

# A SYSTEMATIC MAP OF THE UK LITERATURE ON NAVIGATION ROLES IN PRIMARY CARE: SOCIAL PRESCRIBING LINK WORKERS IN CONTEXT

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**Disclaimer**

The views expressed in this report are those of the authors and do not necessarily represent those of the Greater London Authority

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## 1 Executive summary

The NHS Long Term Plan and associated documents such as Universal Personalised Care places emphasis on 'navigation' as a tool to tackle the increasing complexity of care, provide a more personalised service, and confront deeply rooted health inequalities.

Social prescribing plays an important role in taking forward this agenda with the recruitment of 1,000 new link workers to be employed across England by 2020/21 and even a higher number by 2023/24.

This research places the role of social prescribing link workers in context. It provides a systematic mapping of grey and peer reviewed literature on a number of different 'navigation delivery roles' and highlight their similarities and differences with the social prescribing link workers.

We conducted a systematic mapping of the UK literature in primary care. Our comprehensive search identified 698 potentially relevant titles and abstracts. After screening and retrieval of full documents a total of 69 documents met our inclusion criteria and were analysed in detail (see appendix 2). The analysis was organised around a range of features such as the type of navigator, target group supported, type and level of support offered, location of work and background of navigators, as well as key documented strengths and weaknesses.

This analysis revealed that three quarters of the studies screened had been completed in England. The vast majority of the records analysed (84%) were peer reviewed journal articles. Most of the records analysed were research studies (83%), the remaining being discussion/opinion papers and policy documents. Only 11% of the documents examined were process evaluations. More than half of these studies followed a qualitative approach.

We found 11 types of navigators described in the literature which respond to the basic definition of 'people who provide support to patients and help them to access further services where necessary'. At the stage of screening full text, we had excluded 'care coordination' and other types of support to patients that were strictly clinical and arranged through standard NHS care. It was, overall difficult to find details of the exact mix of clinical and non-clinical support services on offer.

Across navigator types, the majority targeted people with chronic long term conditions and mental health problems. Social prescribing link workers covered the widest mix of health (LTCs, physical and mental health) and social (social isolation, welfare advice, employment, and housing) issues, although health coaches and health trainers also offered a mix of support for both health and social issues to users.

Navigators focussed predominantly on behaviour change (35%), although improving self-care (22%), reducing health inequalities (15%) and providing education (14%) were also important. In terms of the level of support provided, most navigator roles included a form of

structured support (motivational interviewing, coaching, setting goals), although 14% did engage in information only signposting activities. Information presented in documents on the average number of sessions and length of sessions was very poor. This is a problem as many studies of different navigator roles reported case overload. In the absence of reliable information, it is difficult to assess an appropriate average number of sessions and length of support.

42% of documents reported the GP practice as the main location in which navigators met service users, although community buildings were also important.

In conclusion, social prescribing link workers appear to share similarities with other roles particularly health coaches and health trainers. However, social prescribing link workers are clearly different in their orientation toward the proactive involvement of the Voluntary, Community and Social Enterprise (VCSE) sector and their recognition of the need to tackle health inequalities. This evidence is important in building a convincing argument to GPs and healthcare professionals of the unique contribution of social prescribing link workers.

The findings of our review reflect the health and social care integration agenda as social prescribing link workers, health coaches and health trainers are becoming more prominent alongside established health professional roles such as nurses. The concept of 'boundary spanning' which is concerned with studying the factors that are facilitating the growth and effectiveness of navigator roles could be used as a framework for further investigation in the field. In addition, the current map could be extended to navigator roles outside of primary care and to include the literature outside the UK so to capture a more varied range of navigator roles across different contexts.

## 2 Introduction

### 2.1 Background

The growth of social prescribing has been decisively supported by the work of Social Prescribing Link Workers (SPLWs). Typically, SPLWs have a non-clinical background, often in the third sector, have specific skills in counselling, coaching, motivational interviewing or others similar skills that help them to support people with their health and social care needs and aspirations. As such, the role of SPLWs is also concerned with tackling health inequalities: they facilitate access to housing, employment and legal advice, alongside access to health activities which promote mental wellbeing, physical activity, healthy eating. They often have good links and knowledge of non-clinical activities provided by the local voluntary sector, so that they can support social prescribing users to access such services. The service they offer is flexible to the needs of the user, it may be light touch (1-2 sessions) or in-depth support (5-8 sessions). An implication of this flexibility is that they are strongly committed to a person-centred care approach, where the person is not any longer a passive recipient of care, but is at the centre of the decision-making process about their own care. These different functions appear to show a uniqueness of the role of a SPLW.

However, other 'navigation delivery roles' exist. These provide a pathway to connect people to support services including community navigators, care co-ordinators, health coaches, local area coordinators, health trainers, community matrons, occupational therapists, amongst others. These roles have similarities and differences with the relatively recent experience of SPLWs. For example, health coaches and SPLWs share an emphasis on motivational interviewing but they often differ in relation to the focus on health and social care with health coaches primarily focussed on behaviour change and health education.

This research provides a systematic mapping of grey and peer reviewed literature on a number of different 'navigation delivery roles' and highlight their similarities and differences with the SPLWs. We are particularly interested in describing how different navigator roles compare in relation to a range of characteristics such as types of navigators, target population, key focus of navigator roles, level of support for service users, background and location of work of navigators (see sec. 3 for more details). Given time and resource constraints, we have limited our research to finding literature on navigator roles from within primary care in the UK.

Although we could find a scoping review discussing the role of navigators (Carter et al., 2018), this did not include social prescribing and focussed primarily on focussed on examples from the US and Canada. In order to fill this gap, this research will provide an initial understanding of how key navigator roles in UK primary care compare with each other. We follow the Social Prescribing Network definition: 'social prescribing enables healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and well-being' (Westminster Uni, 2016; p.19).

The findings of this review are intended to help commissioners to strengthen current provision and potentially avoid duplications of service, and facilitate the process of matching different roles with their target population, thus ultimately maximising benefits for users of the service.

## 2.2 Aims of the systematic map

This research aims to systematically map the literature on navigation roles operating in primary care in the last ten years (since 2009). Navigators in primary care are defined in this research as “*people who provide support to patients and help them to access further services where necessary*”. These may include social prescribing link workers, health coaches, health trainers, occupational therapists, community matrons, mental health therapists amongst others. Once these roles have been identified in the literature, their similarities and differences will be explored in relation to the following characteristics:

- Key target population (e.g. social isolation, long term conditions)
- Level of support to users (light touch/in-depth), number of sessions offered, length of each session.
- Purpose of the support (e.g. health inequalities, behaviour change)
- Clinical/non-clinical focus (referring to statutory sector versus voluntary sector activities)
- Specific skills and level of training of navigator role, including techniques used to support users
- Location of study

Main Research question:

**What are the similarities and differences between navigation delivery roles across primary care with particular reference to social prescribing and social prescribing link workers?**

We carried out a systematic map which aimed to “*collate, describe and catalogue available evidence relating to a topic or question of interest*” (James, Randall, and Haddaway, 2016:1).

