment very quickly (with significant support from the sheltered housing warden, Cyrenians befriender, her usual team of carers, community navigator and other professionals and services she's already been linked with prior to the move) and reported increased life satisfaction, meeting new people and socialising a lot more and ability to engage in a number of meaningful occupations outside of her flat (shopping, meeting with friends, meeting with befriender, attending short trips organised by the sheltered housing provider).

As a result of introducing the Community Navigator's service MC avoided deterioration of her mental health and further loss of independence and self-reliance. Instead of continuing to live in an unsuitable accommodation and risking extensive loss of independence due to lack of stimulation and limited social interaction, and possibly having to move to a care facility, MC re-gained her independence and embarked on a journey to improved mental health without the need of accessing specialist services or pharmacological means. This collaboration lead to MC's mood improving significantly as she reported feeling more in control of her life. MC also stated that she's learned that she's got the skills to allow her coping in the future and recognise a situation where she may need support and feeling able to accept it.

One achievement that MC felt was most important was the fact that she became increasingly self-reliant and has started independent shopping trips by taxi to the high street

shops which she missed so much! MC stated that she feels like a 'normal person now' and that 'life is wonderful again'.

There were also some positive financial outcomes for MC - as a result of joint work with community navigator MC was successful in applying for £500 for the costs of moving house, and £400 for carpets from the Merchant Company; she also started receiving £600 of additional annual financial support from the Merchant Company.

Oladults face a number of inequalities, particularly in housing and living environment, physical and mental health and perceived well-being as well as social connections. She also increased her social circle and developed stronger links with her local community which lead to increased sense of general well-being, connectedness and improved mental health.

Quotes from clients and colleagues:

LH (community care assistant) 'It's the fact that you can instantly 'magic-up' food parcels, free meals, money, white goods that makes such a huge difference to the people I support. My job would be so much harder without this!'

JN (client) 'Thank you so much for your brilliant support. Means the world to me and makes it so much easier to positively move forward.'

LB (senior OT) 'Because the Community Navigator has such a varied mix of skills and access to so many resources she helps to fill what is often a huge gap in people's lives, providing practical support, such as income maximization, access to nutrition, exercise and well-being, social support etc., but also encouragement, human connection and improved self-reliance and confidence for the people we work with'.

WB (client) 'I can't believe I've missed out on the opportunity to have a more stress-free life. I feel my life has improved and you are always welcome in my house'.

FJ (senior social worker) I'd also like to thank you for your openness to communication- you have been so useful with individual queries.

Mr EM (client) 'Sylvia. Thanks for your warm help in this matter. Gracious.'

DA (social worker) 'Thanks Sylvia, much appreciated. You're a mine of information!'

CC (social worker) - 'Thanks you so much for linking this family in with the supports you mentioned. You are a star and I am sure T. and A. will be very grateful. I think part of the problem with this case was the difficulty in communication which you have very kindly helped with. Thanks again for everything.'

Appendix 1

Source of requests for advice on resources/services/ activities for clients (Total 265):

- Social Workers/ Senior Social Workers - 180 (ca 68%)
- Community Care Assistants (CCAs) – 37 (ca 13.6%)
- OTs – 29 (ca 11%)
- Physios – 12 (ca 4.5)
- Care Coordinators 4 (ca 1.5 %)
- Other (third sector workers, other link workers etc) 3 (ca 1.1 %)

Requests received mainly be email, over the phone and face to face.

Appendix 2

Sources of referrals (Total 53):

- **CCAs 18**
- **Social Workers 14**
- **OTs 12**
- **SCARF Project 1**
- **Service Innovator (Assistant Practitioner) 4**
- **Internal Cyrenians 4**

Appendix 3

Balance of time spent on work tasks:

- Casework (face-to-face meetings with clients, telephone calls, filling in forms and benefit claims etc) ca 35%
- Research/ exploratory activities/advice and knowledge sharing with front line colleagues ca 45%
- Training/ knowledge update/ learning ca 10%
- Linking and maintaining contact with services and organisations/ attending meetings ca 5%
- Reports/ admin/ case studies etc. ca 5%