



# *Case study*

**Age UK Warwickshire (AUKW)  
Primary Care Navigator Pilot**

## Summary

Age UK Warwickshire (AUKW) has been commissioned by a consortium of 31 GP practices in South Warwickshire, (Warwick and Stratford districts) to develop and manage a 12 month Primary Care Navigator pilot. The pilot programme is contacting patients over 75 years of age with the aim of undertaking an assessment and supporting them to identify and access the support they want and need. The pilot is running from April 2015 until March 2016. An independent evaluation of the outcomes of this pilot programme has been commissioned.

Age UK Warwickshire has embedded the provision of specialist information and advice about housing and care options into this delivery model through employment of a dedicated specialist in this field. Age UK Warwickshire provides a handyman service, home safety checks, home improvement agency services and generalist information and advice, with a long history of providing integrated services.

The target group is people over 75. Age UK Warwickshire has a team of care navigators based in GP practices in the area and a specialist housing and care advisor as part of the First Stop network to support the service in relation to housing issues.

As well as this service Age UK Warwickshire has an established triage service called Gateway. Referrals come from hospital staff, Warwickshire County Council's Contact Centre and Community Health and Social Work teams. Referrals are frequently people who are being discharged from hospital or have been identified as at risk, but usually do not meet the FACS criteria. The Gateway service undertakes a telephone assessment through which daily living needs are identified and advice given or arranged to improve people's lives. It is an established step towards helping people to navigate the complexity of community services.

**Name of project** - Primary Care Navigator Project (and Gateway project)

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**Region** - West Midlands

**Location** - South Warwickshire

**Website** - <http://www.ageuk.org.uk/warwickshire/our-services/health-services-partnerships/>

**Target population** - GP Navigator: Older people aged over 75. There are 21,000 people aged over 75 in South Warwickshire.

Warwickshire is a two tier county, a county council and five boroughs and districts. There are three CCGs covering North, South and Coventry and Rugby. Coventry is a separate unitary authority.

Warwick District is dominated by the three towns, Kenilworth, Warwick and Leamington Spa, it is both urban and rural with good life expectancy, with some wards where residents can expect to live 10 years longer than their counterparts in Nuneaton, even 18 years in the most deprived wards. Warwick District Council is an affluent high achieving area with excellent independent and state schools.

Stratford District Council the second largest district in England, is mostly rural with Stratford on Avon and Shipston on Stour the main towns. Stratford District Council is a district of contrasts, people are still retiring to this area from the West Midlands making the over 65s 1 in 4 against the national average of 1 in 5. There are high levels of poverty especially fuel poverty as there is little industry apart from farming and tourism.

The total population aged 65 and over living in Warwickshire is 113,400 which is anticipated to rise to 155,300 in 2030.

It is estimated that the total population aged 65 and over living in Warwickshire with Dementia is 7,791 which is anticipated to rise to 13,130 by 2030.

## Aims

This pilot is an opportunity to identify and fill the gaps in the system and provide an accessible service in South Warwickshire by creating a new, integrated service model using Care Navigators at its heart. Its aims are to:-

- Enable Age UK Warwickshire and Primary Care to provide integrated services by joining up what we do and how we do it
- Identify needs earlier
- Support older people to navigate the internal services and external systems they are faced with to access help
- Enable older people to exploit services to remain independent
- Ensure that AUKW and the GP practices have the flexibility and capacity to respond to what people say they want
- Gather the data we need to evidence that what we are doing is having an impact and improves the lives of older people.

## Activity to date

The service was commissioned in January 2015 with staff commencing their induction in late March. There are seven care navigators including two team leaders and a specialist part time First Stop housing and care options adviser.

The service plan required GP practices to begin to refer patients in tranches in March and April, rising to the agreed number by the end of the summer. Unfortunately this element of the plan did not work as GP practices were engrossed with end of year contract returns. In late April and into May large batches of referrals began to arrive, which is why there is now a backlog. This process also requires the GPs to inform patients by letter to expect a call from Age UK Warwickshire.

### People in the pilot have been divided into 3 categories

- P1s are high users of NHS services. Estimates are that there are 1,100 P1s
- Once the Care Navigator team has contacted and interviewed the P1s, they will make contact with those less apparently dependent on NHS services – the P2s. These interviews will be conducted by telephone, supported by the Gateway team. The target number is 7,000 people overall
- P1s and P2s will also have enhanced clinical reviews via GP Practice staff
- An agreed proportion of P3s will receive an enhanced clinical review via the GP Practice.

### By the end of Sept 15

- P1 referrals – 642 received, with 506 visits completed
- P2 referrals – 752 received, with 350 contacted by telephone.

The home visits (P1) to approximately 1,100 people will be completed by early January 2016. We also expect to catch up with telephone assessments by March 2016 as additional resources have been allocated to this task.

## Outcomes

- Improve/sustain independence, health & well-being for older people using the service
- Reduce demand at the front door of primary care and reduce avoidable admissions to hospital
- Demonstrate the effectiveness and cost efficiency of the AUKW coordination service model to GPs and to inform future commissioning arrangements.

**External evaluation** – the pilot is being evaluated by KHC consulting. An initial 6 months report is expected at the end of October to be presented at a conference in Warwickshire in November. The final evaluation report is due in April 2016.

## Case study

Mr T is a 77 year old gentleman who lives with his wife in a sheltered bungalow. Mr T has Respiratory Disease and as a result he is required to use Oxygen throughout the day and night. He has piped Oxygen at home and carries a portable cylinder when he is out. The Oxygen is crucial to his daily well-being and an essential requirement of his daily life. He is also required to make use of specialist medical equipment throughout the night time. This monitors his breathing. This machine can become very noisy and frequently disrupts Mrs T's sleep pattern. Mrs T is his main carer and supports her husband with all of his daily living tasks.

Mr T and his wife live in a sheltered housing scheme in a one bedroom bungalow. Whilst the bungalow meets their needs in terms of being on one level, it is limited for space and does not offer Mrs T a spare bedroom. This can prove difficult, as often Mrs T is forced to sleep on the sofa in an attempt to try to avoid the intense noise of the Oxygen machine her husband is required to use at night time. Mrs T is now finding this increasingly more difficult to cope with and she is becoming more sleep deprived and anxious that she may not be able to continue to support her husband with his care needs, as she would like.

A P1 assessment was completed following referral from the GP surgery, after initial social needs were identified following an Enhanced Clinical Review.

A P1 assessment identified that Mr & Mrs T wished to look at alternative suitable accommodation. However, it was also crucial to them both that they continued to remain in their current catchment area due to having a large support network of friends. The GP Care Navigator made a referral to the Age UK Housing Options Team to support them with their application to move to a more suitable property. In addition to this, the 'Over 75's Nurse' had also written a letter in support of their application to be rehoused.

The GP Care Navigator identified that Mr T would be highly likely to be eligible to apply for Attendance Allowance. A referral was also completed to the Citizens Advice Bureau to support Mr T to claim Attendance Allowance.

Following involvement with the Age UK Housing Options Team, Mr & Mrs T have been offered a 2 bedroomed house within the same sheltered housing complex. The house comes complete with a stair lift and is set to be updated with a new bathroom and be redecorated. They are currently also seeking support from the Age UK Housing Options Team to ensure that a suitable bathroom is installed.

Following a referral to the Citizens Advice Bureau, Mr T was able to apply for Attendance Allowance. He has now been granted the Higher Rate Attendance Allowance (£82.30 per week).

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We would welcome any feedback about content.

Please email [info@careandrepair-england.org.uk](mailto:info@careandrepair-england.org.uk)

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