INTRODUCTORY LETTER - The Armed Forces Community Healthcare navigation Project

Finding evidence of what works, and what doesn't, that is sufficiently credible to persuade others to take action is as much an art as it is a science. At Forces in Mind Trust we pride ourselves on always generating evidence that is both accurate and credible, and that is *sufficiently persuasive* to effect the changes our analysis suggests are needed.

Of course, the complexity and associated costs of research also acknowledge this paradigm, and it is not, therefore, a simple or indeed a linear relationship between input and impact. Some of our most effective pieces of work have been relatively simple, relatively cheap, and weighted heavily in favour of the qualitative side of the research profession.

The use of a healthcare navigator for the Armed Forces Community presented us with particular challenges. The role itself, as the research team has noted, is being increasingly adopted as a cost-effective way of supporting vulnerable adults. As this role was untested with the Armed Forces Community, the research study was constructed to assess the feasibility of the model, but the wider project also included some ambitious delivery targets such as educating GPs. Perhaps unsurprisingly, not all aspects could be delivered within the constraints of time and budget.

Focusing on the key question of does the navigator model work within the Armed Force Community, this study has shown that it could, but that there are many largely operational and organizational changes that would need to be made if it were to be widely adopted. It is important to recognize that with only one person in the navigator role for this feasibility study, inevitably the experience and views of that individual have assumed a weighting a broader study would have avoided. This is not to devalue the findings, rather to acknowledge the limitations of the study.

It would also be fair to reflect that some of the identified shortcomings were not necessarily viewed in the same way by all partners in this project. Such differences of perspective are not only to be expected, but are also to be welcomed as they prevent unchallenged opinion becoming a baseline of fact. We have tried in this report to avoid criticising individuals or organizations – it was, after all, just a feasibility study – but with such a small number of people involved, inevitably those with some knowledge of the environment will make inferences that perhaps a larger study would have avoided.

What then are we left with? Two key issues: healthcare navigation for the Armed Forces Community can be made to work, and would likely yield considerable health and social benefits; and GP surgeries could do more to identify the Armed Force Community and so adopt preventative measures. On this second point, we know that all four National Health Services within the United Kingdom are fully seized and are making significant inroads. On the basic question of the navigator model, we have the inkling of an answer, and the NHS long term plan offers the potential to build on and develop the model further through the creation of Integrated Care Systems which bring together local organisations to deliver integrated primary and specialist care.

Air Vice-Marshal Ray Lock CBE

Chief Executive, Forces in Mind Trust

The Armed Forces Community Healthcare navigation Project

Feasibility Study

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Executive summary

Launched in July 2017 and funded by the Forces in Mind Trust (FiMT), the Armed Forces Community (AFC) Healthcare navigation Project tested the role of an **AFC Healthcare Navigator in Primary Care** as a means of improving healthcare outcomes for the AFC. Whilst delivering care navigation, the project simultaneously intended to understand the experiences of the AFC and deliver training and awareness across Primary Care. The project team was made up of a Navigator and Service Delivery Manager (based in the Defence Medical Welfare Service), a Project Manager (Birmingham Community Healthcare NHS Foundation Trust), and a research team (the Tavistock Institute).

This feasibility study of the Armed Forces Community Healthcare navigation Project **assessed the project delivery model** to understand if it was replicable. It also explored what adaptations would be needed if it were implemented elsewhere. The key messages from this study are outlined below:

The model had a number of key strengths including the recruitment and training of the Navigator, planning processes, steering committee support, well-articulated policies and processes, clinical supervision, scheduling and following up appointments. The team were committed and highly skilled in relevant areas to care navigation and working with veterans. They also worked effectively at regional level to embed the service in a wider policy framework and train GPs. Despite this the navigation model developed requires significant alterations to be feasible for further roll out. These adaptations are outlined below.

Embed Care Navigators within NHS services: What makes Primary Care navigation work is day to day contact with patients and building systems across their organisation to make sure referrals work effectively. Care navigation for veterans therefore requires very strong engagement with NHS surgeries. The Navigator was based in a Third Sector organisation and the project was insufficiently embedded with Primary Care services. Future Care navigation of veterans in Primary Care would benefit from locating the work directly in surgeries.

Base care navigators in teams: Care Navigators benefit from working in strong teams with support and opportunities for peer learning. Whilst organisational support processes had been arranged at the onset of the project, the Navigator was a lone worker. The project encountered difficulties in engaging surgeries and veterans to the service and the Navigator was too distant from organisational resources to successfully troubleshoot. Given the type of complex mental and physical health issues that some veterans face there is a strong burden on navigators and so future models should avoid a lone worker model.

Address systemic barriers in NHS before considering nationwide rollout: The project was hampered by two contextual issues from the beginning. First, the read code for veterans was poorly applied by Primary Care organisations. Second, the chronic underfunding of Primary Care services means there is little capacity to engage in Primary Care navigation without diverting resources from elsewhere. Education on the veteran read code, revising the read code to indicate where health issues were caused by Armed Forces service and ensuring administrators and doctors have capacity to engage in care navigation would all provide more positive conditions for Primary Care navigation of veterans be successful. Veterans are a hard to reach group whose population differs by area, so the potential feasibility depends on implementation of the veteran read code to identify areas that most need care navigation service.

Introduction

Project description

The Armed Forces Community Healthcare navigation project was established by Birmingham Community Healthcare NHS Foundation Trust in partnership with the Defence Medical Welfare Service (DMWS) in July 2017. Funded with a grant from the Forces in Mind Trust (FiMT), the project is a pilot whose feasibility is assessed in this report by the Tavistock Institute of Human Relations (TIHR).

This navigation project adapts a healthcare model of support called **care navigation**. Care navigation is a cost effective means of improving health and social care outcomes for vulnerable adults. Care navigation is part of a growing trend to connect patients who are lost in the care system with helpful services.

When their health issues are related to their service, the Armed Forces Community have priority treatment in the NHS. However many veterans do not tell their GP surgery about their status and GPs have little knowledge or training on what support the Community requires. A number of veterans face **emotional and physical difficulties when leaving the Armed Forces** and often struggle to ask for help. This programme aims to bridge the health service gap by offering non-judgemental guidance for the Armed Forces Community and to primary healthcare services to raise awareness of the issues, and improve the health and wellbeing of those who have served. Birmingham has a relatively high veteran population, of around 7 percent of the population (Goodier and Regen, 2019).

The TIHR is a nationally and internationally recognised independent, not-for-profit, multi-disciplinary social science institute, established in 1947. What distinguishes the TIHR is its integrated research and consultancy practice; its action orientated research, and knowledge based change and development consultancy. TIHR is committed to working with people and organisations to make sense of situations, robustly evaluate complex policy and practice systems, to solve problems, develop, and apply learning from research into practice.

The Tavistock Institute are responsible for this **feasibility study which assesses the potential for further roll out of the delivery model on a larger scale**. This feasibility study seeks to validate our hypothesis that a multi-functional healthcare Navigator for the Armed Forces Community (AFC) will:

- Improve the engagement of Primary Care and the Armed Forces Community.
- Enable improved access to health, social and third sector support.
- Provide robust evidence of the needs of this community.
- Provide robust evidence of the gaps in availability and accessibility of services.
- Provide evidence to support continuation of the role and incorporation into future local policy transformation and the development and commissioning of services.

Feasibility study data and outcomes provide foundations for the strategic transformation of services by inclusion within health needs assessment, Armed Forces Community needs assessment, and informing future service developments and commissioning decisions.

The study used a mix of a literature review, primary research data, and monitoring data and case studies generated from the project team to understand the feasibility of this model of care navigation in Primary Care settings. Secondary data included reviewing academic literature relating to care navigation and veterans, and relevant grey literature produced by government and third sector veteran's charities.

The primary data collected by the Tavistock Institute included:

- Five interviews with the project team;
- Two interviews with GPs;
- Two interviews with project partners;
- Notes from email exchanges and meetings with project team.

The data collected by the wider project team at DMWS and BHC NHST included:

- Routine data of the Navigator's clients including age and complexity measures;
- Case studies of all clients accessed;
- A survey of a training workshop with GPs;
- A review of veteran's health issues and healthcare pathways in Birmingham.

This data was analysed using a **theory of change framework** to understand the assumptions and drivers of the model and how it worked in practice. The results were analysed with respect to the **success factors for navigation projects** identified through Valaitis et al's (2017) review of Primary Care navigation studies and our own evaluations of navigation programmes to understand the extent to which the model developed was viable.

We end the report with our **summary** of the project and our **recommendations** for future directions in Primary Care navigation for veterans.

Veterans in the UK

Several factors combine to suggest the need for the improved integration of veterans, and their families and carers, with community based and social care services. These include: the invisibility of veterans in health care systems; poor health help seeking behaviours among veterans; unclear care pathways; and, the need for a holistic approach to community based support. These factors inform the Armed Forces Care navigation (AFCN) project.

The Ministry of Defence's annual population survey a population of around 2.4 million veterans in England (Ministry of Defence, 2019). The NHS recognises that the transition from serving to veteran is key to good health. Clinical needs that vary from those of the general population have been identified among veterans. For instance, 60 percent of medical discharges from the Armed Forces deriving from musculoskeletal injuries (NHS, 2018), such conditions are twice as common as in the general population whilst hearing loss is three times as common (Tansey, Raina and Woldbson, 2012).

Prior to this project, FiMT conducted a focus group with veterans in 2014 that highlighted a number of challenges relevant to veterans' engagement in community based health and social care support. Veterans reported that:

- **GPs have limited awareness** of the range of support available and limited time to manage holistic support via a healthcare pathway;
- The Armed Forces Community have some awareness of the wide range of support but were **less knowledgeable on how and when to access** it;
- The support on offer is valuable however the links between the support available and the AFC are often weak;
- There is no follow-up data on the effectiveness of interventions or the quality of service user experience.

These findings are reinforced by Coleman et al (2017) who, in a review of the literature on veteran health-seeking behaviours, confirmed that the **stigma** associated with mental health difficulties **can be a significant barrier among armed forces personnel seeking help**. They also found that social support plays a significant part in encouraging help-

seeking behaviour with treatment offered by those familiar with the military culture more likely to be taken up. Similarly Murphy et al (2017) in their study of a six week course of treatment of veterans for Post-Traumatic Stress Disorder (PTSD) found that the delivery of an intervention in veteran specific clinics was more effective than the more generic approach used for the wider population. This supports the argument that there is scope for better tailoring to veteran's needs in mainstream NHS services.

In their 'A Call to Mind' report on the mental health challenges faced by some veterans in the community the FiMT (FiMT, 2015) recognises the value of:

1. Targeted and intelligent use of **data and information**;
2. Appropriate and sensitive **evidence based services**;
3. **Involvement and participation** of veterans and family members in accessing and using services;
4. An understanding of the **healthcare needs of veterans** and their families in shaping the commissioning and delivery of services.

In a similar vein the UK government's 'Veterans Transition Review' (2014) identifies four key issues that have subsequently shaped the AFCN:

1. **Access:** For the most vulnerable veterans, identifying and gaining access to appropriate support and assured healthcare can be a challenge.
2. **Pathways:** There is a need for clear routes to evidence based, sustainable and quality assured healthcare.
3. **Priority treatment:** The Armed Forces Covenant and its encapsulation of priority treatment for veterans is not always fully understood by veterans and their families or community health services.
4. **Identifying who needs what:** For community based services to be able to identify and provide access for veterans in a community is a challenge. How their needs differ from, or coincide with, the rest of the population is not readily understood. Equally, extracting and identifying information about veterans' health and their needs within a specific community is challenging. Delineating and quantifying the veterans in a community is a challenge, as are the extraction and validation of information about veteran health, the analysis of their associated needs and understanding how these may, or may not, differ from the rest of the local communities.
5. **Third Sector:** This report also called for a directory of accredited Third Sector providers which, if offering healthcare services, comply with the appropriate NHS, NICE or CQC guidelines.

The Armed Forces Covenant

Implicit in this discussion is the Armed Forces Covenant. It was enshrined in law in the 2011 Armed Forces Act as a "promise by the nation ensuring that those who serve, or have served in the Armed Forces, and their families, are treated fairly". (Ellwood, 2018) The Covenant focuses on helping members of the Armed Forces Community to "have the same access to government and commercial services and products as any other citizen". It states that:

- The AFC "**should not face disadvantage compared to other citizens** in the provision of services"
- Veterans should receive priority treatment (subject to the clinical needs of others) in respect of NHS secondary healthcare **relating to a condition resulting from their service** in the Armed Forces
- It should be clearer and easier for members of the Armed Forces

Community to access available support.
- There is a need for a mechanism to **identify localised problems** and address them (The Armed Forces Covenant, 2015).

A survey conducted by FiMT prior to this project among the AFC on the Covenant revealed that **many veterans believe the Covenant provides a right to a service** while a significant number of respondents, (38%) felt they had been disadvantaged at least once as a result of their service. In our discussion with people associated with the Navigator project we found that an understanding of what the Covenant means in practice is still evolving. Interpretation of the Covenant also varies across Primary Care especially when it comes to "priority treatment".

For the Covenant to be effective its architects see it as dependent on the establishment of a **core infrastructure at local authority level for its successful implementation**. This could include: championing by an elected member; a dedicated council officer as a point of contact in the council; web based communication of the covenant and how to raise concerns; a covenant co-ordinating group; vision and commitment realised in a plan of action.

The evidence laid out above has been used to establish the case for the development of the Navigator project. It suggests a potentially widespread and relatively hidden challenge in ensuring **access to services for veterans** and their families. It also emphasises the value of **identifying, recognising and working with the conditions** that are more prominent among the veteran population. Equally it acknowledges the value of an approach that is **sensitive to military culture**. Recognition of these needs led to the formation of the Navigator project in order to understand if and how care navigation can address these challenges. Within this though there is a constant dilemma.

Care navigation models

Care navigation was chosen as the model to address these issues in South Birmingham. Care navigation is a relatively new type of intervention. The first patient navigation programme was established in 1990 by Harold P. Freeman, who has been credited with introducing the term in 1989 in an American Cancer Society report. Despite the variety of approaches all Care navigation projects aim to support and direct patients. Health care navigators have been shown to be effective at: **reducing health disparities**; improving prenatal care; smoking cessation; adult immunisations; and chronic disease self-management. (Huber et al, 2014)

At its heart, care navigation enables **individuals to find their way through the health and social care system to achieve bespoke solutions**, including non-clinical help, to improve individual wellbeing. In doing so navigators provide people, despite their conditions, with the support, knowledge and pathways that will enable them to take control and seek out and gain the services and opportunities that could lead to a more fulfilled life.

The literature describes two key elements to a navigator role:

- **An enabler who helps to coordinate services**, similar to a key worker function in a multi-disciplinary team, to achieve integrated care across the health, social care and voluntary sector.
- **Personalised support**, offering an individual a number of different options including referral to relevant condition specific groups and ideas and referrals for non-clinical interventions, such as clubs, courses, and swimming lessons. This is also associated with social prescribing, a term used to indicate the different nature of the services offered.