## 3 Method

This report adopted the following steps outlined in systematic mapping guidance from the Social Care Institute of Excellence (SCIE) (Clapton, Rutter, & Sharif, 2009).

### 3.1 Initial planning, topic setting and preliminary work

The topic of this mapping review was discussed at a social prescribing evaluation sub-group of experts from academia, primary care, commissioning and voluntary sector engaged in the development of the vision for social prescribing in London led by the Greater London Authority. Social prescribing is an important part of the London health inequalities strategy and of interest to the Mayor of London. The panel, chaired by the first author of this report, discussed several research priorities for the development of social prescribing and the need to place the role of social prescribing link workers into the wider context of primary care and local health economies.

The team involved in this project included a project manager (MB), two researchers (HWH and CL), an information scientist (SP), and input from an expert in systematic reviews (AH).

In order to clarify the area of study and gather relevant publications, we contacted 10 professionals who had expert knowledge of navigator roles and navigation processes. Although we were interested in pulling together knowledge on diverse navigator roles from a larger pool of experts representing a wide array of expertise, owing to the short time scale of this research, we could speak to only three experts. These included a health coaching expert, a professional advisor - an occupational therapist, and a patient experience /volunteer coordinator with experience of managing health trainers. Insights from these experts were valuable in firming up our understanding of the characteristics of a variety of navigator roles and subsequently informing the coding stage of this research.

### 3.2 Searches

Conversations within the research team (three researchers, an information specialist, an expert in systematic reviews and an expert in social prescribing) and with experts in the field of navigation informed the drafting of search criteria. The full list of search terms used by the information specialist are included in appendix 1 of this report. We tried to balance searches for navigation as a 'process' by including search terms such as Social-prescri\* or signpost\* or system-navigat\* or community-navigat\* or system-coordinat\* and navigation as a 'role' by including health-coach\* or health-trainer\* or community-matron\* or link-worker\* or close-loop-prescribing or closed-loop-prescribing or occupational-therap\*. Preliminary searches for navigation as a process did show a very high number of clinical pathways which looked at navigation, but were only restricted to conventional clinical treatment available in the NHS as standard. Although the vast majority of publications selected were peer reviewed publications, we also included records from the grey literature (see sec. 4.2 for more details).

### 3.3 Screening for title and abstracts

We used EPPI Reviewer 4, an application developed and used by many researchers to manage the entire lifecycle of a review process in a single location, in this mapping exercise. As noted earlier, we restricted our search to the UK and primary care as the time and resources available for this study were limited. Title and abstracts were screened according to the following criteria:

#### Exclusion criteria

- Language other than English
- Records published before 2009
- Studies taking place outside the UK
- No mention of navigation process or navigation role
- Setting other than primary care

#### Inclusion criteria

- Material published in English
- Since 2009
- Studies taking place in the UK
- Mention of a navigation process (referral, signposting, care coordination) or role (e.g. link worker, health coach, health trainer)
- Focus on primary care (e.g. GP practices, pharmacies, dental, and optometry)

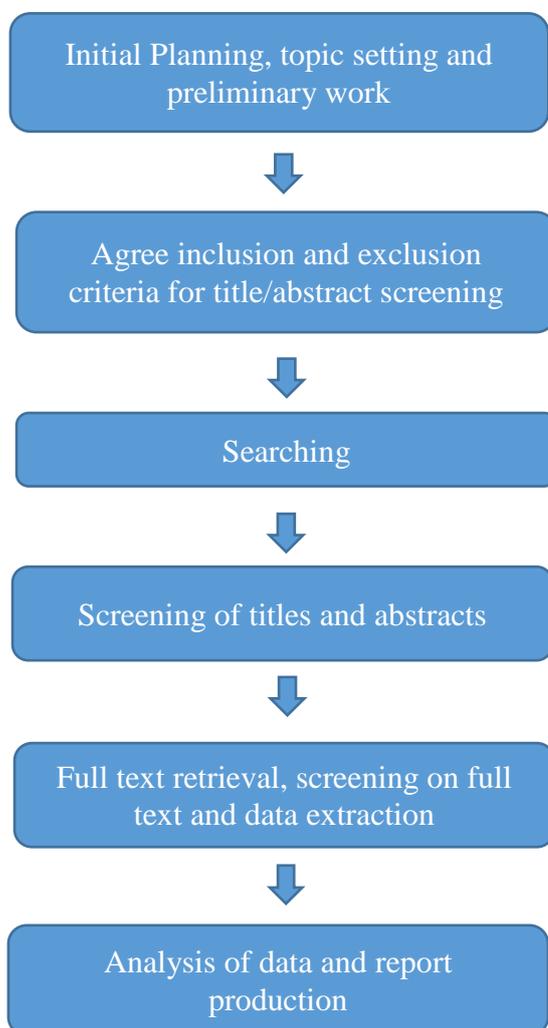
Three researchers were involved in all stages of screening, and the use of the criteria were piloted to ensure consistency and coherence across researchers. The first 100 titles and abstracts were screened by all three reviewers independently who then met to compare screening decisions. Any discrepancies were discussed until agreement was reached. This process continued until there was a good level of consistency between the researchers. At this point the remaining records were distributed amongst the team with only one researcher screening each record.

### 3.4 Full text retrieval, screening at full text and data extraction

An information specialist retrieved most of the full texts that had been included following the first title/abstract screening. Only a few records were obtained through Inter Library Loan (UEL Library). The same exclusion criteria (as for sec. 3.3) with the addition of a 'clinical versus non-clinical focus' were again applied at full text screening. This enabled us to focus on navigation processes or roles that included non-clinical referrals as the main focus of this study. From the 185 records available for full text screening the same 26 records were screened on full text by all three researchers. Discrepancies were resolved through discussion. We then allocated the remaining number of records to the three researchers for single screening.

In order to proceed to extraction of relevant data from the documents deemed to meet our inclusion criteria, we created a specific coding tool which covered a wide range of characteristics including aims, relevance, name of navigator role, key target population, focus of role, level of support for users, type of support provided, location of navigator, destination of referral (clinical, non-clinical), background of navigator, training of navigator, key strengths and weaknesses and recommendations. We also used a generic coding tool which provided details of the type of document extracted (e.g. journal or policy, primary research, method). Consistency in the analysis of data extracted was ensured by three researchers screening the same 26 records and reconciling divergent opinions.

Figure 3-1: Outline of systematic mapping process

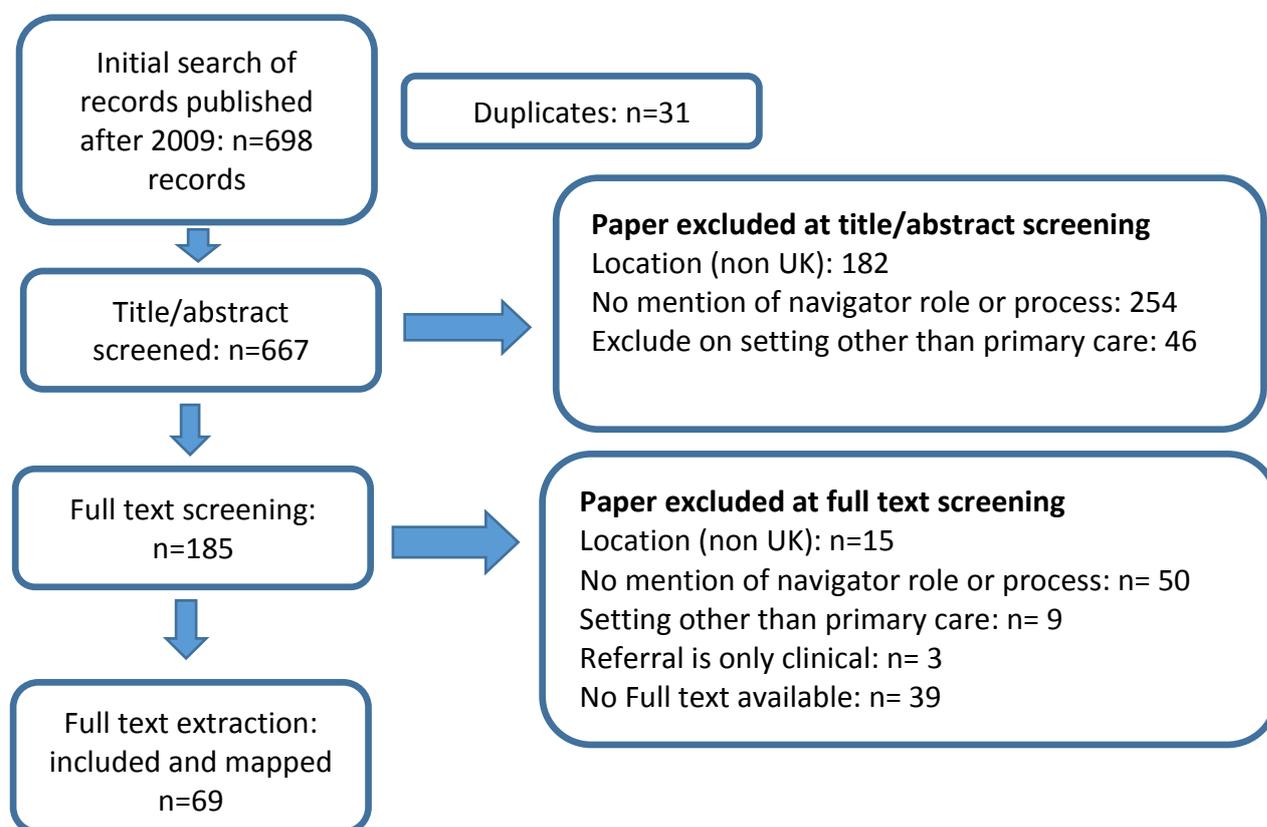


## 4 Results

### 4.1 Title and abstract screening

The initial search of published documents identified 698 records. Exclusion criteria are reported in sec. 3.2 alongside full methodological details of the process followed (sec. 3) and full details of search terms and strategy are available in Appendix 1. Following the identification of 31 duplicates, we analysed the titles and abstracts of 667 records (Fig. 4.1). We excluded 182 as the study did not take place in the UK, 254 records as they did not mention any navigator role or process, and 46 were excluded as the main focus of the document was outside primary care (GP practices, pharmacies, dental practices). At this stage, we broadly defined navigation as the communication between a navigator and a service user and the successive referral to further support. We also included abstracts which did not specify any navigator role but described or referred to a navigation process defined as support given to a service user through a care pathway. We came across a range of examples of 'care coordination' which we excluded from the systematic mapping as this relates to conventional clinical support to a patient available as standard in the NHS. Care coordination is normally delivered by a team of healthcare specialists who are responsible to support patients into treatment and/or management of health conditions from a strictly clinical perspective. We also encountered a further problem: much of the peer reviewed literature focuses on evaluations of health outcomes, the description of navigator roles is often only a marginal part of this.

Figure 4-1: Flow chart of the systematic map



Some 185 records were available for full text screening after initial title/abstract screening. A further 39 records were excluded as we could not retrieve their full text. We re-applied inclusion/exclusion criteria we had set for the first title/abstract screening (sec. 3.3). This resulted in 69 records which we proceeded to extract and analyse in full below.

## 4.2 Full data extraction

As suggested by SCIE systematic mapping guidance (Clapton, Rutter, & Sharif, 2009), we provide here a generic picture of the 69 records we analysed including their location, the type of document (e.g. policy, research study) and research design. This is followed by a full analysis of results (4.3).

Location: Only studies conducted in the UK were included in this review, of which nearly three quarters (75%) of the studies screened were based in England and nearly half of these were conducted in North East and South East of England, some in the Midlands, London and North East and North West of England. Fewer studies included were conducted in Scotland (14%) and Wales (2%).

Type of record: records were screened on criteria set for type of papers. The vast majority of records (84%) were peer reviewed journal articles (n=57). Documents were classified according to policy documents, Discussion /Opinion papers and research studies. Over four fifths of all articles screened (83%) were research studies of which nearly half (45%) evaluation studies. About one quarter were exploratory type studies (21%). Less than one quarter of the articles included were process evaluations (11%) and even fewer feasibility or pilot studies (8%).

Research design: The design of more than half (54 %) of all articles included in this review employed qualitative methods of investigation; these included a range of qualitative methods such as focus groups, semi-structured interviews and case studies. Fewer articles included were systematic reviews (n=2), scoping study (n=2) and secondary data analysis (n=5). Not many of the articles included adopted intervention study designs, however of those included more than half (60%) used pre and post-test designs and nearly one quarter of the intervention studies adopted randomised controlled trial designs (20%) and longitudinal study design (20%).

## 4.3 Studies included in the map from data extraction

Out of the 69 records shortlisted for further screening, we examined a range of characteristics as outlined earlier in section 3. These are examined below.