The benefits navigators provide include: understanding needs; finding the way to

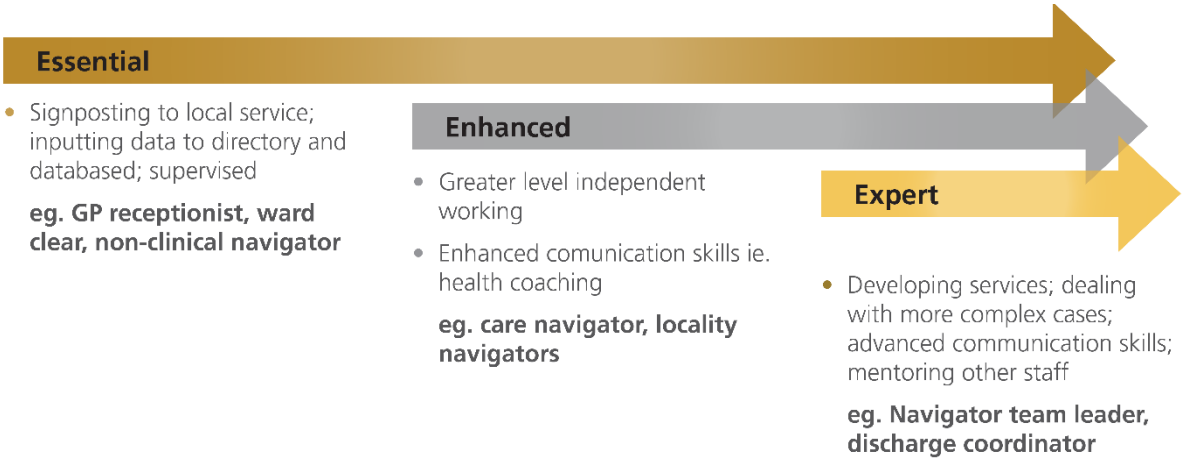

Figure 1 Overview of the tiered competency framework (HEE, 2016)

useful information and services; sorting out practical problems; emotional support and helping patients to make sense of their condition. The Navigators come from a wide range of backgrounds, for example: volunteers; peers with direct experience of a similar condition; GP surgery receptionists, pharmacy staff, and health professionals.

Care navigation Competencies

Care navigation can also be considered as a set of competencies. In the competency framework for care navigation developed by Health Education England published in 2016, nine different competency domains were developed with a set of integrated competencies. What is interesting in the context of this evaluation is the three tiers for care navigation competencies. Figure 1 above indicates the **Essential (Bronze), Enhanced (Silver) and Expert (Gold) tiers**, with progression representing "increasing levels of autonomous working, greater knowledge or core conditions and policy, with a greater leadership and management capability." (HEE, 2016)

Figure 1 above indicates by whom, and how, the navigation role is taken up at each of the levels. This framework is helpful as a planning aid and as a diagnostic tool.

Models of care navigation

The underlying hypothesis for all models is that responding to the person holistically and providing non-clinical opportunities within the community, helps a person develop broader wellbeing as well as improving health outcomes. In the longer term this provides a contribution to reducing health inequalities and increasing personalised care. It also has the potential for a further impact of **encouraging patients to take control over their own health**.

In terms of successful models of care navigation, Valaitis et al's (2017) review of literature on the implementation and maintenance of patient navigation programmes found many factors that influence the implementation and maintenance of these patient navigation programmes. These factors are:

- Appropriate **patient characteristics**;
- Effective **recruitment and training** of navigators;
- **Role clarity** in teams;
- Effective and clear **operational processes**;
- Adequate human, financial, and tangible **resources** including technological resources;
- Strong inter and intra **organizational relationships**/partnerships;
- **Available services** in a community;
- Effective **communication** between providers;

- Programme **uptake and buy in** by end users of the programme;
- **Valuing** of navigators;
- **Evaluation** of navigation programmes.

level, the range of health issues suffered by veterans, and poor help-seeking behaviours by veterans. These are outlined below.

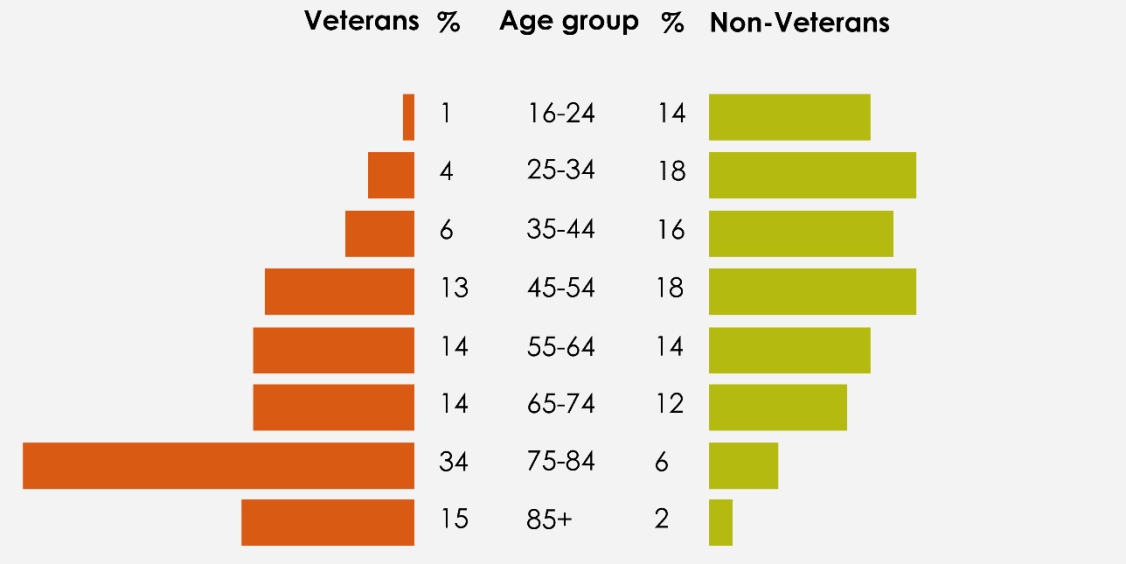

Figure 2 2016 AFC Annual Population Survey (APS)

The factors are supported by the theoretical model of **Diffusion of Innovation**. This is significant in that it shows the importance of the **overall climate of the organisations** that patient navigation is conducted in to the success of any programme – an organisation more receptive to innovation (e.g. one which has slack resources, and decentralized lines of management) is more able to develop a successful care navigation programme. Innovations must also fit the **norms** of clinicians, build on **relationships**, and **leverage the shared values** that drive clinician behaviour (e.g. in the adoption of guidelines).

Issues related to navigating Armed Forces Veterans in the UK

Following this review of veteran's issues and care navigation, we can summarise that navigation for Armed Forces veterans at Primary Care level is challenging in four main respects: the diversity and scale of the population, care pathways and identification of veterans at Primary Care

Diversity of the veteran population

There were an estimated 2.56 million UK Armed Forces veterans residing in households across Great Britain (GB) in 2015 (MOD, 2016). Each year approximately 24,000 men and women leave the British Armed Forces and enter civilian life. The number is made up of everyone who is 16 plus, residing Great Britain, who has previously served in the UK Armed Forces for at least one day (AFC, 2016). This means that to be effective, **navigators need to address the needs of a wide ranging population**.

The age and gender of the veteran population differs significantly from the non-veteran population. The veteran population is predominately male and contains a much larger proportion of elderly people than the rest of the UK. For an Armed Forces Navigator, these demographics mean that the majority of veterans have been out of the Armed Forces for a significant amount of time and that Armed Forces culture is male focused.

Within this group there is a large variance between length of time served and reasons for leaving, including veterans who have not completed basic training (Early Service Leavers), to veterans who have completed their full service or veterans who have been medically discharged, which is most common amongst 30 to 45 year olds.

Veterans' health needs

The age profile of British veterans implies that focusing only on veterans in transition, who are perhaps more likely to have conditions relating to their recent service, would ignore the vast majority of veterans in the UK who are over 65. This means that **a holistic service would need to have a deep understanding of different types of veterans** and the needs that are likely to have.

Veterans health needs are wide ranging. There is increasing international recognition, both within the military and in civilian society, of the health and social needs of ex-Service personnel, in particular mental health problems, such as post-traumatic stress disorder (PTSD), and social exclusion (Fear, Wood & Wessely, 2009). Other health issues veterans suffer from include poor mental health (often linked to childhood adversity), alcohol/ substance misuse, hearing loss, obesity, musculoskeletal problems, chronic pain and long term illnesses such as type 2 diabetes and hypertension. The extent to which these health issues are caused by service in the Armed Forces is unknown.

Care pathways for veterans

For Primary Care services, the wide definition of veterans and diversity of health issues gives no easy approach to engage with veterans. Even with the Armed Forces Covenant in effect, **care pathways remain confusing for veterans and care services**. In principle, upon leaving the forces, veterans resume their entitlement to NHS care. During their transition, veterans are encouraged to register with an NHS GP. Once registered, GPs are responsible for determining whether a veteran's condition requires referral to specialist care and is service related. In these circumstances, clinicians are asked to prioritise veterans over other patients with equal clinical need if their condition results from their service in the Armed Forces (Ashcroft, 2014).

However veterans are not visible to care services as there is poor data collection on veterans in general at local levels. The veteran read code (titled "Left Service") is often misunderstood or ignored by health practitioners and administrators, resulting in low numbers of veterans recorded at Primary Care level. This means the Covenant would not in many cases be activated and veteran specific issues are not accounted for.

Veterans' help seeking behaviours

Finally, veterans and family members are often **reluctant or lacking confidence to be identified as veterans** in health services. Accessing veterans who are isolated and who struggle to seek help are another issue for care navigators working with veterans.

These behaviours are more severe with regards to veterans with poor mental health. The mental health issues associated with veterans, such as PTSD, and the culture of the Armed Forces which promotes stoicism, means that navigators need to build trust and their own skills in order to address the needs of the AFC. Once veterans are reached, instead of focusing on a specific mental health illness, a veteran's mental state is difficult to determine. Experts recommend looking at these four areas: thought process, (Hynes and Thomas, 2016) mood, (Tansey, Raina and Wolfson, 2012) anxiety, and substance use (Cooper et al., 2018) Veterans may be adept at masking feelings. Formulating the correct question is important to promote an open dialogue. Equally important is the visual assessment related to patient attire, habits, facial

expressions, and eye contact (Algire and Martyn, 2013). These issues make identifying and engaging veterans a particularly hard task for navigators as it requires clinical competences that navigators are unlikely to possess.

Whilst most veterans are over 65 and male, the group with acute medical conditions related to their service, are more diverse, particularly the more recently discharged. **Veteran diversity is clear when compared to other care navigation programmes focused on a subset of the population**, such as a navigation project aimed at improving breast cancer screening and treatment of women of South East Asian origin (Nguyen et al, 2011).

The diversity of the veteran population, unclear care pathways for veterans, veterans' health needs and veterans' help seeking behaviours, combine to present **serious barriers for care navigator programmes working with veterans**. These issues also imply that an effective veteran navigator in these Primary Care settings will need to either have the 'Silver' or 'Gold' rated competences shown in figure 1. Alternatively, 'bronze' level navigators would need strong support from a competent navigator colleague.

The invisibility of veterans in health care systems is a particularly challenging aspect as care staff may lack awareness of who their veterans are and what they need. The unclear care pathways even with the Armed Forces Covenant means there are no well-established routes from Primary Care to community care. Poor help seeking behaviours among veterans make many veterans hard to reach and engage. And the wide ranging health needs of veterans implies the need for a holistic approach to community based support combine to improve the integration of veterans, and their families and carers, with community based and social care services.

Figure 3 Jigsaw of issues faced by a care navigator for veterans

Armed Force Care navigation model

The service under consideration was a pilot project established through a partnership between the Defence Medical Welfare Service (DMWS) and Birmingham Community Healthcare NHS Foundation Trust. Funding was provided by FiMT. The project's purpose is to:

1. **Test the role of an AFC Healthcare Navigator in Primary Care** as a means of improving healthcare outcomes for the AFC;
2. **Understand the experiences** of the AFC in accessing and receiving healthcare through their GP and whether improvements and / or further training is required in order to improve the health and well-being of the AFC who have left the service;
3. **To deliver training and awareness** of the AFC across Primary Care and demonstrate that a local approach will improve identification, early engagement, prevention of ill-health and data collection.

The final purpose of the project through the feasibility study was to **create a framework and approach that can be adopted in other locations** to replicate the outcomes elsewhere. The feasibility study is the main component of this aspect of the work, considering the model of navigation under development and its viability elsewhere.

Roles and responsibilities of the team

Within the project roles were divided between **service delivery** and **project development**. The Navigator was the only service delivery position funded by the project. The Service Delivery Manager had overall responsibility for the service and was the Navigator's line manager. The

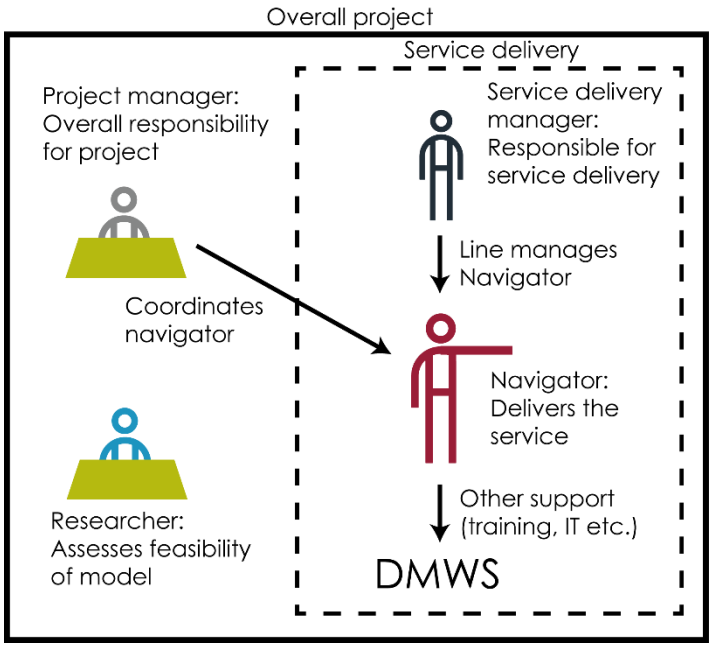

Figure 4 Roles and responsibilities amongst the project team

Project Manager had overall responsibility for the project and had a direct relationship with the Navigator through his coordination role. The researcher's role was not linked to service delivery but gathered data through direct engagement with the project staff and wider stakeholders.

The Navigator was therefore the central role in the team. This was reflected in the time given to the role as it was the only full time role funded. The Navigator was responsible for taking referrals, meeting patients who were eligible for the service, making referrals to other services, and acting as a key worker to the veteran for other needs. The Navigator's tasks were multifaceted including support for veterans, research, training support, awareness raising, and identification of veterans.