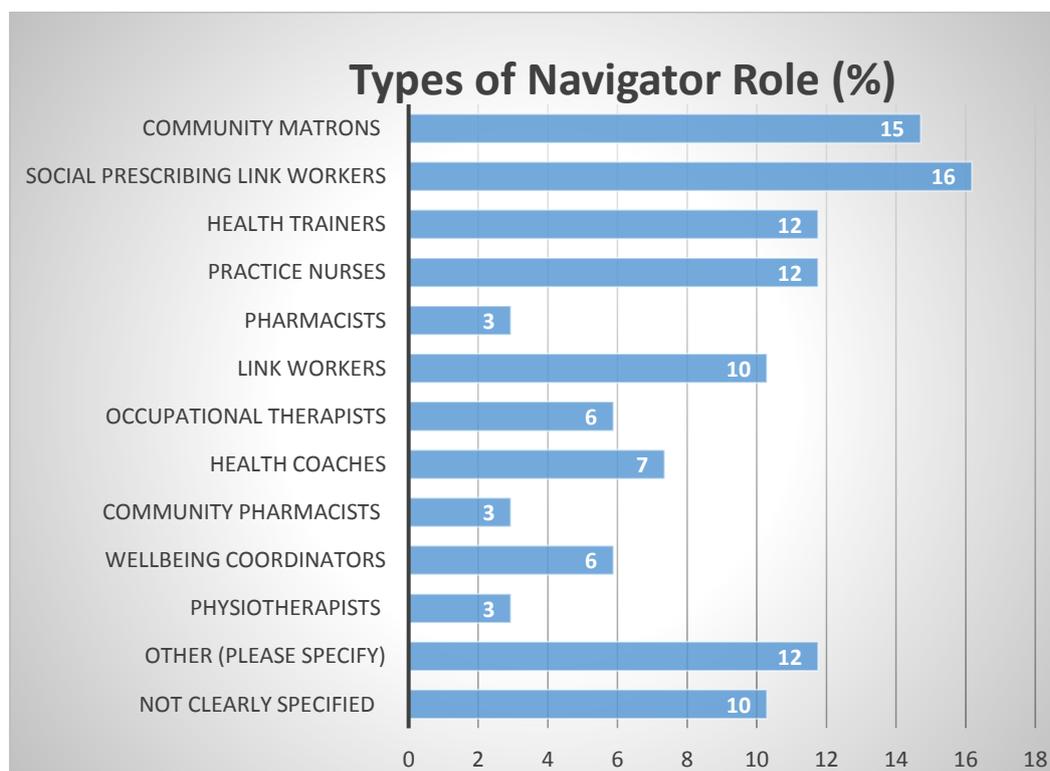
### 4.3.1 Types of navigator roles identified through the systematic mapping

One of the most important aims of this research was to identify the similarities and differences between navigation roles. We start here from classifying the roles we identified from the systematic mapping search.

Through the search, we identified at least 11 different types of navigator roles (see Fig. 4.2). We found that there were more roles with a focus on non-clinical care operating in primary care than initially anticipated. For example, some practice nurses were involved in delivering some non-clinical support (e.g. behaviour change) but overall it was difficult to understand the exact amount of non-clinical support on offer (Campion-Smith et al. 2014; Maio et al, 2016; Matthews et al 2017; Maxwell et al 2018). There were also examples of physiotherapists providing opportunistic health promotion and behaviour change interventions (Rawlinson et al 2019; Holden et al 2017) and 'Healthy Living Pharmacy' (Donovan and Paudyal 2016) who focussed on behaviour change interventions particularly around health promotion. Dental health support workers (Hodgins et al 2018) also offered another example within primary care which had significant success in increasing dental care of children from disadvantaged groups.

We assigned a broad category 'Link workers' to some documents as there was no specific mention of social prescribing in these documents. These 'link workers' were engaged in supporting people experiencing diabetes (Bush et al 2014), mental health (Evans et al 2014), dental care problems (Hodgins et al 2018), and focussed on referrals between primary and secondary care (Sundaram et al 2012).

Figure 4-2: Types of Navigator Roles



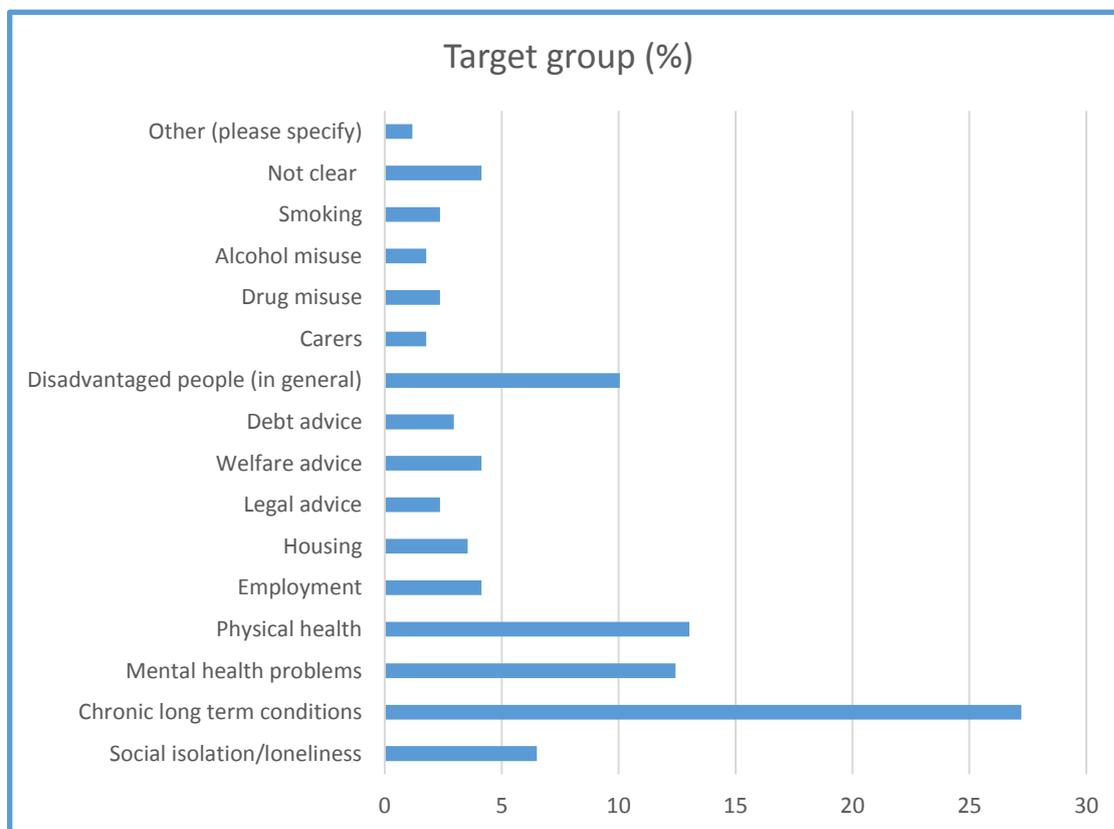
### 4.3.2 Target population

We found that the vast majority of navigation schemes were primarily concerned with the physical and mental health of disadvantaged people, in particular, chronic long term conditions (27%) and mental health problems (12%). The types of chronic conditions targeted included hypertension, diabetes, BMI over 30, smokers, cancer, asthma, chronic pain, osteoarthritis, Chronic Obstructive Pulmonary Disease (COPD), stroke survivors, frailty, and dementia. The level of mental health problems targeted was primarily mild to moderate with only one scheme including severe mental health problems (Verbeek et al 2018). To some extent, this is not surprising given that people with severe mental health problems would have been referred to specialist care delivered by professionals (e.g. psychologists, psychiatrists).