Support for the Navigator came through both the Project Manager and the Service Delivery Manager, though **the division was left somewhat unclear** between coordination responsibility and service delivery responsibility. The amount of time available for support from DMWS was limited to one day a week, and this included both the Service Delivery

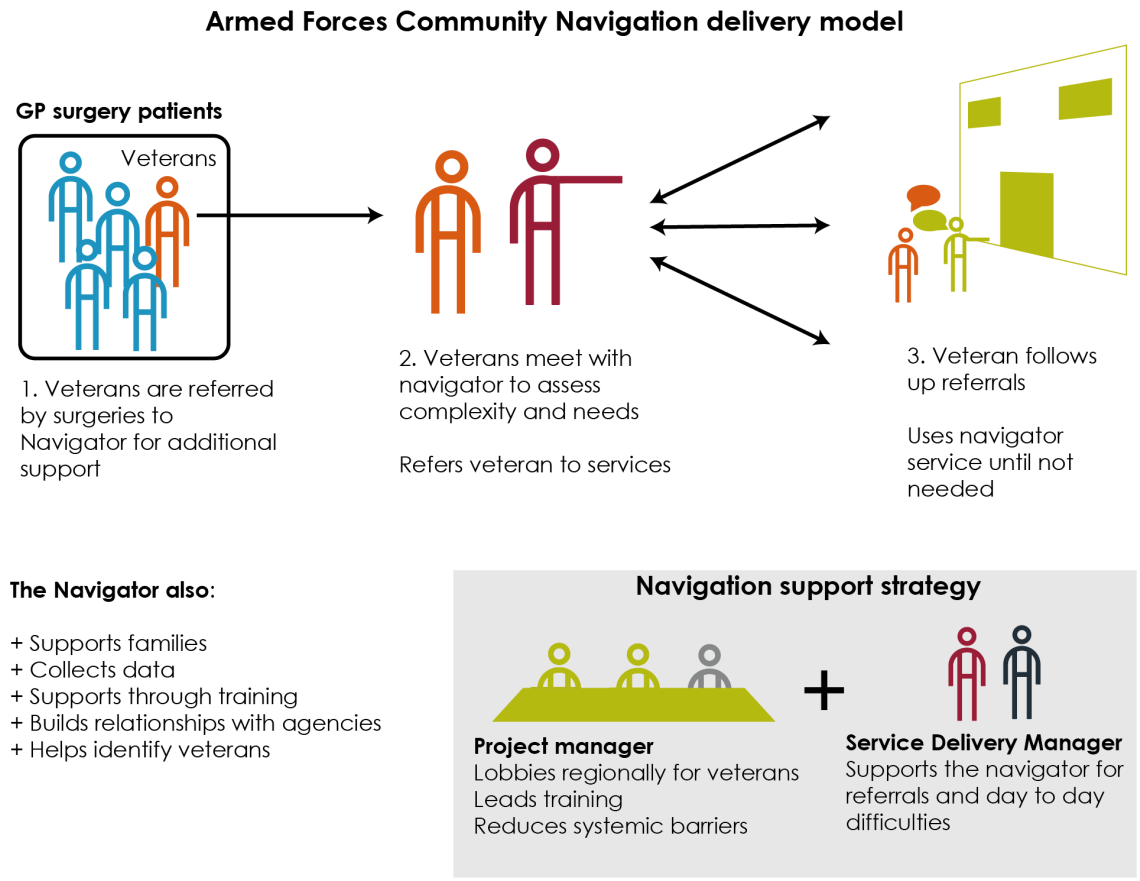

Figure 5 Armed Forces Community Navigation delivery model as proposed

Manager's role and any other DMWS support as required.

Service delivery model

The delivery of the service was driven by the interaction between the Navigator and Primary Care services. The model followed a **key worker** notion where the Navigator would be a continuous point of contact for the veteran until discharged from the service. Through relationships built during the planning phase of work, the Navigator would be informed by Primary Care services about veterans who were suited for the navigation services and receive a referral. The Navigator would set up an appointment to meet with the veteran in the surgery which referred them. At this initial meeting the Navigator would conduct a welfare assessment of needs as well as collecting routine data from the veteran. They would collectively decide upon what services the veteran would benefit from. The Navigator would make referrals to relevant organisations for social, health, educational or financial services. This would not end the contact as the Navigator would remain the primary contact point in a crisis and continue the role until both were happy to be discharged from the service. The model is outlined in figure 5 above.

Service delivery needs to be understood as only one part of the project, nested within **six other work streams** covering:

1. Planning
2. Communications and marketing
3. Training and Awareness
4. Developing the Navigator operational model
5. Governance
6. Research and data
7. Spread and scalability

Of these work streams, service delivery was covered through *developing the Navigator operational model* and active service delivery support was conducted through the *communications and*

marketing, and *training and awareness* work streams. Therefore the Navigator would **not only be focused on delivering navigation services** but would also have responsibilities for research (data collection on experiences and survey using well-being metrics), training support (of Primary Care staff, and identification of others in need of training), awareness raising (embedded in GP practices the Navigator would build relationships with key agencies), and identification of veterans (support GP surgeries to identify veterans in the surgeries).

Given these requirements, **the care navigator recruited needed to be at 'Gold' standard on the competency scale** shown in figure 1. The Navigator's role was ambitious in comparison to other programmes in this holistic approach. Usually, Primary Care navigators are expected to perform needs analysis, referrals and monitoring. In this case an additional role of being a primary contact point, similar to a key worker, was expected as well as service development across Primary Care services and preparation for scaling up the service through data collection and developing the operational model.

To perform their core tasks, the Navigator was supported primarily by the Project Manager (PM) and Service Delivery Manager. Both roles would be working generally at the inter-organisational level with Primary Care services. There was recognition in the model that **Primary Care services in Birmingham had issues with caring for veterans**, particularly with the low use of the veteran read code. Given this, the PM would run a series of training sessions for Primary Care staff on providing services for veterans, essential for running a behaviour change initiative to encourage engagement in veterans and the Navigator. The PM would also be working more generally at regional level to instil care pathways and more active engagement in the Armed Forces Covenant.

Theory of Change

A Theory of Change has two parts:

1. A theory setting out how and why you think a programme, or project, is going to work and what it will achieve.
2. A theory of implementation setting out the steps that will lead to realising the Theory of Change.

Both parts of a Theory of Change tell the project 'story' – from the 'presenting problem' it addresses through to the change it hopes to make on that problem at the end of the project and beyond (i.e. the project's expected 'impacts').

The presenting problem the project was set up to address is set out below:

- In terms of the Armed Forces community, there is no clearly defined record of the veteran population in Birmingham. It has however been estimated at 78,000 (Goodier and Regen, 2019). These veterans are likely to suffer from a number of health issues above the average of the UK non-veteran population and are **likely to require tailored support to deal with these**, particularly in light of their poor help seeking behaviours. Current mainstream services do not sufficiently tailor their services to their needs and the Covenant has had issues being applied due to low awareness at Primary Care level.

The overall theory of change for this programme was:

- *If* the project team engage and navigate veterans to services they need whilst training Primary Care service staff, *then* veterans will have improved experiences, health and wellbeing whilst Primary Care services will be better able to identify and support veterans within their services.

The Project aimed at two overarching outcomes to address these needs: **direct benefits to AFC** in terms of their wellbeing, physical health and experiences in using health services; and **better engagement of AFC in health services** and understanding of their local needs. This would be achieved through engaging veterans through surgeries to engage with a care navigator who can improve their access to support as a key worker attached to veterans until they are ready to be discharged.

At Primary Care level in Birmingham, the project was set up to address a thirst for further training in engaging with veterans and the e-training module has been underused implying dissatisfaction with that model amongst Primary Care staff. It was also noted that there was underuse of the veteran read code. To address these needs, **the programme would improve engagement, training and awareness of veterans at Primary Care level**. This would mainly be achieved through a training programme of Primary Care staff at selected GP Surgeries as well as a data collection campaign which would demonstrate the needs of veterans as well as the positive impact the Navigator service had on them.

The Theory of Implementation is set out in Figure 6 below.

This Theory (essentially a logic map of the proposed activities) contained a number of significant assumptions including:

1. The specific challenges for veterans are addressed by care navigation;
2. Veterans needed the service and it was not replicated elsewhere;
3. The coding of veterans is sufficiently developed that cohorts

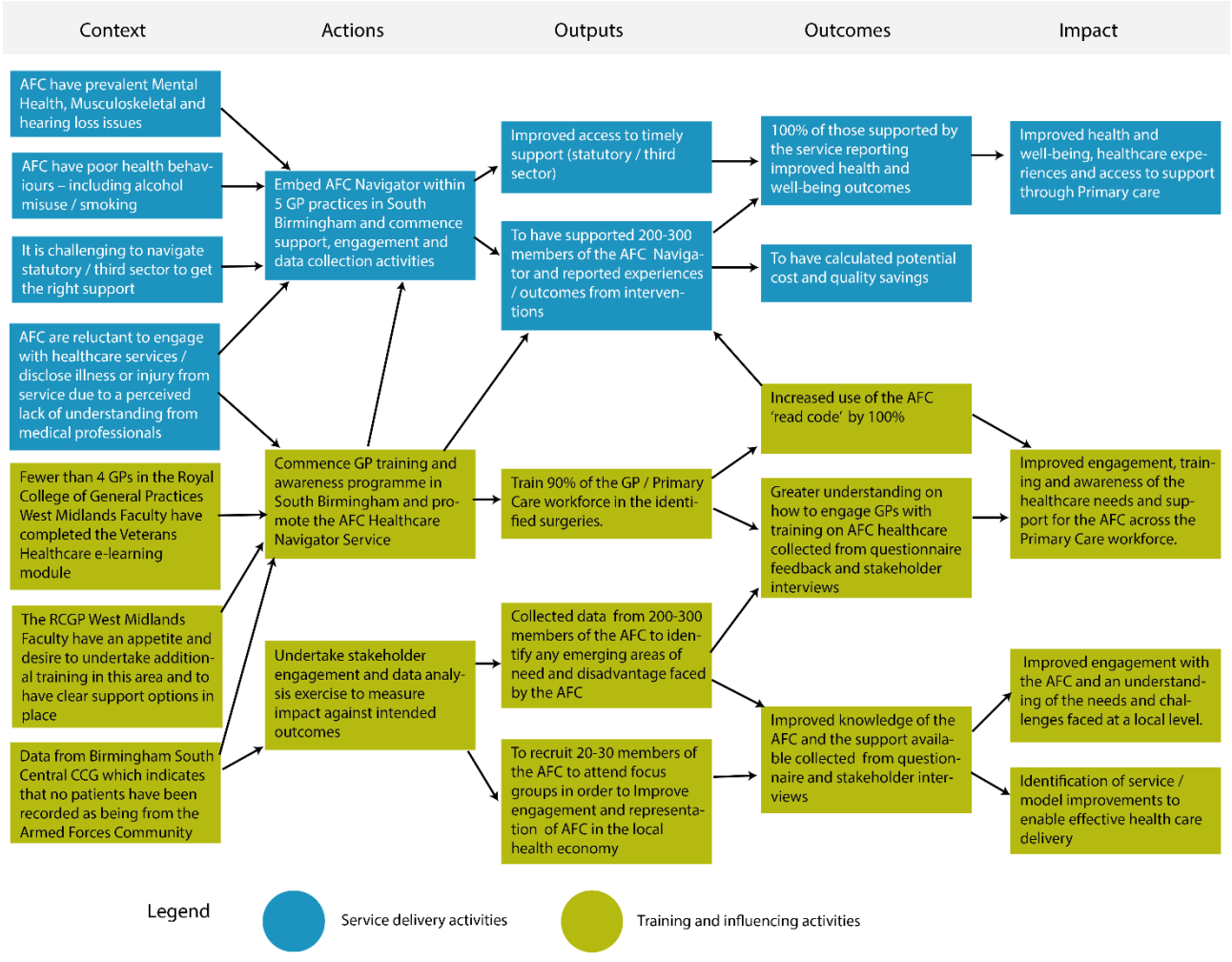

Figure 6 Theory of change of the project as proposed

of veterans could be referred from Primary Care to the Navigator.
4. There was sufficient time to engage Primary Care services into using the veteran read code and the Navigator service would be increasingly used as the project went on;
5. The Navigator was sufficiently supported and capable to delivering the service;
6. Relevant services are available for veterans to be referred to;
7. GP surgeries were sufficiently motivated to improve the health of their veterans to engage in the service;
8. The selected five surgeries were the best placed in South Birmingham to engage in the Navigator service;
9. GP surgeries would refer veterans to the Navigator;
10. A training scheme would be effective in engaging Primary Care staff with veterans;
11. There would be sufficient volume of veterans for a robust data collection.

How the model worked in practice

The project was immediately challenged by a delay in finding a suitable candidate for the Navigator role with the appointment finally made in July 2017. The delay resulted from a desire to ensure that the Navigator had the skills and experiences that would enable them to work effectively with veterans who might be reluctant to seek help.

The project was to begin working with the selected five GP Surgeries to train their staff, and begin referring the veterans registered in the practice to the Navigator. In practice there were six points in the delivery of the model where barriers were faced or overcome. Whilst the model worked well in many respects these six issues and recovery actions meant the model shifted significantly during delivery as shown in figure 7 below.

A: The five GP practices engaged little in the project despite agreement to do so;

B: In response to the lack of engagement from the selected GP Practices, the team networked with other services and received referrals, often of complex cases;

C: The Navigator was not given the support anticipated in the model in part due to not being based within surgeries as often as planned;

D: GP training was successfully conducted with mixed groups of GPs and an effective delivery model was established, though with fewer surgeries than planned;

E: In response to the lack of awareness of veterans' issues at Primary Care level, the Project Manager successfully contributed to steering groups in Birmingham and set up an Armed Forces Forum;

F: Due to little client throughput, planned research with veterans was not conducted extensively.