Socially related issues such as employment (4%), housing (4%), legal, debt and welfare advice (9%) were not so prominent. Interestingly, social isolation/loneliness was the target group for 7% of all navigation schemes. A considerable proportion of schemes targeted disadvantaged people (10%).

In addition to specific health conditions, some schemes targeted specific age groups such as the elderly, frequent attenders to primary care (Chapman et al 2009) or unplanned hospital admissions (Dix 2016).

Figure 4-3: Key target groups for each scheme involving navigation



In order to understand more about the similarities and differences between navigator roles, we conducted further analysis on the target groups in each navigator role. We focussed our analysis on documents that had included clearer information on the different aspects under analysis. All types of navigators offered support to Long Term Conditions (LTCs), physical and mental health. Social prescribing link workers covered the widest mix of health (LTCs, physical and mental health) and social issues (social isolation, welfare advice, employment, and housing), although health coaches and health trainers also offered a mix of health and social support to users. Our findings suggest that none of the social prescribing link workers documents targeted just one target group. The other types of navigators (community matrons, occupational therapists, and practice nurses) were primarily focussed on supporting health conditions. For example Community matrons targeted people with high consultation rates (Chapman et al., 2009) and unplanned admissions to secondary care and Practice nurses supported people with cancer; family carers of people with dementia (Maio, Botsford and Iliffe, 2016).

Table 4-1: Target population by type of navigator

	Target population by type of navigator								
	Mental health issues	Disadvantaged people in general	Chronic LTCs	Physical health	Social isolation/loneliness	Welfare, legal, debt advice	Employment	Housing	Drug, alcohol misuse
Social Prescribing Link Workers	6	3	5	4	3	3	3	2	
Community Matrons (*)	1		9	1					
Health Coaches	2	1	2	1	1	1	1	1	1
Occupational Therapists	2		3	2					
Health Trainers	3	7	4	3	1		1		
Practice Nurses (**)			5	2					

(\*) Community matrons also targeted people with high consultation rates (Chapman et al.,2009) and unplanned admissions to secondary care (Dix, 2016 )

(\*\*) Practice nurses: a group of these nurses supported people with cancer; family carers of people with dementia (Maio, Botsford and Iliffe, 2016)

#### 4.3.3 Key focus of navigator roles

Navigators focussed predominantly on behaviour change (35%), although improving self-care (22%), health inequalities (15%) and education (14%) were also important. The other category included reducing inappropriate hospital admissions, emergency hormonal contraception, needle exchange schemes.

Behaviour change included activities such as physical health, volunteering, counselling, help with emotional problems, nutrition advice, and creative art. The health inequalities category included welfare and debt advice, employment and housing support. With the exception of social prescribing and health trainers, it was difficult to identify whether some of these activities were delivered by the VCSE sector.

Figure 4-4: Key focus of navigator roles

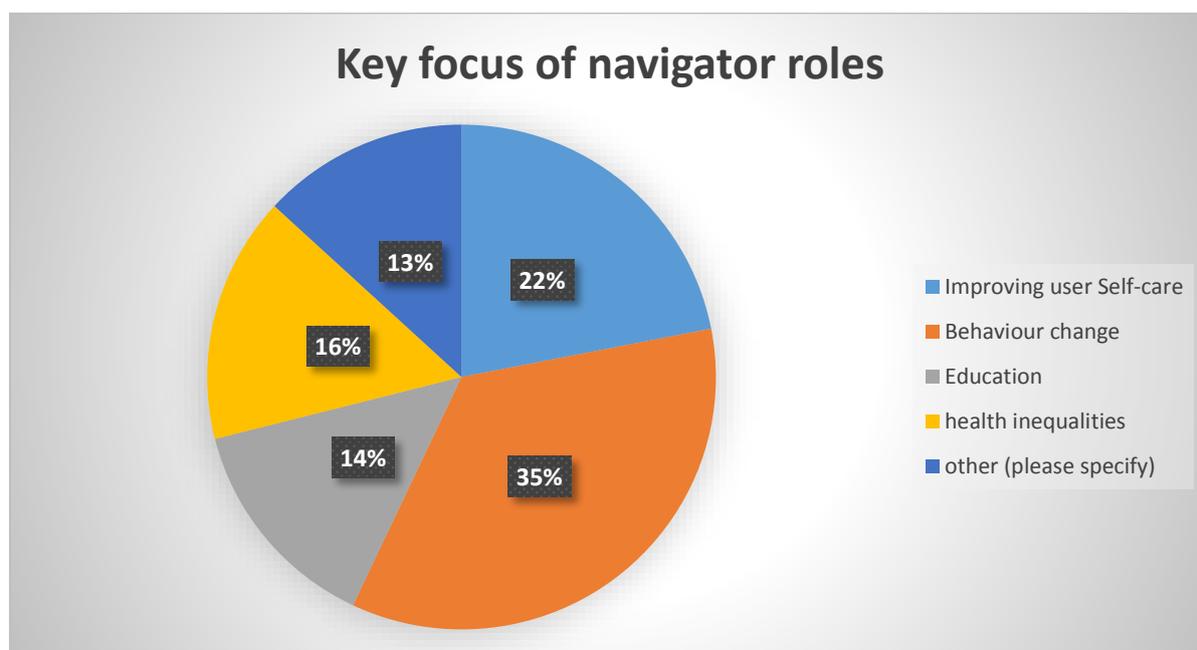


Table 4-2: Focus of support provided by navigator role

	Focus of support provided by navigator role				
	Behaviour change	Improving self-care	Education	Health inequalities	Other
Social Prescribing Link Workers	6	2	2	7	1
Community Matrons	3	4	2	1	4
Health Coaches	5	2	4	2	
Occupational Therapists	1	1			1
Health Trainers	8	3	3	3	
Practice Nurses	5		3		

Some social prescribing link worker pointed to the multiple challenges many clients faced. In some cases, this meant that physical health problems formed a relatively minor part of a role that centred on supporting clients in dealing with the economic, social and environmental determinants of health (Steadman et al, 2017).

Most of the support delivered by community matrons was centred upon improving self-care, and behaviour change. Health inequalities did not play an important part of their role. Few community matron schemes focussed on reducing inappropriate hospital admission (Dix, 2016; Grange, 2011; Randall, Furze and Thunhurst, 2015). One community matron

scheme focussed on supporting patients who had experienced problems with medicines (Oboh et al 2018).

Health coaches were particularly focussed on behaviour change and education, improving self-care and health inequalities were relatively less important.

There was little clarity on the main focus of occupational therapists. However, they mainly provided support for people with acute health care needs (e.g. pulmonary oedema), supporting early discharge from hospital as well as preventing avoidable admission and re-admissions.