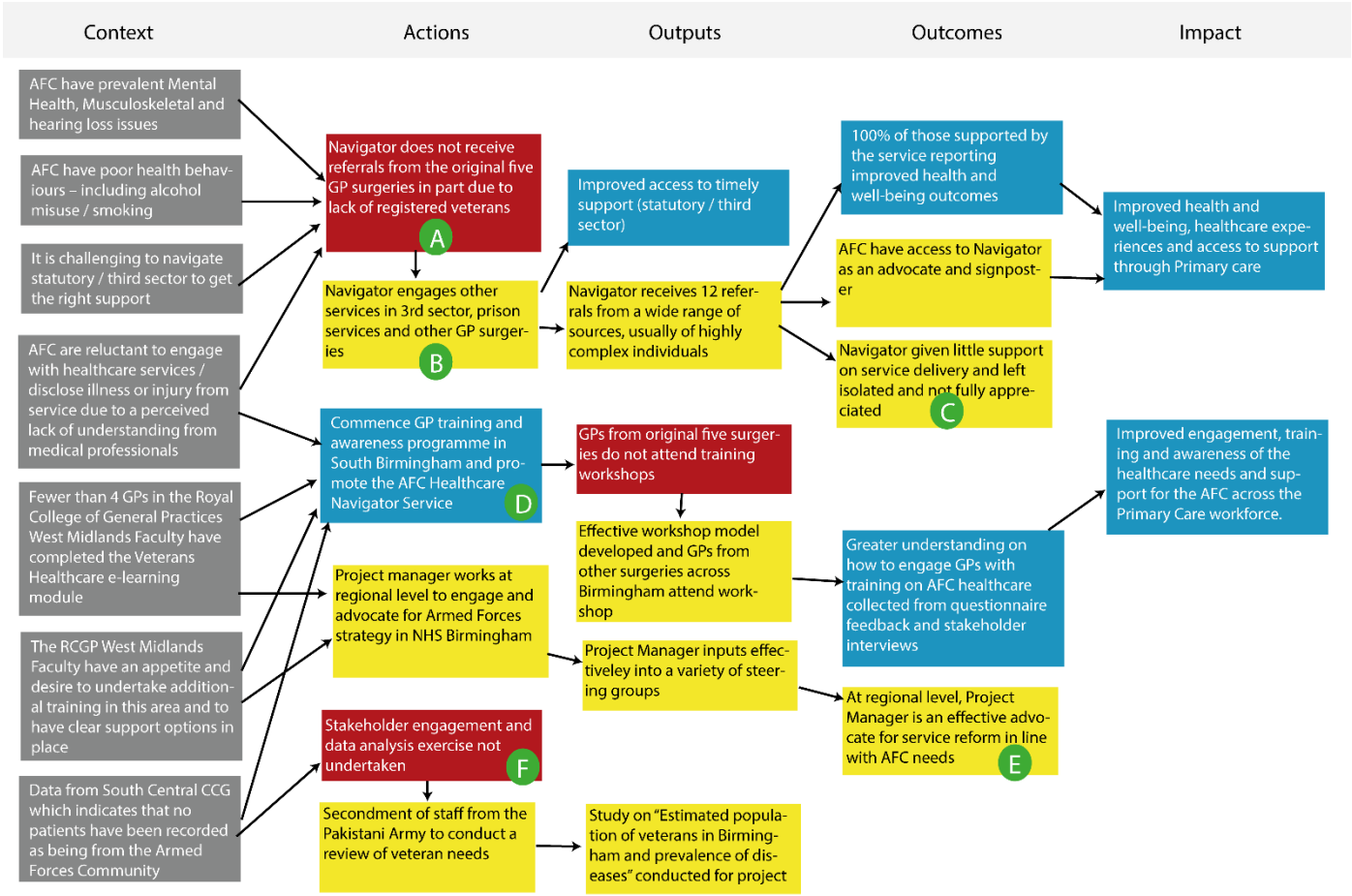

Figure 7 Theory of change of the project as delivered

The response to the challenges by the project team and feasibility of the finalised model are discussed in the section below.

Discussion of feasibility

The feasibility of the model to be replicated elsewhere is discussed below. This discussion is framed using eleven key questions derived from Valatis et al (2017). **These are factors selected based on a review of all research available on navigation programmes to understand what makes a successful navigation project.** These categories have been adapted here to find points of inquiry on the feasibility of a care navigation project linking primary and community care. The questions are shown in figure 8 below and clustered by questions related to patient characteristics, navigators, organisational factors and external factors.

From our previous studies of care navigation for the NAPC (2016), HESL (2017), and MacMillan (2018), these factors are an effective and accurate assessment of the underlying conditions for successful care navigation programmes. One factor not addressed in Valatis et al (2017) has been added relating to the **identification of the target population**. In our previous work in the area of care navigation, finding the target group is a key foundation for a patient navigator, particularly for programmes that target subpopulations that suffering from health inequalities. In our evaluations on care navigation the populations – whether diabetics, patients with long-term conditions or patients with cancer – have all been identified prior to the navigation beginning which made the task of navigation easier.

These eleven factors have been mapped against the assumptions in the theory of change in the section above. This shows how the success of care navigation

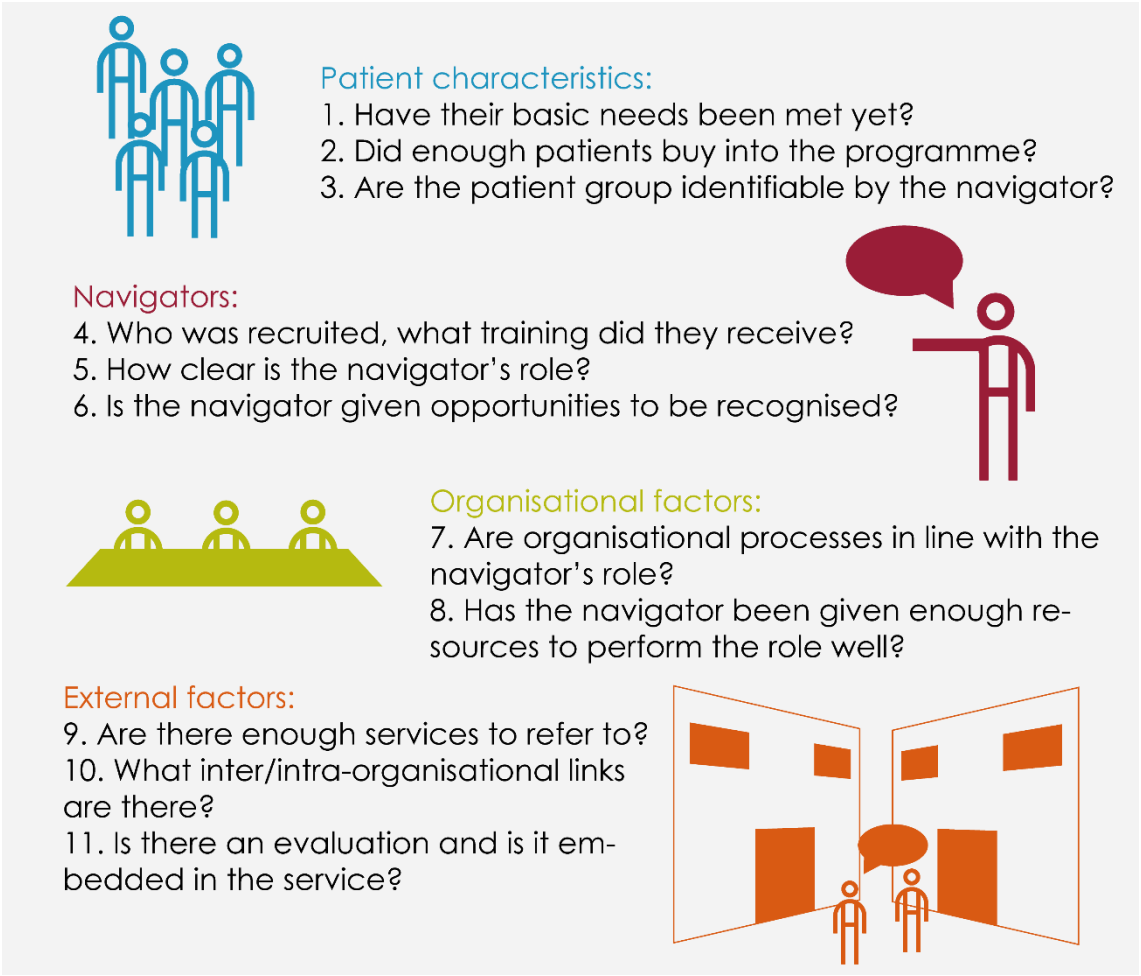

Figure 8 Feasibility questions for care navigation projects in Primary Care

projects in general relates to the specific nature of challenge for this programme and its clientele.

The feasibility of the model is explored through checking the degree to which the model matched these eleven factors. Whilst no care navigation model will be able to fulfil all these factors, **this process will highlight any areas in which the model was particularly effective**, or ineffective and how it was tailored to local conditions.

1. Patient characteristics

Relevant project assumptions:

The specific challenges for veterans are addressed by care navigation.

The AFCN programme required the service to **address multiple overlapping health issues** that veterans face. As shown in figure 6, the AFC often have specific health issues such as mental health, musculoskeletal and hearing loss, their health behaviours are often poor with a large subset of the population who are abuse alcohol, and many are reluctant to engage with healthcare services.

The confluence of these issues makes veterans a difficult group to navigate, as some veterans do not feel deserving of special help or with substance misuse issues are unlikely to be self-directive after being given a referral from a navigator. Poor health seeking behaviours in particular are likely to result in **some clients being in crisis upon entering the service**.

Three papers in Valaitis et al's (2017) review of factors leading to well implemented and maintained care navigation programmes found that **patients basic needs, such as affordable housing, should be addressed before navigation programme's would work**. Navigators can find it challenging to provide support beyond referrals in a navigation model, and usually it is important for patients to be able to take up referrals independently. This means cases should generally not be complex where basic needs such as housing and food have not been met that impede any independence.

This aspect was anticipated by the project which set out with the intention of providing a "holistic approach by supporting the individual service user and their family" (Proposal document). For this project, the Navigator stated that "some of the cases were too complex, I have had to contact some services and advocate on their behalf. **I had to be a navigator and a social worker**, as some didn't even have social networks to use."

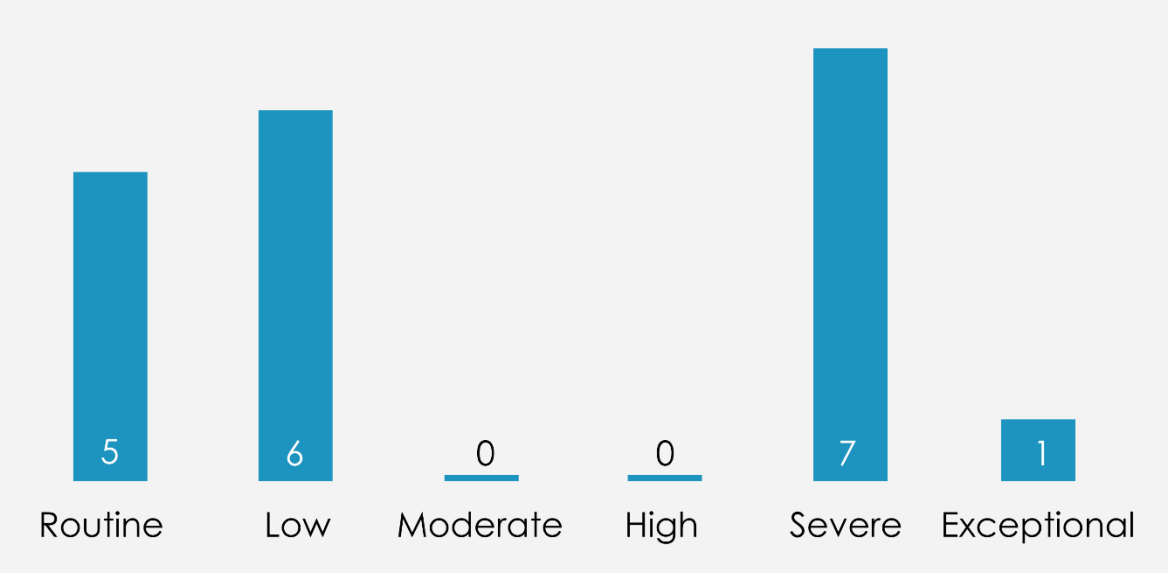

Figure 9 Service user complexity levels for referrals received

(Navigator interview) Therefore it appears clear that the veterans referred were often at a level too complex for most navigators.

Rather than being an advocate, **the role of a navigator is usually to work in partnership with the patient** in providing a conduit to services and solutions for maintaining, or improving, quality of life built from a shared knowledge of the patients' holistic needs. Usually this in the context of patients managing the impact of complex long term conditions. Care navigation can operate well, as part of a holistic and systemic approach, to address aspects of a complex case rather than the whole of it. However, because of the challenges produced by the invisibility of veterans in the system and, for some, the problems associated with seeking help, the care navigator found herself operating as a case-worker for a small number of complex cases. DMWS use a measure of case complexity.[1] This gave 42 percent of the cases reported a high average complexity score, much more than expected by the model developed.

[1] This matrix is subject to intellectual copyright by DMWS but covers a range of wellbeing measures.

Case study of a complex client

Referral path: Health Exchange referral

Complexity score: 36/36 (this meant that the client had six or more issues that were having a multiplier effect on his wellbeing)

Presenting issues: The client has type 1 diabetes, which was poorly managed due to his fear of needles. He had a poor diet, was on a low income due to unemployment though he was in receipt of benefits. He had frequent admissions to hospital due to high blood sugar and related problems. He had mental health issues including not liking crowds or being in situations with too many people. He was using cannabis as a means of coping. He was low in mood, and socially anxious when making calls and attending appointments on his own.

The client was isolated, single, and grew up in care. His housing was problematic as he had an infestation of mice and his front door had been removed from its hinges. As a result, his bank card and food had been stolen from his housing association property. He had been searching the streets for food and staying out for lengthy periods as he did not want to return to his accommodation. Safeguarding procedures instigated by the Local Authority as a vulnerable adult. He expressed disappointment that his career in the army was cut short due to health issues. He also expressed that he had a poor experience with other military charities in the past.

Navigator activities: This case was referred by the Health Exchange for the Navigator service to provide a specialist service- to accompany the client to appointments, to coordinate services and to seek out what services were available, the referrer didn't have the remit to do this. The Navigator's role coordinated the response of multiple agencies and kept the client engaged with a sense of control over what was happening. She fed back to the referrer - the Health Exchange - and liaised closely with the housing provider, updating the client at all times.

In specific terms, the Navigator accompanied the client to the GP, job centre, hospital appointments and dental appointments. As he had had no food for two days she took him to a food bank and a local Sikh temple that provides a free hot meal to anyone who accesses it. The Navigator also took him to the bank and contacted his housing association regarding repairs. Subsequently she contacted Birmingham City Council regarding housing options, another housing provider and then found a new housing provider. She also took him to a training and education centre to obtain course information. Obtained adult education information from another centre to provide him with different options.

The Navigator contacted the therapeutic service he was accessing and requested they refer to NHS Transition, intervention and liaison service with his consent as his 6 sessions were coming to an end. Both client and therapist felt he would benefit from further support. The Navigator also contacted a local organisation to send details of activities and events in his area. She also provided him with details of how to obtain a replacement veteran's badge, and they made the call together to encourage independence.

Following the move to new accommodation, the Navigator liaised with the staff in his new housing, discussed with him and them budgeting, and him about recording his blood sugar daily and transferring his care to a different GP for the new area. This was a long-term case due to its complexity. The client expressed a wish to explore employment issues in the future and wants to reduce his cannabis intake but for now he sees it as a means of relaxation.

Impact on veteran: The client is now in a shared house which has floating support 6 days a week. Staff ensure he has a nutritious breakfast and lunch. He visits the local library, is managing his finances and is hoping to do a course. He has registered with a GP in his new area. His diabetes is better controlled, and he is having less hospital admissions.

The case study above demonstrates a number of positives of the model in dealing with difficult patient characteristics. The Navigator knew a great deal about how the health and social care system worked in Birmingham and the best avenues to pursue. She was **able to interact with services effectively** and enable services to take on clients through a robust hand over process, whilst still remaining the client's key worker. Finally the Navigator was able to generate positive outcomes in complex cases by first meeting basic needs such as food and housing then beginning to address higher level needs such as education. This indicates that the Navigator was a highly skilled individual who was able to perform well in the role.

The cases undertaken by the Navigator, such as the example above, are evidence of **direct and valuable support to individual veterans and their families provided by the project**. For most navigators presented with the types of cases detailed in appendix 3 we would expect them to struggle more as cases became more complex. In this model the success was due to the resourcefulness and tenacity of the Navigator, derived in part from her background in social work. If the Navigator had had a large case load it is less likely that she could have had sustained successes in dealing with such difficult cases but in the project as delivered the Navigator coped well with complexity.

The results of the 19 client referrals demonstrated a number of short- to medium-term outcomes, including the ability of the Navigator to address the patients' basic needs:

- **Meeting basic needs**: rehousing; reduced levels of hunger and more access to food through 1) food banks, 2) luncheon clubs, 3) supportive housing; wheelchair arranged to be replaced; home adaptations.
- **Improved physical health**: fewer hospital admissions; hospital dental appointments arranged; better control over type 1 diabetes; referral to alcohol/drug dependency service; veterans made aware of rights under the Armed Forces Covenant; referred to Invictus Games for double amputee; registering with GPs; liaison with hospital staff from number of departments including PALS to ensure good discharge process.
- **Improved mental health**: felt less overwhelmed by situation; more sense of control; more future goals and plans for future; emotional support from navigator.
- **Reduced social isolation**: mentoring arranged whilst in prison, spent additional time with clients who felt isolated; discussed how to extend social networks with clients; joined gardening club.
- **Improved finances**: better management of finances; benefits sign up (PIP); visits to bank with client.
- **Access to education**: plan to do college courses.

The range of outcomes from so few cases demonstrates the varying needs of veterans in need of navigation services and **indicates the nature of the challenge to navigate such a diverse group**. Using non-surgery referral routes became the dominant model for referrals in terms of volume with ten of the cases were through non-NHS organisations. This approach has more in common with US approaches to care navigation which focus on health and wellbeing outcomes within a community setting rather than embedding in healthcare settings (Meade et al, 2014).

Because of the effectiveness of the Navigator, many of the patient's basic needs were met through participation in the project. This allowed people in such complex starting positions to gradually

take up referrals independently. However, **the poor health seeking behaviours may have led to difficulties in recruiting clients into the programme**, which is discussed in the section below.

2. Programme uptake and buy-in by patients

Relevant project assumptions:

Veterans needed the service and it was not replicated elsewhere.

The specific challenges for veterans are addressed by care navigation.

There would be sufficient volume of veterans for a robust data collection.

The AFCN model **assumes that the service was needed by veterans** in the area and another navigation-like service was not already available. As shown above, the target number of clients was 200-300. The achievement of this target would be needed to fulfil the full data collection activities by the project team.

Care navigation programme uptake is aided if there is a clear relative advantage to taking part. (Valaitis et al, 2017) The Navigator's direct experience was that whilst her clients did buy-into the service, for them it was "just another service to access." (Navigator interview) For some patients, the Navigator reported that they were not 100 percent clear on what the difference was between the navigation service and the services offered by mainstream Armed Forces charities such as The Royal British Legion, The Poppy Factory and Help for Heroes. However for GPs, there was a relative advantage for engaging the Navigator at Primary Care level due to the time and connections needed to effectively deal with a veteran's issues: "a GP can't work with solicitor, police, etc. There is a waiting list for therapy as well." (GP interview) Whilst there are a number of veterans' services, **the personal, key worker approach of the Navigator appeared to set it apart and led to good engagement from patients**.

As stated above, only 19 referrals were received by the Navigator from all sources. In terms of numbers, **the programme did not reach its target number of beneficiaries** (200-300 members of the Armed Forces Community). As a result, the Navigator was underemployed and may have over-delivered on some cases. However, of the cases that the Navigator had, almost all appeared to buy-into the service. For the referrals the Navigator dealt with the patients consistently had good outcomes regardless of complexity score, which is a good indication that they engaged well in the service.

Whilst veterans who accessed the service appeared to buy into the service, the uptake was low, and far below the target.

3. Identifiable patient group

Relevant project assumptions:

The coding of veterans is sufficiently developed that cohorts of veterans could be referred from Primary Care to the Navigator.

GP surgeries were sufficiently motivated to improve the health of their veterans to engage in the service.

The selected five surgeries were the best placed in South Birmingham to engage in the Navigator service.

GP surgeries would refer veterans to the Navigator.

One of the biggest assumptions that any navigation programme makes is that there are clients available to navigate. This was explicit in the theory of change that **GP practices had sufficiently developed coding practices of veterans and so would be able to refer a cohort to the Navigator when the project began**. In the theory of change the existence of a client group was also eluded to in the assumptions regarding ability, motivation and intentions of GP surgeries to refer veterans to the Navigator.

As seen, **few veteran patients were identifiable by referring services**, particularly in Primary Care. These services were not sufficiently engaged or motivated in the project to reverse this issue. Arguably this factor was the most fundamental for the success of any navigation model and was not present in this case.

As a result of the poor use and misuse of the veteran read code, there are few people registered as veterans in GP surgeries in South Birmingham. With the local veteran population not easily visible in care systems, awareness of veteran issues is low among staff at GP surgeries. Although several surgeries took part in the project, it is hard to argue that GP engagement had been successful though this appears to be due to **unwillingness to improve coding practice of veterans, and low awareness** of veterans. Given the estimated size of the veteran subgroup in the local population the gap in numbers between visible and invisible veterans is surprising. Ultimately, for the surgeries concerned, "a lot of the impact will depend on how many ex-service people you have on your list. There's also a big difference between how many veterans you actually have and how many you recognise at the moment. I imagine it might be a bit of a tip of iceberg situation." (GP interview)

The low use of the veteran read code made it hard to target Primary Care services at veterans. Early in the project, the Navigator stated that "When I've been to surgeries with the Project Manager or alone, **they never seem to know who has served**." (Navigator interview) One of the usual approaches navigators use at the beginning of their service is to contact all patients with the appropriate read-code yet this technique could not be applied in this model as the databases needed to be filled and corrected in the first instance.

Time constraints meant that the difficulties in identifying veterans at Primary Care level could not be addressed systematically thus reducing the options available to the delivery team. Without sufficient lead time **the project could not effectively deal with the poor coding** of veterans and led to less than 10 percent of the client target being reached.

4. Effective recruitment and training of navigators

Relevant project assumptions:

The Navigator was sufficiently supported and capable to delivering the service.

The theory of change model assumed that the Navigator would be capable of delivering the service and would have sufficient training support to fulfil the role.

According to all participants, **the Navigator recruited was the right person for the role**. The Navigator employed was appropriate to the role being **self-motivated, resourceful, resilient and good at client work**. She came from a social work background, having worked with HIV patients amongst others. Recruiting the right level of navigator was difficult and took two rounds of advertising and interviewing before the candidate was selected, with the proposed salary being increased in the second round in order to attract a sufficiently qualified candidate.

One GP interviewed discussed the Navigator's approach when discussing a patient he referred to her:

> "The attitude of this veteran towards the Navigator is 'this is someone who can help me, she knows understands and can listen.' She can allow their vulnerability to surface. She seems to have specialist knowledge but is also empathic. There seems to be a benefit of her not being of the forces, as the person had been subjected to brutality in the Army." (GP interview)

This testimony demonstrates the empathetic nature of the Navigator hired.

Beyond empathy, according to the Navigator to do the role "You need to be **quite assertive, resilient and proactive**, also organising and promote the service. Resilience is key especially dealing with housing providers and safeguarding issues. Sympathetic – I make calls if have a deal for them to do tasks like register for adult education." (Navigator interview) This description fits well with the attributes that a navigator requires.

The training she received was **limited but appropriate to the role and her existing skills**. The induction programme was particularly robust:

> "I went down to Andover for the induction with seven Welfare Officers for Age Veteran projects. We met with marketing, HR managers, and looked around the offices. It was useful to meet each other. A week later I did a five day welfare diploma course with Christchurch Canterbury, which covered case recording, safeguarding, self-care, mental health first aid and legalities. This was alongside DMWS staff and Help for Heroes staff. I already knew a little about safeguarding" (Navigator interview)

Following the induction, the timing of further training was often delayed, including database training which took three months, then was repeated at the end of the project to update on the new system. However, as a whole **the training was largely supportive and useful**.

5. Role clarity

Relevant project assumptions:

The Navigator was sufficiently supported and capable to delivering the service.

Part of the support for the Navigator related to ensuring that communication and team structure is sufficiently clear that they are able to communicate a clear service to clients and can access support whenever needed. This also implies that the Navigator was **capable of holding the boundaries of a navigator role**, which usually guides clients and promotes self-reliance rather than direct support.

Navigators benefit from patients understanding that **they do not provide clinical advice**, they have a clear role in relation to patients as partners in their care, and they maintain boundaries with patients with complex needs. (Valaitis et al, 2017) In this model there was an issue with role stretching in complex cases for the Navigator.

The Navigator's ability to provide individual support and to be the primary contact point in crisis enabled her to take up a direct support role as a caseworker. The low volume of cases, combined with her skillset, meant that in many cases, **she provided advocacy as well as navigation**. Examples are contacting services on the client's behalf, accompanying the client to meetings, and, even advocating within secondary care services for the patient.

The Navigator found herself walking **a fine line between creating dependency and enabling empowerment in seeking and obtaining help**: "I have to be quite firm to not do everything for them. I'll say I'll meet you again in 2 weeks' time, I'll do XYZ and want them to do things too. I'm sympathetic if they can't do it and aren't motivated. I'll do research too on who to contact, I'm conscious of not doing things for them." (Navigator interview) The presence and availability of the Navigator, with her military culture awareness, signalled to clients that there is someone who understands them thus reducing any reluctance they have to seeking help.

The Navigator role was arguably substituting for the absence of, or relatively weak, pathways into primary and secondary care for veterans with complex long term needs. While it is completely understandable, and admirable, that the Navigator, with her skillset, willingly and successfully took on these cases it is not a sustainable practice. Systemic integration

is key, especially for the navigation of complex cases. Without integration successful casework could lead to higher and unmeetable demand resulting in the eventual collapse of the service. This is something that the Project Manager was well aware of but it could not be addressed in the time available.

6. Valuing of navigators

Relevant project assumptions:

The Navigator was sufficiently supported and capable to delivering the service.

The relevant assumption in the programme's theory of change was that the support for the Navigator allowed them to perform their main task. This support for the Navigator should include **motivation and recognition of good work**.

One paper found the importance of giving navigators the **opportunity to be recognised**. (Valaitis et al, 2017) From the Navigator's point of view, she did not feel as if her work was very visible or recognised by her organisation. (Navigator interview) Whilst this is a common issue for navigators and was more predicable in this design as the Navigator worked remotely without close supervision, there were instances where more effort should have been made. Ensuring adequate operational support and capacity to identify and recognise the positive impact of the Navigator role is a key recommendation for future Navigator type support models. (Navigator interview).

The perceived lack of recognition was in the context of a three way split of roles between the Navigator role, service delivery management, and project development. Management of the overall project was divided between Birmingham Health Care (BHC) and DMWS. It is likely that the delayed appointment of the Service Delivery Manager led to **the Project Manager taking up a larger support role than envisioned** in the original model. Also the rapid shift from an expected, but not achieved, high throughput of clients to a greater emphasis on infrastructure and development had, according to our interviews with key staff, generated role uncertainty amongst the support team.

As a lone worker recognition is often difficult to achieve. If a greater stream of referrals from practices was achieved then it is unlikely recognition would have been a significant issue. In the original vision, the Navigator would have been largely based in the five surgeries working with veterans and liaising with staff. Also much of the service development manager's and Project Manager's time would also have been spent in these same surgeries promoting close contact between the team members. This would have provided a team-based environment working with colleagues from different surgeries, alongside the support from the Service Delivery Manager and Project Manager.

7. Effective and clear operational processes

Relevant project assumptions:

The Navigator was sufficiently supported and capable to delivering the service.

Part of the support that the Navigator required in this model was for **decision making, discussion of difficult cases, and procedures for client relations** that mutually helped both the client and the Navigator. This would all help the Navigator to ensure that any blockages to service delivery were temporary and that clients had a clear and rigorous service delivered to them.

Operational processes covers a number of factors that lead to more successful navigation programmes: planning processes, steering committee support, discussion of cases, well-articulated procedures and policies, safety procedures, planning between partners, careful decision making on the service model, clinical supervision, scheduling and

following up appointments. (Valaitis et al, 2017)

Of this list, we found evidence of the following:

Planning process/careful decision making on the service model: Multiple conversations between the Project Manager, Navigator and Service Delivery Manager about how they could revise their model and re-engage Primary Care Services.

Steering committee support/Discussion of cases: The Project Manager helped establish an Armed Forces Forum steering group at Trust level. This allowed professionals from a number of veteran's services to strategize about the care of veterans in Birmingham and to discuss individual cases and how best to deal with these. For one participant in the Forum, "The Forum is very good for case referral as well, especially when the do the round the table cases. They can refer to the Project Manager and refer to the Navigator to do the navigation work. Round the table they can talk about the whole person – housing employment health and benefits issues." (The Poppy Factory Manager interview) This group is also likely to be sustained and provides an alternative holistic method for dealing with veteran issues regionally and on a case by case basis.

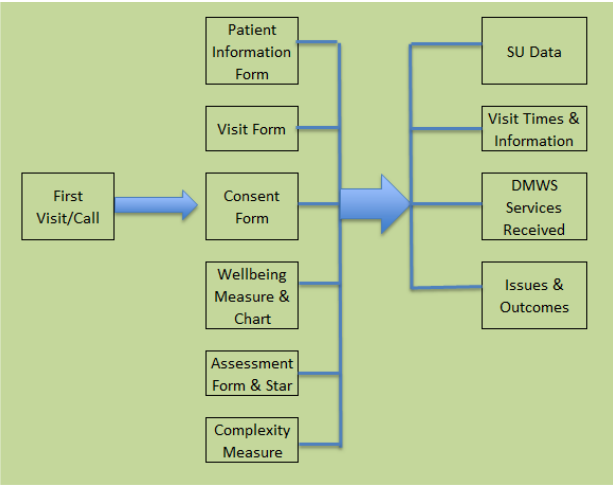

Figure 10 DMWS process for initial client contact

Well-articulated policies and processes: DMWS gave the Navigator a series of clear processes to go through with each service user at three stages: first call/visit, subsequent visit/call, discharge call/visit. During the first visit/call, the Navigator would have administered a consent form, a visit form, a wellbeing measure, assessment star, the complexity measure, and an information leaflet for the service user. The information gathered would then be inputted into a database. The workflow for the first visit is shown in figure 10.

Planning between partners: through the Armed Forces Covenant meetings, the Project Manager included the project in discussions on improving healthcare services for veterans between a series of partner organisations.

Clinical supervision: DMWS provided funds for a clinical supervisor which was taken up by the Navigator. Whilst it was not necessary for the Navigator, in particularly challenging roles staff can receive extra funding for supervision.

Scheduling and following up appointments: When referrals came through these led to the Navigator setting up face to face meetings to talk through their needs. We found no evidence that appointments were no followed up and most cases displayed long term follow up.

Safety procedures: DMWS provided robust training to the Navigator on safety policies and assessing risk levels prior to home visits. During the Diploma course the Navigator was provided with specific training on extraction from challenging situations. As a lone worker, DMWS provided the Navigator with a security app called Guardian 24. The app gives lone workers the ability to "raise an alarm at the press of a button and the functionality to allow lone workers to log in and out of daily tasks, leaving details of their location and the expected duration." (Guardian 24, website) Six months into the project the app was discontinued and was not replaced before the end of the project.