The work of health trainers was mainly focussed on behaviour change and sign-posting to existing services for further lifestyle changes. Health trainers helped people to achieve their own behavioural change goals and supported them to self-manage (Ball and Nasr, 2011). Similarities between health trainers and social prescribing are evident here in relation to being employed by the voluntary sector, and referring people from primary care to other services, some of which were delivered by the VCSE sector. However, the role of health trainers in supporting people to tackle health inequalities was not so clear, whilst it is a much established part of social prescribing link workers role.

#### 4.3.4 Level of support for service users

The map sought to identify what level of support navigators were able to provide to services users. We attempted to find information about the level of support including light touch/signposting (one session), mid-level (2-3 sessions), or in-depth (4 sessions and over), the average number of sessions that were provided by navigators to service users, the number of service user supported per year, and the average length of session. These indicators have an impact on the design of effective interventions.

All navigator roles provided face to face (except one) one-to-one support. We found a total of 44 records which had sufficient information about type of support provided to users. Most records that had been shortlisted for full extraction and had sufficient information about sessions of support provided 'in-depth' support (42%) (4 sessions or over), 38% provided mid-level support (2-3 sessions) and 21% light-touch signposting (1 session only). This may suggest a publication bias where papers demonstrating high level support schemes were deemed to be of higher quality, thereby making them more worthy of being published.

In terms of the level of support provided, most navigator roles included a form of structured support (motivational interviewing, coaching, setting goals), although 14% did engage in information only signposting activities.

In the case of social prescribing link workers various levels of support were offered depending on the need of the service users (e.g. Dayson and Bennett, 2016; Kimberlee, 2013; Mercer et al., 2017). These ranged from information provision to structured support, referral and sometime accompaniment to services. Some community matrons, for example, accompanied patients to hospital appointments. In 13% of cases support also included

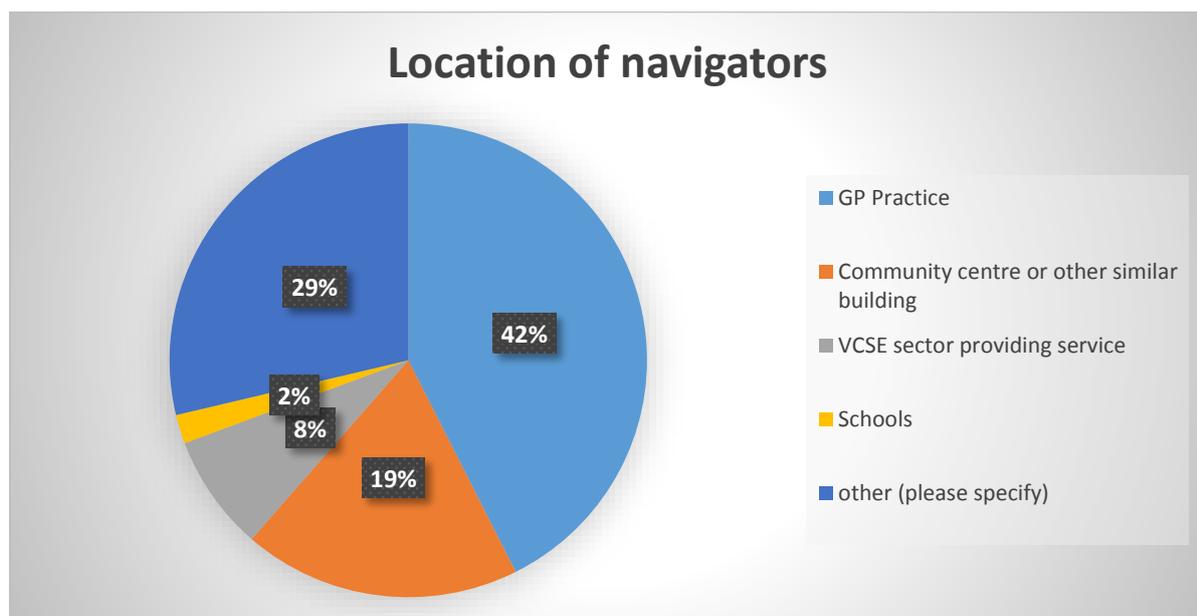
direct clinical support, for instance, a nurse who could review patients' medication and if necessary alter their prescription (Chapman et al., 2009).

In relation to average number of sessions, Ways to Wellness, a social prescribing scheme in Newcastle reported a case load of 40 to 70 clients per year per navigator (Steadman et al., 2017). Another study (Veerbeck et al., 2018) reported an average of 30 clients per year in their study on community mental health teams for older people in England. In reporting another study (Sargent, Boaden, and Roland, 2008), Chapman et al., (2009) concluded that caseloads for 50-80 patients all with complex needs would be a much too heavy burden for one navigator. Not surprisingly, this was seen as depending on the complexity of the case with an optimal number of 20-40 for community matrons (Grange, 2011). There was virtually no information about average length of session with only one study (Sackley et al., 2016) reporting an average of 30 minutes per session for occupational therapists supporting people with stroke-related disabilities in UK care homes.

#### 4.3.5 Location of navigators

Most of the navigators were based either in a GP practice (43%) or in a community centre (19%). A small number were based in the VCSE sector (8%) and only 2% were in schools. The remaining 29% of navigators were spread across different settings, for example pharmacies, cafes, local care homes. On a few occasions they would visit patients' homes or would be more directly involved into community life and visit local football clubs; in one instance, they would address service user needs directly over the phone (Woodall, 2018).