Whilst on the whole there were effective and clear operational processes, there was evidence that the **safety procedures were problematic**. For one referral, an unstable veteran would sometimes call the Navigator at 5am whilst drunk – this client took a GP hostage two weeks after the Navigator had severed contact due to harassment. A challenge identified by the Navigator was expressed with regards to supporting complex cases where prior behaviours presented a potential risk, For such clients the Navigator would have felt more comfortable with tools such as Guardian 24 on offer. Given the complexity of the cases being managed by the Navigator our recommendation would be to supplement robust training and assessment with additional support tools.

Some of the procedures were also unwieldy in practice such as the consent form which was long and hard to administer. (Navigator interview) Also some procedures were not set up for such a close relationship with Primary Care service: the Navigator found early on that it would be **helpful to have a referral form** to demonstrate professionalism in the project. The Navigator asked DMWS for a referral form for GP Surgeries to use after a request by a Practice Manager. This was initially refused because DMWS do not use referral forms. A few months later, the Project Manager separately asked for a referral form and after several delays this was produced and then used by surgeries. (Navigator interview)

8. Adequate human, financial, and tangible resources and time

Relevant project assumptions:

There was sufficient time to engage Primary Care services into using the veteran read code and the Navigator service would be increasingly used as the project went on.

The Navigator was sufficiently supported and capable to delivering the service.

The AFCN model assumed that problems identified, such as the use of the veteran read code and veteran's reticence to ask for help, would be **resolved over time with joint resources** from Primary Care services and the project team.

In the literature, this category covers a wide range of resources including available space for navigations, external funding, dedicated clinical staff, maintaining funding, and adequate time for the programme to integrate into care system. (Valaitis et al, 2017)

The Navigator did have space for navigations available either in surgeries, in public spaces or in a patients' homes. **The project also had external funding** which gave freedom for the project staff to dedicate time to navigation and system change.

However there were a number of resource-related difficulties:

Dedicated clinical staff: At the start of the project few clinical staff were engaged in the project. Over time this dedicated cohort grew primarily through the Project Manager's training activities and networking at institutional level.

Maintaining funding: The project was funded for only one year and no further funding has been secured for the project to continue. Two of the staff funded through the project have subsequently moved into other areas of work: the Navigator and Project Manager.

Adequate time for the programme to integrate into care system: As the project was funded for one year and ran counter cultural to the way that Primary Care services dealt with veterans there was arguably insufficient time to make a significant and lasting impact on Primary Care services in South Birmingham. The original vision of a two year project may have been more successful in overcoming systemic barriers such as the coding of veterans at GP surgeries.

In the end it appears that there were resources to tackle the initially identified issues but these could not be mobilised in time, especially given the lack of engaged clinical staff.

9. Available services in a community

Relevant project assumptions:

Relevant services are available for veterans to be referred to.

The model assumed that there would be enough services in the area of Birmingham to refer veterans too. Whilst this was not seen as a risk for this programme, some navigation projects face the barrier of having nowhere to navigate clients to. (Valaitis et al, 2017)

The number of potential services that veterans could be referred onto was one of the core strengths of this model. As one of the largest cities in England, Birmingham has a large number of relevant services. Many veteran-specific services are also available including The Royal British Legion, Help for Heroes, and The Poppy Factory. The Navigator faced no problems in finding services: "it was easy to find places." (Navigator interview) From her own experience in social work roles she often knew of places such as a local Sikh temple that gave free meals.

This referral process was aided by the Navigator being given a **list of people to contact** by the Project Manager when she started.

10. Strong inter and intra organisational relationships/ partnerships

Relevant project assumptions:

GP surgeries were sufficiently motivated to improve the health of their veterans to engage in the service

GP surgeries would refer veterans to the Navigator.

A training scheme would be effective in engaging Primary Care staff with veterans.

The selected five surgeries were the best placed in South Birmingham to engage in the Navigator service.

There was sufficient time to engage Primary Care services into using the veteran read code and the Navigator service would be increasingly used as the project went on.

Relevant services are available for veterans to be referred to.

As above, the model made many assumptions regarding the organisational and links and partnerships that would be formed by the programme. This implies that **these links were crucial to the project's success**.

Of particular importance, the model assumed an **interest in veterans by Primary Care services** and that they would be motivated to give some priority to these patients. This motivation would lead surgeries to refer patients, and engage in training. Additionally the surgeries selected had to be appropriate and there had to be appropriate services for the Navigator to send them to. The strength of these relationships was likely to correlate to the strength of the programme as a whole.

The literature also suggests that **organisational relationships are an important factor** which includes the model having strong relationships with community agencies, commitment from partners, community based steering committee, established communication strategies with partner organisations, going from agreements to buy-in from partners, and the use of boundary spanners who can link inside organisations to outside. (Valaitis et al, 2017)

For the programme partnership, there was strong commitment from third sector partners, such as The Poppy Factory. **The project team struggled more to find firm commitment from Primary Care partners**.

This was shown in the Armed Forces Forum which did not have members from Primary Care but several from the third sector.

The main issues faced were **going from agreements to buy-in from partners and establishing communication strategies with partner organisations**. In particular, the project often gained agreements from Practice Managers to embed the Navigator programme at their surgeries but then only received a few referrals and low interest in training activities. For the Navigator, it was "frustrating for me, going to practices, calling them, visiting and nothing coming through." (Navigator interview)

It is unclear why buy-in did not result from these engagement activities. **In other Primary Care based navigator programmes, payment to surgeries has incentivised take up in the programme**. In a recent Health Education England navigator programme for patients with long-term conditions, surgeries received a small amount of funding to participate in the programme which covers the costs of member of staff becoming a navigator within the surgery. Whilst the amount of funding was low, the financial incentive led to a large number of surgeries engaging when they otherwise would not have according to interviews with Practice Managers.

Part of the financial incentive was also that there are **no Quality and Outcomes Framework (QOF) standards in place that reward practices for reaching a certain number of veterans**. According to the Service Delivery Manager, "Maybe the surgeries didn't see the benefit. Personally, I suggest that GPs are driven by targets, especially financial targets and that wasn't a part of the package we offered. There was a change in the GP contracts a number of years ago so that GPs got paid a certain amount depending on meeting personal targets." (Service Delivery Manager interview)

Identification of potential boundary spanners: As the programme progressed, more potential stakeholders were engaged who could act as champions for the project from within their GP surgeries. This was most clearly achieved through the training activities.

The first half day training workshop was held on November 1st 2017 and included a speed dating component, where **attendees could talk to veterans support services such as The Royal British Legion about what help they provided**, as well as presentations by veterans about their experience. 11 GPs attended, which was below the target of 30 but this cohort represented a good starting point for the training work stream for the project.

A survey was conducted at the beginning and end of the training and the pilot training results were positive from the attendees' point of view. As shown in figure 11 below, **the reaction to the training was positive in terms of recommending the training to others**, meeting expectations, organisation of the workshop, improvement in confidence, and variation in delivery. A participant in the training stated that "I thought it was very good. It worked on the level of information, making you aware of specific special needs that veterans have. Members of AFC were present too. It increased my awareness of health and specific instances of what we can do such as the veterans' read code. I've not used the code correctly before." (GP interview)

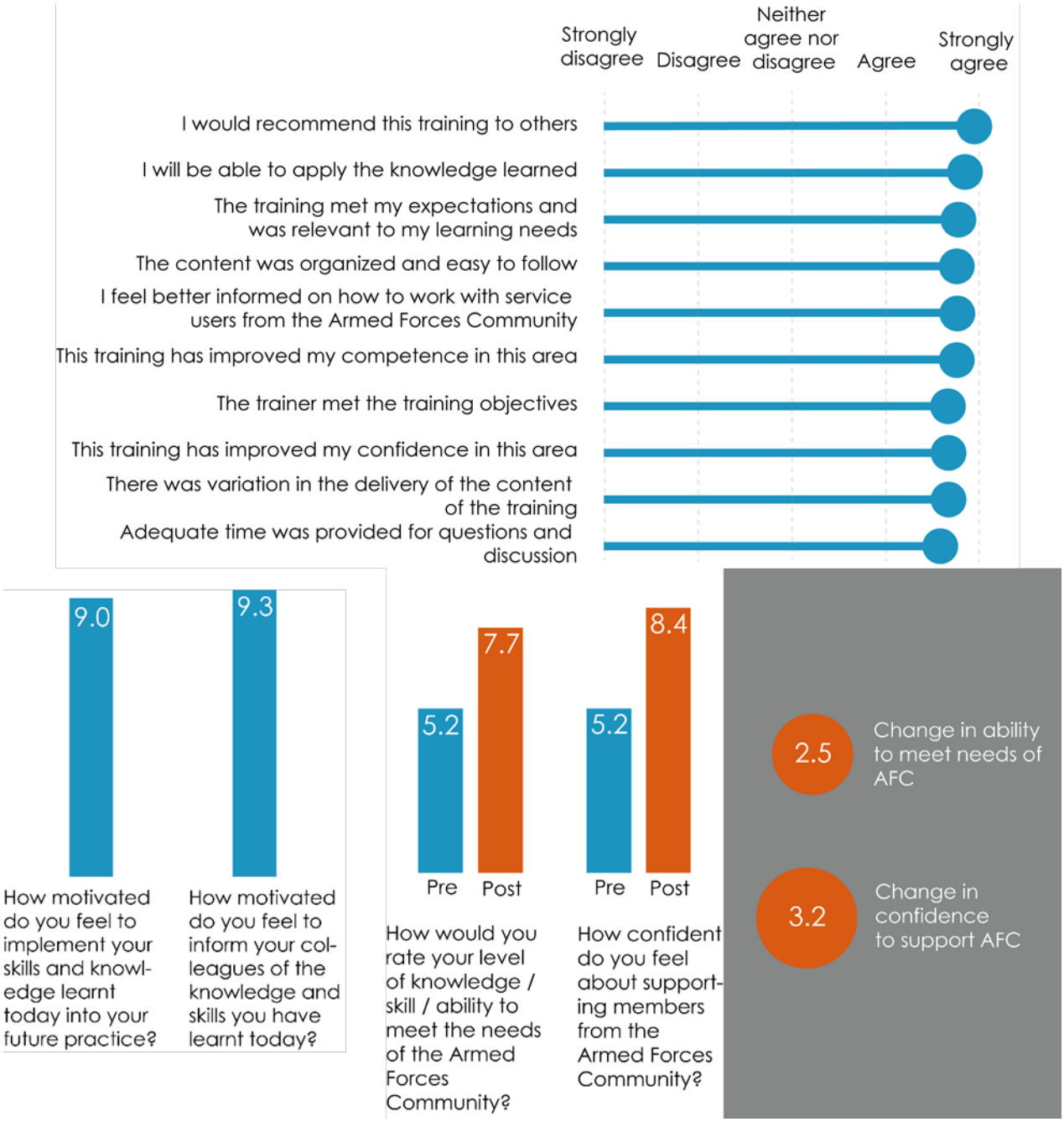

Figure 11 Infographic of survey results from first GP training

The training also potentially had an impact on the behaviour of attendees given **it left GPs very motivated to both apply their new skills (9.0/10)** and to inform their colleagues about what they had learnt (9.3/10). Finally according to survey responses, the training also improved the ability to meet the challenge of delivering services to veterans as it increased the ability (by 2.5 point) and confidence (by 3.2 points) of attendees to meet the needs of veterans.

The training grounded the attendees in actual veteran issues by inviting Armed Forces charity representatives and veterans to be present. For one GP, interviewed for the project, "**The event I went to was fantastic.** The format is great for a small workshop – having ex-servicemen and relevant charities present really cemented the learning in my mind. That face to face time with ex-service personnel was great." (GP interview) This

implies that the model for training was highly successful.

By the end of the project, **the Project Manager had engaged surgeries at surgery group level** as well as individual practices:

> "In the latter stages, we had started to work with the RCGP West Midlands Faculty who started to pilot the GP Veterans Accreditation Programme to encourage GP support for the Armed Forces Community. I think at the last count there were approx. 90 GPs in the West Midlands who had pledged their support. We did run a number of on-site sessions to GPs off the back of this." (Project Manager, email)

This latter initiative was important in sustaining the successes of the project. The proposal to embed the training within a GP accreditation programme as well as the training already accomplished at individual surgeries, will aid **the training being mainstreamed at an appropriate time in the GPs/surgery staffs' development** rather than as a one off workshop making marketing the training much easier. This stream of work if continued could be important in ensuring the sustainability of the project and guaranteeing that the learning from the project is continued.

Because of the training and regional networking the strength of **links between the project team and the relevant organisations grew throughout the project**. Beside Primary Care links, other inter-organisational links that developed through the project are in Appendix 2.

The model then appeared to **overestimate the level of motivation that GP surgeries would have in identifying and referring cases to the Navigator**. The inclination of Primary Care staff to engage in veteran related training also may have been overestimated even if the training itself was effective. It remains unclear whether the surgeries selected were best placed as it is likely that no surgery had a robust coding method for veterans.

11. Evaluation of navigation programmes

Relevant project assumptions:

There would be sufficient volume of veterans for a robust data collection.

The main assumption related to the evaluation in this case was the volume of veterans contacted. The majority of the primary data was intended to derive from patient contacts, with pre- mid- and post-surveys intended for all veterans who used the service. In addition, 20 to 30 veterans were meant to be involved in focus groups. These activities were **premised on the project navigating sufficient numbers of veterans**. Without this aspect of the work, the primary evaluation data would only be derived from the feasibility study which had a different purpose to evaluation.

Evaluation can help the success of a navigation programme, particularly when there is a collective development of an evaluation plan, use of an internal evaluator, and tracking achievement of outcomes. (Valaitis et al, 2017) For this project, a feasibility study was conducted who were part of the project team and inputted regularly to meetings as well as being kept abreast of project developments by email and phone contact. **The evaluation plan was decided at the proposal stage in dialogue with the other project partners** and was intended to be delivered by the whole team and particularly the Navigator.

Tracking the outcomes of the project proved a challenge. The original model included provisions for data collection by the core team from the clients reached. This included planned focus groups with 20 to 30 veterans reached and surveys of all veterans. **Due to the low numbers of veterans reached most data collection activities were not carried out**. It was felt by the team that the lack of veterans

reached combined with the highly complex yet diverse clients would make running focus groups difficult and so these were not executed. Survey data was not collected though there were protocols to do so.

In substitution for these additional data collection activities, **a health needs assessment (HNA) for veterans was conducted** by a Lt Col on secondment from the Pakistani army. Whilst the seconded staff member came from a research background she found through the work that "there's basically no data to be had" on veterans in Birmingham. (Navigator interview) Primary data was not collected for HNA report yet this work filled some gaps in knowledge in the team and provided an overview of the types of health issues and pathway issues faced by many veterans in the UK. This HNA report was used as a project document to inform service delivery.

Recommendations

Summary of discussion

There are some clear successes in the model. The recruitment and training of the Navigator was a particular plus: the Navigator **was an excellent case worker and was given appropriate training**. This allowed the project to deal with much more complex cases that would be usual in a care navigation project. Having a navigator operating at the 'Gold' or 'Silver' standard shown in figure 1 is helpful in a veteran care navigation programme due to the diversity of need and poor health seeking behaviours which lead some veterans to reach crisis point before accessing help. Patients who reached the service did not often have their basic needs met but still achieved good outcomes through the project. All service user data suggested that patients who reached the service usually bought into the service offered, and the style of the Navigator suited the clientele despite her lack of prior Armed Forces expertise.

Beyond case work, there were **strong organisational processes** usually seen in strong care navigator programmes which were available to the Navigator. These included planning processes, steering committee support, well-articulated policies and processes, clinical supervision, scheduling and following up appointments. Whilst there were some potentially serious issues with the safety procedures and delays in setting up a formal referral process, the processes were generally appropriate for the Navigator's role.

Other advantages of the model developed included being based in **Birmingham, which has a great number of referral services**. Knowledge of the locality by the Navigator and the Project Manager meant clients benefited from local knowledge. The programme was internally evaluated throughout and the findings were embedded in the service leading to good quality reflections on the project.

There were a number of issues which challenged the delivery of the navigation service. These were potentially serious issues but were possible to overcome and did not make the model unfeasible. In the first place, **the links between Primary Care and the project team were weak** although the connections grew stronger throughout the programme. It was clearly a difficult challenge for the project team to adapt to the lack of referrals from Primary Care services and the poor engagement of the five selected surgeries in training activities. Arguably, these surgeries were not incentivised to participate as they often are in other Primary Care navigation projects (Child, Drabble and Benson, 2017); financial incentives are particularly valued currently given the funding pressures at Primary Care level.

At an organisational level, **the Navigator's role stretched beyond delivery** so she was also providing advocacy to patients. There was some role confusion in the other team members' support of her tasks. The Navigator also felt she was given little recognition for her work which was in part due to the model using a lone worker as a navigator: she was physically distant from all other project team staff making support more difficult to access. It is also unlikely that the project had sufficient resources to achieve its aims as it was **only funded for one year**: given the amount of preparatory work that was needed to engage and train the Primary Care workforce, a longer project which was frontloaded with research into the local population profile, and education and engagement at Primary Care level would have been beneficial.

Ultimately, **the project accessed few veterans within Primary Care settings**, only receiving 19 referrals compared to the initial aim of referring 200 to 300 veterans over the 12 months of funding. Despite continuous engagement work by all

members of the project team, the number of veterans identified remained stable throughout the project. The low number of veterans identified at Practice level also meant surgeries had low motivation to engage in the programme: when less than ten patients in a surgery were identified as veterans it seemed to some Practice Managers that the clinical rationale for engaging scarce resources into veterans was weak.

Overall the lack of veterans identified in Primary Care settings meant that the model could not be implemented as planned. This leads us to **recommend revisions to the model** particularly in identifying veterans and creating strong organisational links. We also provide a range of suggested models for how any future Care navigation programme should be set up which focusses on veterans.

Recommendation 1: GP Practice led Armed Forces Navigation

The main challenges facing any veteran navigation project are to improve the identification and engagement of veterans in Primary Care and to strengthen the links between the navigation service and GP surgeries.

These challenges can be addressed through GP practice led navigation. It would work by **basing navigators in a number of GP Practices** in a region with a high number of veterans such as Birmingham. It should be an **opt-in service** for surgeries who receive funding for their employment of navigators. It would suit Practices with staff who champion veteran care and are motivated to improve the healthcare of veterans. In this model, the Navigator**s would be current employees** of GP Practices rather than employees of an Armed Forces charity. All facilities and support would be provided by the surgery.

To be successful this model should be **coordinated centrally by a project manager** who could organise peer learning, training, awareness raising and influencing across the identified region. The project manager would require the knowledge and ability to lead training and awareness raising and so would be best based at an Armed Forces charity such as FiMT or The Royal British Legion. However in the planning phase, the project should engage NHS commissioning services to ensure it is delivered in line with NHS strategic priorities.

Within this model the Navigation tasks would be a **bolt on role**, and not full time. The person identified should know local services, and feel able to offer support more widely. This role would be for a general navigator who would learn additional expertise in the types of health challenges veterans face and help in identifying them.

The relative advantage of this model is that it would achieve an **integrated pathway at the outset**. Referral pathways would be easier if the Navigator had direct access to the local surgery's patient database. This would allow the database to be 'cleaned' and expanded. In addition, it would be possible to create links to Secondary Care so that veteran's discharged from hospitals and registered at a participating surgery could be automatically referred to a navigator.

To illustrate the benefits of system integration we have compared the Armed Forces Care navigation Project (AFCN) with a care navigation project in Gateshead by using information available in an earlier Tavistock report on Care navigation (Allen and Drabble, 2017). **This model was applied at a single GP practice and integrates primary and secondary care.** The Gateshead project is for people with dementia and their families and its similarities with AFCN are its use of professional care managers and its locality focus.

The Gateshead model uses two full time HCAs who were trained in care navigation and now spend 50 percent of their time

acting as navigators. Referrals to the Navigators are made automatically following discharge of patients with dementia from hospital. The needs of these patients are clear and specific as their issues are identified following discharge. The potential population of clients is all patients within the catchment area of an urban GP practice in Gateshead who have been diagnose with dementia. The Navigators are integrated with health services as the Navigators are based in a large GP practice. The support provided by navigators to patients includes **Care Plans, NHS health checks, post discharge support, and signposting to other agencies**. This type of service has been shown to **reduce further Secondary Care admissions**. (Deloitte, 2015)

The comparison below identifies some of the **conditions that enabled the Gateshead model to succeed**. The comparison illustrates the depth and extent of challenge faced by the AFCN project in setting up a local care navigation service for veterans.

Attribute	Gateshead Oxford Terrace and Rawling Medical Group	AFCN Birmingham
Navigators	Two full time staff trained in navigation as a bolt on from their HCA roles	Full time and trained navigator from an appropriate background
Access to clients	Direct referral following discharge from hospital	No single point – access has to be generated by developing a number of channels and relationships and via publicity
Knowledge of need	Specific and direct as it is identified following discharge	Strong knowledge of the needs likely to be experienced by the veteran community. Little knowledge available of the specific needs of the community served
Location	The catchment area of an urban GP practice in Gateshead	5 General Practices (located in South Birmingham)
Integration with health services	Navigation placed in a large GP practice	Developing integration via GP training on veterans' needs and circumstances and network development liaison with other agencies
Support provided to patients	Care Plans, NHS health checks, post discharge support, further admissions avoided; signposting to other agencies	Direct support to 19 cases over 12 months experiencing a wide range of difficulties. Some of them experiencing complex multiple long term problems. Signposting is challenging. This results in the Navigator providing direct support and advocacy
Clinical Pathway	Clearly positioned on clinical pathways for people with dementia	Pathways for veterans are not defined, or it is unclear which pathways they could be on

Attribute	Gateshead Oxford Terrace and Rawling Medical Group	AFCN Birmingham
Communication/Publicity	Publicised within the practice in order to ensure referral. Strongly supported by the Practice Manager	Publicised across the community in the expectation of reaching veterans in need
Numbers supported	Defined by patients registered with the Practice and a dementia diagnosis	To be drawn from a potential veteran population across 5 GP practice areas

Six factors contributed to the success of the Gateshead navigation project:

1. There was **wider practice engagement**, achieved by introducing the programme and expectations at practice meetings and multi-disciplinary staff meetings. The concept was introduced to patients and carers through a 'Health Fair' and by using practice and patient champions to spread the word.
2. **Agreeing individual care plans** and accountable GPs.
3. **Providing nursing homes with a single Point Of Contact** for prescriptions and requests for visits.
4. **Supporting doctors and nurses** in their interaction with vulnerable patients by enabling them to refer to the PCN for longer consultations.
5. Working with and supporting the nurse practitioner and frailty nurse.
6. **Being a core part of co-ordinated care planning** and Multi-Disciplinary Team meeting/ planning. (Deloitte, 2015)

Whilst acknowledging that the contexts and client groups are different, a similar care navigation programme for veterans might work if adapted to another context and target group:

1. Gateshead has a smaller, clearly defined and manageable size of local potential clients combined with a close integration of the navigation service with established pathways and provision. **Focusing on particular localities**, bounded by surgery catchment areas would give veteran navigators a specific population and institutions to connect with.
2. Knowledge of specific local need within the context of the broader knowledge of the impact of particular conditions is essential. **Training in conditions that are more common to veterans** such as musculoskeletal injuries, hearing loss and PTSD would make identifying and navigating veterans much easier;
3. Integration with relevant practitioners and their direct engagement with the anticipated clients of the navigations is essential. **Knowledge of local veteran charities and wider community and financial aid** would be an important set up task for a project manager which can be fed into by the group of navigators.

The impact of this model appears well established. An evaluation by Deloitte reported that in the first three months the Navigators supported the GPs at the practice with screening 117 patients for dementia, agreeing 396 care plans with patients and connecting 43 carers with local services. They undertook post-discharge support, coordination of services and medication for 86 patients, removing the need for GP appointments. **Hospital admissions fell, by as much as 80 percent**, for patients in contact with the Navigators. (NHS England website)

This model has some unique advantages to working with veterans including its

embedment in Primary Care, connection to Secondary care for referral pathways, capacity for scale up. These are important factors as navigators work best in teams and when there is potential for peer learning. For these reasons, we consider this to be the **most viable model for veteran care navigation** and could be applied effectively to the Armed Forces Community in Birmingham or elsewhere. It would be relatively inexpensive whilst having a large economic benefit in preventing readmissions. Using the transition from Secondary Care is key in potentially preventing further hospital admissions which has a clear financial benefit to the NHS. The referral mechanism could be set up so that any veteran registered at the selected surgery who was discharged from Secondary Care services would be automatically referred to the Navigator.

There are also a number of potential funding partners for this work besides FiMT. NHS England commission specialised services rehabilitation services for veterans and so could fund care navigation pilots in relevant localities. If the service operated in surgeries but was integrated with discharge units in Secondary Care services the service could be co-funded by the local CCG.

Advantages:

- Proven to be preventative for Secondary Care admissions and relatively inexpensive;
- Can integrate care between statutory services from secure base in a GP surgery;
- Good base to train others within an organisation;
- Model based in Primary Care but does not focus on time-poor GPs;
- Easy to replicate elsewhere using same roles, systems and criteria.

Disadvantages:

- Potentially small local veteran population;
- Care navigator would be a bolt on role and so may struggle with complex cases;
- Practices are not incentivised to target veterans as they are through dementia/elderly/diabetic patients, no rewards for doing so for GPs or Practices.

Recommendation 2: System intervention

The recommended navigation model would be **most likely to succeed if it were delivered alongside recommendation 2** to ensure that surgeries can recognise veterans they come into contact with.

Recommendation 2 is to **launch a separate initiative at Primary Care level which focuses on boosting the visibility of veterans at Primary Care level across the nation**. In summary, early preventative interventions with veterans would be best achieved in Primary Care through the following measures: (1) GP practice staff should be trained to better identify veterans and their conditions; (2) The veteran read codes should be made fit for purpose (3) GP practices should be incentivised to target veteran care.

One of the major findings of this study was the lack of systems readiness at Primary Care level. According to the Service Delivery Manager:

> "Primary Care is probably not ready, they're overworked. They're dealing with what faces them on a daily basis not thinking globally. Some Practices are ready though, that's where the Practice Manager comes in, embedding new technology and targets. We had to find some ways of getting their buy-in, but didn't find advocates. In hospitals you can see that, but not in GP practices, they work autonomously." (Service Delivery Manager interview)

Given some Practice Managers are ready to embrace changes, behaviour change

at Primary Care level is a powerful proposition that needs to be addressed systematically. **Without this systems readiness work, any veteran navigator project at Primary Care level is less feasible**.

The main purpose of this initiative would be to improve the visibility of veterans at Primary Care and Secondary care level, with a view of improving health outcomes and the application of the Covenant. **This initiative should focus on increasing the use of the veteran read code, and potentially revising the category.** An upturn in the use of the veteran read code so that the vast majority of veterans are identified at Primary Care level would have a number of benefits:

- **Use of the read code would improve local understanding** of the size and the needs to the veteran population. This would allow better implementation of the Armed Forces Covenant locally.
- Given the poor health care seeking behaviours of many in Armed Forces Community, identification would **allow the NHS to engage in preventative interventions with veterans much more effectively**. This could include care navigation, physical therapy and assigning appropriate mental health services, which lead to better management of veteran's conditions and reducing costs to Secondary Care.

There are a number of potential avenues for this work. Initially, **work should start with steering groups, Armed Forces Covenant groups and GP Practice groups to establish formal agreements with a clear set of outcomes and incentives for engagement**. One of the greatest successes of this navigator model was the work in regional engagement, which resulted in some of the best results of the project and gathered momentum to address veterans' health issues more systematically. This work should be the basis of any future project working with Primary Care as planning with individual surgeries only does not represent an economical use of resources.

Training of GPs and surgery staff should be a strategic priority as part of this work. For GPs, future projects should work with the Royal College of Physicians so that identifying and coding veterans is part of GP development either during initial training or during protected learning and development hours. Besides GPs, training should be delivered to whole GP practices so that as many staff as possible are able to identify veterans. Receptionists for instance often have greater contact time with patients than GPs and may be more able to identify veterans if trained. A multi-pronged training approach would let veterans be identified more easily. Where prolonged access to the whole staff team at a surgery is challenging, staff could attend monthly team meetings. (GP interview)

We propose two systemic changes to improve visibility of veterans to the NHS and make a veteran navigation project more feasible:

1. **FiMT and NHS partners should consider submitting requests for new read codes via SNOMED CT given the evidence in this report that the current veteran read code is confusing and no longer fit for purpose**. The current phrasing of the read code was also ambiguous and led to some miscoding. We found several interviewees questioning whether the current code was too general and considerations that it could be made more specific, for instance 'has medical condition relating to service in the armed forces'. The rationale for this is that the Armed Forces Covenant is difficult to implement at Primary Care level and would be able to be activated if a group could be identified across NHS services. This

revision would help clarify pathways to care and lead to better enforcement of the Armed Forces Covenant at Primary Care level.

2. A behaviour change initiative would be made much more effective if Primary Care services were further incentivised to care for veterans. **To incentivise surgeries to make serious efforts to improve veteran health, veterans could be included within the QOF which would financially reward GPs who meet a target for seeing a certain number of veterans.** This would greatly encourage better use of the read code by Practices whilst also recognising the financial pressures that Primary Care services are under. Without doing this, national behaviour change to make veterans visible for Primary Care services would be a resource intensive and uphill struggle.

As shown at the beginning of this report, veterans are a difficult group to engage and require specific processes at Primary Care level to identity and encourage participation from. This includes marketing, recording veteran status, referral pathways staff education and application of learning. Whilst there was goodwill by surgeries towards improving veteran health in the surgeries contacted, **very few surgeries were sufficiently motivated to improve their systems for recording and referring veterans to the programme**. In other Primary Care navigation projects engaging GP surgeries is challenging even when the navigation is for a group within the Quality and Outcomes Framework (QOF) and small financial compensation is given.

Revising the read code and incentivising surgeries to improve healthcare outcomes of veterans would be likely to **lead to better identification of veterans and better service referral**, particularly for those whose health has been affected by their time in the Armed Forces.

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Appendix 1 Comparison of potential alternative models

For future care navigation to the Armed Forces Community we developed a series of scenarios. The model which fit best to Primary Care was outlined in the recommendations section. However we consider two other models to be viable for veteran navigation: revising the current model or changing the sub-group of veterans. These two alternative models have been tested elsewhere and may possess stronger links to the referring organisations than the AFC project.