Figure 4-5: Location of navigators



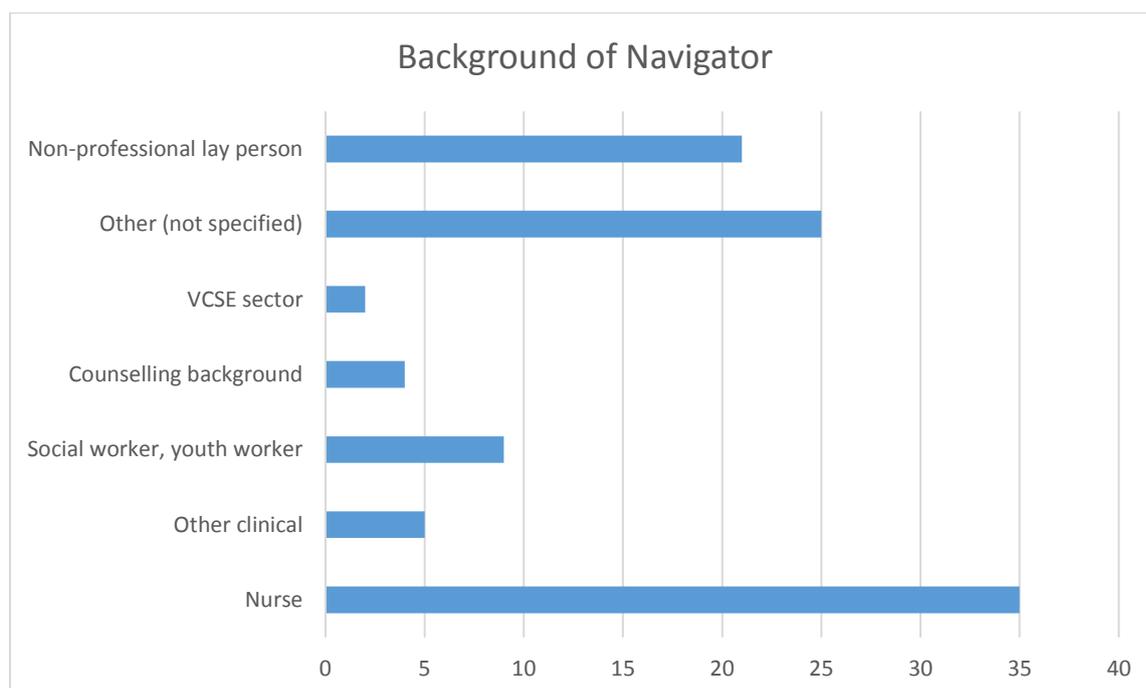
### 4.3.6 Background of navigators

Few documents contained clear indications about the background of navigators so this information may not represent the background of navigators in most roles. Our analysis shows that most of the navigators (35%) were trained as nurses, but this is likely to rely on the fact that most of the documents that had information about the background of the navigator were community matrons, and practice nurses. Some 21% were represented by non-professional, lay people who are mostly health trainers. The remaining are likely to be social prescribing link workers and included social workers (9%); some (5%) had a clinical background other than nursing (e.g. pharmacy); 4% were trained in counselling and an even smaller percentage had a background in VCSE (2%).

We found that 25% of the documents mentioned training for navigators. There was wide variation across navigator roles and within navigator roles from on the job-training to structured accredited specific training courses (Simms, 2016). For example, health trainers typically completed informal job-related training which included and training to support people to self-manage (e.g. goal setting) (Ball and Nasr, 2011), although in other schemes they were encouraged to take more formal accredited qualification (Cook and Wills, 2012; Harris et al., 2014). One document reported the lack of a structured career pathway and lack of retention as key general issues in a non-clinical workforce (Tavabie and Simms, 2017).

Training for social prescribing link workers was also different across schemes. In some cases, fives ways to wellbeing, motivational interviewing, the use of the wellbeing star and community development training were cited, and, in one case, training for health trainers was used for social prescribing link workers (Wildman et al., 2019).

Figure 4-6: Background of navigators



## 5 Key strengths and weaknesses of the navigator roles reported

We searched all the 69 extracted records for their key strengths and weaknesses in relation to role of navigators. The findings are sometimes quotations of navigators or service users opinions, sometimes the direct opinion of the authors. Some 49 documents exhibited details of the strengths of navigator roles. The personal relationship between the navigator and the service user was noted to be the most important feature for all types of navigators. In social prescribing, listening skills (Steadman, 2017), and a non-judgemental/empathic approach (Wildman, 2019) were reported as important in various studies. Similarly, for community matrons it was a ‘professional friend’ (Randall, 2016), for health trainers it was the easy going, enthusiastic and relaxed attitude that did not place service users under pressure (Bailey, 2012; Harris, 2014), including the respect of cultural values more generally (Valaitis, 2017).

In many cases, the non-clinical nature of the relationship was also seen as important (Carver, 2012) particularly in studies of social prescribing link workers (White, 2013), health coaches (Jolly, 2018) and health trainers (Ball, 2011).

An array of advantages was further identified in relation to the social prescribing role. These included emphasis on strengthening links between healthcare providers and the community (Kimberlee, 2013) and promoting the role of link workers as producers of change (Wildman, 2019) and that of boundary spanners (Gilburt, 2016).

The work of navigators benefitted patients in a number of ways. Some examples are listed in table 5.1:

Table 5-1: Reported advantages of navigator roles for service users

	<b>Advantages for patients</b>
Social Prescribing Link Workers	<ul style="list-style-type: none"> <li>• Sense of connection with community (Baker, 2016); improved self-confidence, weight loss, increased physical activity, greater resilience (Moffatt, 2017)</li> <li>• Trusting relationship; Meeting the link worker was the catalyst for change (Steadman, 2017)</li> <li>• Improved sense of social connectedness as well as reduction in anxiety; offering opportunities to engage in enriching activities (Woodall, 2018)</li> </ul>
Community Matrons (CM)	<ul style="list-style-type: none"> <li>• Patient education, developing self-management of health and social needs; direct patient care; single point of access (Chapman et al., 2009)</li> <li>• CM fulfilling a social need by making themselves more approachable (Williams, 2011)</li> </ul>

Health Coaches	<ul style="list-style-type: none"> <li>• Telephone health coaching showed potential benefits on self-efficacy, health behaviour (Jolly, 2018)</li> <li>• Meeting somebody who knows you and your health</li> </ul>
Health Trainers	<ul style="list-style-type: none"> <li>• Key facilitators of health promotion messages (Ball and Nasr, 2011)</li> <li>• Service made accessible to clients from low socio-economic groups and BME groups</li> </ul>
Other	<ul style="list-style-type: none"> <li>• Time to spend with outreach worker and see patients in a less medical manner (Carver, 2012)</li> <li>• Staff motivation, effective team working for Healthy Living Pharmacy (Donovan, 2016) community pharmacy: better information about condition and access to other relevant pharmacy services (Gray, 2009)</li> </ul>

Some 33 documents identified a range of key barriers. Overall, there seemed to be a tension between spending sufficient time with each individual user to meet their needs with the need to meet identified targets and therefore support the largest number of users.

In some studies, service users reported a lack of continuous monitoring and feedback as after the initial referral, they had been left to manage their health independently. Although this may be due to high case load as reported from social prescribing link workers and community matrons, part of the problem was also due to the risk of over attachment between navigator and service user. Social prescribing link workers reported that some users would become too attached to their navigators so it was seen as important to be a ‘friend but not a friend’ (Wildman, 2019).

Other barriers were more specific to each type of navigator role. For community matrons one important challenge was to understand the boundaries of their role. Health coaches and health trainers reported the lack of continuous monitoring and feedback. In some studies, health trainers appeared to be from a different socio-economic and/or educational background from their service users (Cook, 2012), although in another study (Wilkinson, 2011) service users tended to be sufficiently educated and confident to seek help elsewhere not requiring navigator support.