If taken forward, the models should be piloted for at least two years to give sufficient time to become embedded within statutory or Third Sector services.

Model A: Readjust roles and responsibilities in current model

The model described in this report would have been largely fit for purpose if veterans were more visible to Primary Care services. However, one of the disadvantages of the model developed was the split in roles between the Project Manager (nominally a training and influencing role) and the Service Delivery Manager. If this programme followed a Primary Care behaviour change programme, support could focus on delivery of the service as a case worker, such as setting up a group set up at the start of the programme to discuss cases. The Navigator would need a host organisation including a supervisor, from either one of the partners from the AFCN work or an organisation with closer links to surgeries such as Health Education England: West midlands.

A readjustment of the AFCN model should also reflect the needs of Primary Care services. Within the project architecture there should be a stronger presence for the chosen host surgeries on the steering committee. This should allow a configuration of the project that emphasises the needs of the Primary Care services rather than the Navigator. To motivate surgeries to take part there should be a financial incentive to refer and host the Navigator service and a written contract which is enforceable. Within each surgery there should be a selected 'champion' who holds the project and is mentored by the Navigator. The champion can be taken from any part of the organisation but the best roles may be Receptionists and HCAs as these are client facing roles. Having a set of champions across a number of surgeries would have the by-product of giving the Navigator peer support from others who buy-in to the programme. If all navigation sessions were held within surgeries this would also pre-empt the safeguarding issues that were identified in this report.

Advantages:

- An adjustment of the model under discussion;
- Excellent case work;
- Clear operational processes and standards;
- Flexibility in case of difficulty due to lone worker model.

Disadvantages:

- Potential lack of cases;
- Relatively expensive;
- Weaker Primary Care links than other models;
- Lone worker has less recognition;
- Practices are not incentivised to target veterans as they are through dementia/elderly/diabetic patients, no rewards for doing so for GPs or Practices.

Alternative models

However given the difficulties faced in lone working, particularly the weak organisational links between the Navigator and referring organisations, we would recommend exploring alternative models where the Navigator would be embedded in service delivery rather than an 'outsider' delivering services. The following two models of veteran navigation would maximise navigator support and make use of existing referral mechanisms.

Model B: Targeting sub-group of veterans

Given the difficulties in identifying and accessing veterans through GP Surgeries we have provided one other model that would be based outside of Primary Care.

This model would build upon the case working successes of the Armed Forces Community Navigator model. This model would focus on a sub-group of the veteran population that have been identified as particularly vulnerable such as homeless veterans or veterans with insecure housing. The Navigator would be based within a single non-veteran third sector organisation, such as Shelter or Crisis. A navigator with social work expertise would be hired or internally reassigned to the role of veteran navigator. Once veterans are contacted through the service they would be automatically referred to the veterans' navigator who would act as a key worker upon discharge. The Navigator could also work in partnership with other agencies such as Primary Care, Secondary Care, Probation services, or third sector organisations like Age UK to receive additional referrals. These organisations could also form a steering group as part of the model.

A similar model has been used by Age UK. Their Safe and Independent Living (SAIL) service in Southwark and Lewisham is carried out using a SAIL checklist which is linked to a directory of services relevant to their needs. Underpinning the SAIL checklist are SAIL Care Navigators, who visit the older person at home and work with them to identify goals and support needs, facilitating and joining up professional involvement in the older person's care. Seven Care Navigators across Southwark visit older people who are socially isolated or at risk of malnutrition for up to six weeks. During this time, they help them to access appropriate health, care and support services. They create and implement person centred support plans with the older person, unpicking issues and sharing information between the older person and professionals involved in their care.

This model could be adapted to work well with veterans. The Navigator could be hosted by any number of organisations who deal with complex cases of veterans and would build on the successes of dealing with complex cases in this programme. We mention homeless veterans or veterans with insecure housing as there are a large number of veterans in these positions and organisations such as Crisis and Shelter would be well suited to host navigators.

One advantage to this model over the lone worker model would be that the Navigator would be part of a wider team of colleagues rather than supported from afar. Being based in an organisation with many potential qualifying clients would lessen the risk of low throughput of cases whilst the intensity of these cases would mean that a large number of cases would not be appropriate. This model could potentially have a great impact on the lives of those who accessed the service, as shown in the case study in the previous chapter, where housing, health, finances and self-management all improved through a dedicated navigator service.

There are some potential difficulties with this model. It would be difficult for any navigator to hold their boundaries with the clients if given complex cases and no strong support. The reason that navigation with complex cases often fare poorly is that referrals without advocacy are often not taken up by clients in crisis. It may also be hard to recruit the appropriate person given the experience and resilience that would be needed.

Advantages:

- Reaches complex cases with the very hard to reach;
- Work embedded in a third sector organisation for support so have peer support and strong organisational processes and standards;
- Potentially strong outcomes for prevention of hospital admissions and improved quality of life.

Disadvantages:

- Potential for duplication from social services;
- Lack of data on veteran status;
- A mix of advocacy as well as navigation makes it difficult for the Navigator to hold boundaries and potential risks to navigator.

Summary

Our models have focused on Primary Care settings as this remains the most appropriate entry point for a typical navigation programme which encourages self-management rather than advocacy. We also considered other models not outlined here where the Navigator would be based in, and receive referrals from, either a major Armed Forces charity or directly in Secondary Care. However there are clear disadvantages to having navigation models based in either of these settings:

Armed Forces charities: Established charities such as The Royal British Legion already offer services similar to navigation so it is unclear what the added value would be for creating pure navigation roles in parallel to Welfare Officer roles. Whilst targeting a difficult veteran subgroup such as homeless veterans would address a hard to reach group, hosting the Navigator in an Armed Forces charity would engage veterans who are already engaged in Armed Forces services and so misses both those who only engage in statutory services or who do not engage in either Armed Forces charities or statutory services.

Secondary Care: In previous evaluations, basing a navigator in Secondary Care often leads to clients only being navigated to different hospital departments: it is difficult for in-patients in the middle of a health crisis to consider services such as social prescribing. Alternatively if patients were engaged at the point of discharge it would make more sense to base the Navigator in Primary Care in terms of ease of follow up, prevention of health complications and being locally embedded.

Given this we believe that further engagement in Primary Care services is necessary. As noted this will be difficult to achieve without first addressing the issue of the visibility of veterans at Primary Care. If a behaviour change initiative could be undertaken which educates and incentivises surgeries to identify their veterans, there could viably be a nationwide veteran care navigation scheme following Model B which integrates primary and secondary care transitions, works as part of wider healthcare prevention programmes and effectively activates the provisions of the Armed Forces Covenant.

Appendix 2 Roles and responsibilities of partnership

Armed Forces Community Healthcare Project Manager (BCHCFT)

Overall project management, partnership building, QA and risk management, budget management, service development and commissioning. (0.6 FTE)

Service Delivery Manager (DMWS)

Responsible for service delivery, navigator coordination, service development, line management, data collection/evaluation of delivery, asset mapping, DMWS training and development, service management reports (0.2 FTE)

AFC Healthcare Navigator (DMWS)

Five overlapping roles: support for veterans (welfare assessment of needs, primary contact point in crisis and make referrals to relevant organisations), research (data collection on experiences and survey using well-being metrics), training (of Primary Care staff, and identification of others in need of training, awareness raising (embedded in GP practices, build relationships with key agencies), and identification (support GP surgeries to identify veterans in the surgeries). (1 FTE)

Researcher (Tavistock)

Reviewing data, interviews, generating alternative models and report writing.

Appendix 3 Contacts Review

September – December 2018

Contact with:

- SSAFA,
- Blind Veterans UK,
- Birmingham and Solihull Mental Health NHS Foundation Trust,
- Sustain UK a housing provider,
- Kaleidoscope Plus group-a health and wellbeing charity.
- Adullam Homes Housing Association.
- The Royal British Legion
- The Poppy Factory
- West Midlands employer relationship manager
- MOD partnering – Right Management
- Employment Advisor – Community Midlands RFEA The Forces Employment Charity
- Dental Practices
- 5 nominate GP surgeries in South Birmingham
- Worked with Ltd Col Shamim Irshad a Doctor from the Pakistani Army along with Hashum Mahmood Service Manager Birmingham Public Health.
- Attended an Armed Forces Steering Group Meeting.
- Attended Armed Forces Partnership event next Monday 2nd October.
- Northfield Community Partnership
- Working in Mosley Hall Hospital with a specific client and promoting the service
- Haig Housing,
- HMP Sudbury,
- HMP Birmingham,
- Shelter,
- 3 additional GP surgeries,
- HMP Winson Green,
- Combat Stress,
- NHS Community Health Trust
- Age Concern,
- NOVA,
- Spring Housing,
- Fry Housing,
- SIFA Fireside,
- Prison Service
- Veterans Employment Service,
- RSVP charity.
- Haig Housing and
- Riverside Housing
- Walking with the Wounded
- Joanne Lewis Age Concern,
- GP - Paul Turner
- VAMOS Theatre production – distributed leaflets to the production theatre goers
- Birmingham City Council re promoting the service
- BVSC-Birmingham Voluntary Service Council re: promoting the service.
- TILS MH Service – West Midlands

Additional Leaflet drops at:

- Tesco Rubery and
- Morrison's Rubery,
- Birmingham Research Park-Royal College of GP's x 65 leaflets,
- Health Exchange Birmingham x 15 leaflets,
- SIFA x 10 leaflets,
- Bourneville Working Men's social club,
- Kings Norton Ex Serviceman's Club,
- Strichley United Working Men's Club,
- **4 x GP Surgeries plus posters,**
- Post office,
- shopping Centre

Appendix 4 Case studies

I. Male, 30s, army veteran, alcohol dependency. DV issues, in prison. Significant mental health issues. Was released from prison on bail. Absconded, was picked up by the police, he was intoxicated and lying in the middle of the road. He was taken to a PDU psychiatric decision unit, 4 or 5 weeks post release from prison. He went missing from the PDU after 3 days and was picked up by the police again. A referral was made to BSMHFT mental health trust demonstrating how the service is increasingly being recognised. He was discharged from mental health services to the GP.

Unemployed, in receipt of benefits. Supportive parents. Separated from his partner and children. Expressed a poor service from other military charities in the past- lack of communication and follow up, didn't get in touch with him. His parents and sister were extremely anxious, his Mother was worried about the impact her son's behaviour was having on her daughter, she expressed concerns that her son's drinking was going to kill him, he had been through 8 or 9 detox programmes.

Action taken

Contacted prison staff, the client and his Mother, liaised with hostel staff. Contacted DWP re ESA Employment and Support Allowance and PIP Personal Independence payment. Liaised with hostel staff regarding support around alcohol dependency and housing, client rehoused and has been referred to a drug and alcohol service by staff.

Wellbeing Complexity Score 25

II. Male, 50s, army veteran, married. In employment, good support network. Was experiencing pain in his ankle- was an ongoing issue. Was enquiring about priority treatment for veterans-wanted to confirm this before discussing with his GP, wished to be referred for further investigation.

Action taken

Met with the client, advised if injury or illness attributable to service then yes he will be entitled to priority treatment. Advised him GP can put this on the referral letter to an orthopaedic hospital. Followed up with a courtesy call, client hadn't seen the GP yet, to follow up to ascertain how the GP appointment went.

Wellbeing Complexity Score 3

III. Male, early 40s son of a veteran, initially wished to discuss volunteering options as wished to 'give something back' as Father is critically ill in hospital on a ventilator. Is 80 with complex health issues. He advised he feels he is grieving as it is a time of uncertainty-unknown if his Father will recover, if he does his son feels he will require intensive rehabilitation and a blue badge in the future. He is worried about his Father and how his Mother is managing. Son has to return to work. He spoke of his Father's time in the army and expressed how proud he was of him. He picked up a navigator leaflet in the GP surgery, him and his Mother read it and he rang.

Action taken

Home visit arranged to visit the referrer's Mother- the client's wife to offer support, she is just recovering from having cancer. Providing emotional support, advised the referrer he can ring if he wishes to talk and I would also ring to see how things are. Rang the local hospital to ascertain when the patient was admitted and to clarify which ward he was on as the son stated he was now out of ITU.

Wellbeing Complexity Score 20

IV. Male, 62, army veteran, retired Major, hospital inpatient. Homeless, very isolated. Previously living abroad for 12years. Separated from his wife for over 12years, recently resumed contact. Resumed contacted with brother, hadn't seen each other for 14 years, no other support. Financially stable. Client expressed concerns with his treatment and the high turn over of staff and issues with staff not introducing themselves etc. Felt things were disorganised and it was a failing system. His behaviour on the ward is challenging. Questions over whether his behaviour towards staff on the ward is attributable to service culture and hierarchy, he has been verbally aggressive. He is demanding and as a result this is taking up a considerable amount of staff time, it is having a negative impact on other patients, the quality of care provided to other patients. This gentleman was referred from a hospital in the South of England on the understanding that he would go to a military ward at the QE Hospital in Birmingham and receive priority treatment for his condition as per the Covenant. However there is no military ward at the QE Hospital and his condition is rehab focused not acute. He has ended up in an intermediate care centre in a geographical area where he has no links. He is extremely frustrated that the Covenant is not delivering what he expected.

Action taken

Met with the client, initially tried to manage his expectations regarding him wanting priority treatment on a military ward. Contacted Veterans UK regarding his pension and requested a new assessment of his circumstances. Contacted the British Dental Association and the NHS regarding eligibility for dental treatment. Provided emotional support as isolated and expressing frustration with being in hospital for 7months, feeling very isolated in a side room. Contacted his previous GP so he could re-register, requested the nursing staff refer him for a social work assessment with his consent. Researched dual registered care and nursing homes in the geographical location he wished to reside in upon discharge from hospital. Discussed

care and housing options with him and explained CQC care quality commission ratings and explained the social work needs assessment process and the importance of registering with a GP so he was in the system. Contacted a housing provider for veterans. Talked about extending his social network once discharged from hospital and settled. Provided him with the opportunity to raise concerns about his care. Liaised with nursing staff, doctors, physiotherapist and attended a case conference with PALS present, patient advice and liaison service. Aiming to facilitate a smooth, safe and timely discharge to avoid any unnecessary additional days in hospital. There is a risk he may be an inpatient for a lengthy period of time.

An investigation is being conducted to establish why the hospital transfer took place and whether it was attributable to his behaviour on the ward in the hospital in the South of England.

Wellbeing Complexity Score 36

V. Male, 63, army veteran. Lives with partner and adult daughter with a disability in rented accommodation, enquired what support was available. Significant health issues, is waiting for an assessment for a gastric band. Fractured back during service. Debt issues. Highlighted poor communication in the past with other military charities when he approached them for support.

Action taken

Supported the family, phoned an OT occupational therapist regarding adaptations, researched and provided information regarding luncheon clubs, community centres and carers support. Assisted with paperwork-financial incomings and outgoings-budget spreadsheet. Supported family, client's brother is palliative in hospital. Client's partner has alcohol dependency issues. Family recently bereaved-client's Father died. Provided information regarding another military charity that was running a luncheon club. Enquired if he wished me to contact his regiment to ascertain if they could assist with financial support, he declined stating others were more in need. Navigator involvement to maximise independence and improving overall wellbeing.

Wellbeing Complexity Score20