Table 5-2: Key Barriers reported

	<b>Key barriers</b>
Social Prescribing Link Workers	<ul style="list-style-type: none"> <li>• Lack of access to community organisations, lack of continuity of staff and very high caseload (Skivington, 2018)</li> <li>• Link workers demonstrated a lack of awareness of employment support for the community (Steadman, 2017)</li> <li>• Ongoing strained relationship between healthcare professionals and the VCSE sector (White, 2013)</li> <li>• High case load, lack of clarity on referral criteria, need for a balanced approach to managing relationships with users ‘friend but not a friend’ (Wildman, 2019)</li> </ul>

	<ul style="list-style-type: none"> <li>Concerns over the sustainability of the VCSE sector in delivering health and social care activities.</li> </ul>
Community Matrons (CM)	<ul style="list-style-type: none"> <li>Lack of clarity on role definition, lack of consensus on professional barriers between CM and district nurse (Chapman et al., 2009; Cubby, 2010; Grange, 2011)</li> <li>Lack of consensus on CM role which led to their disappearance from policy documents within 2 years (Drennan, 2011)</li> <li>Very high caseload with demand outweighing resources. Neglect of lower risk patients and visits made only when their condition worsened (Grange, 2011)</li> <li>Little evidence of championship by local medical leaders, CM found it difficult to integrated their provision.</li> <li>Considerable overlap between primary and secondary nurses specialists and CMs (Procter, 2013)</li> </ul>
Health Coaches	<ul style="list-style-type: none"> <li>Lack of continuity and follow up with consultations. A number of patients felt that they would have benefitted from increased contact. Lack of regular feedback (Shaw, 2012)</li> </ul>
Health Trainers (HT)	<ul style="list-style-type: none"> <li>Issues accessing HT in some areas especially if they were of the opposite gender (Ball and Nasr, 2011)</li> <li>Lay identity of HT and adoption of a formalised role. (Cook, 2012)</li> <li>Lack of continuous monitoring (occasional drop-in or telephone contact) was seen as a barrier to maintain any lifestyle change (Visram, 2017)</li> <li>The service needs to ensure that it does not attract high number of educated individuals who are more able to seek help elsewhere (Wilkinson, 2011)</li> </ul>
Other	<ul style="list-style-type: none"> <li>Paramedic unable to undertake prescribing accreditation (Baird, 2018)</li> <li>Lack of listening skills, lack of access to professional development, difficulties in re-shaping role to 'educate' service user on how to manage their health-care needs (Carr, 2014)</li> <li>Outreach workers: little agreement on what the role involves (Carver, 2012)</li> <li>Community pharmacists: lack of staff time and public awareness (Healthy living pharmacy) (Donovan, 2016); pharmacists must recognise the value of the service for it to work, seen as a burden by some. Very low number of user supported i.e. lack of awareness (Gray, 2009)</li> <li>Exercise referral scheme: motivational interviewing, goal setting and patient follow up being delivered poorly.</li> </ul>

## 6 Strengths and Limitations of this systematic map

This systematic map is the first attempt (we know of) to provide an initial understanding of the similarities and differences between a wide range of navigation roles described in the UK primary care literature. We hope this report will be a useful trigger for thinking about 'who' does 'what' in relation to navigation in primary care and general practice, in

particular. However, we are aware that many more navigation roles do exist outside primary care, in secondary care and in local communities commissioned by local councils, housing associations and other similar institutions, sometimes even sponsored by large charities (e.g. MacMillan, Mind). As a result, this systematic map does not cover the entire universe of navigation but only a slice of that and we do not yet know how big it is. Yet, this slice is quite important as navigation helps primary care substantially and can help it even further if it is more effectively organised.

In relation to methodological weaknesses, this mapping has primarily looked at peer reviewed evidence in journals and much less to grey literature. As time and resources were limited, we decided to place our effort on peer reviewed evidence as a form of qualitatively higher source of information which would help us to establish a 'mapping' baseline on which subsequent maps may decide to build upon by incorporating more detailed grey literature.

As much of peer reviewed literature focuses on the evaluation of health outcomes (did it work?), successive maps of this kind should include a larger search of the grey literature that we were able to perform here because this is likely to provide further important information about the characteristics of navigator roles (how did it work?).

## 7 Conclusions and implications of the systematic map

This systematic map aimed to identify the similarities and differences between navigation delivery roles across primary care with a particular focus on social prescribing link workers. Although descriptions of different navigation roles are available, they have never been searched together and compared within one mapping exercise. This is particularly important in the current policy climate where self-care and personalisation are central part of NHS policy. For example, the NHS document entitled 'Universal Personalised Care' (Sanderson, 2019) which operationalises personalised care and much of the NHS Long Term Plan (NHS, 2019), refers to a range of navigator roles including health coaching, health trainers, and social prescribing.

In constructing the systematic map, we followed guidelines authored by Clapton, Rutter and Sharif (2009) for the Social Care Institute for Excellence (SCIE). We identified a wide range of navigator roles that would meet the criteria of navigation i.e. 'people who provide support to patients and help them to access further services where necessary'. These can be viewed in detail in sec. 4.2 of this report. It was interesting to find that there is considerable variety of navigation roles all of which provide support for people with Long Term Conditions (LTCs) and mental health problems. However, whilst community matrons, occupational therapists and practice nurses were more focussed on LTCs, other roles such as social prescribing link workers, health trainers provide a more holistic support which included health inequalities (e.g. welfare, legal and debt advice, employment and housing) and social isolation (Table 4.1 and 4.2).

Social prescribing link workers - and to a lesser extent health trainers – were also heavily engaged with the VCSE sector, whilst for other navigator roles, this was not very clear. More detail might be found with a more systematic search of the grey literature to better understand the involvement of other navigator roles such as community matrons, practice nurses, and pharmacists with the VCSE sector.

All navigator roles provided face to face (except one) one-to-one support. Most of the support provided was in-depth (i.e. 4 sessions or over) with some navigators accompanying users to appointments. Most navigators provided a form of structured support (e.g. motivational interviewing, coaching, setting goals), although the details of this were difficult to assess.

There was only scant detail available on the average number of sessions offered by navigators, although there was a common problem reported with case overload across all navigator roles. Perhaps not surprisingly, the vast majority of navigators were located in GP practices. It was difficult to get a real sense of the background of navigators as this was rarely clarified, except in the case of nursing related navigator roles like community matrons.

In conclusion, social prescribing link workers appear to share similarities with other roles particularly health coaches and health trainers. However, social prescribing link workers are clearly different in their orientation toward the positive involvement of the VCSE sector and their recognition of health but also tackling health inequalities.

Two key factors are shaping the trajectory of future care: the first is the complexity of caring for an increasingly ageing population which experiences a range of multi-morbidities. Multi-morbidities require a coordinated approach where different healthcare professionals and non-healthcare professionals work together to provide effectively and timely care. The second is the growing health inequalities that determine a further gap between rich and poor. Both of these challenges need to be tackled at the same time. Further care integration can help with tackling both of these challenges which need navigators to be able to work across organisational boundaries.

The concept of ‘boundary spanning’ (Williams, 2002) is concerned with studying the factors that are facilitating the growth and effectiveness of navigator roles. These include systemic support for integration, managing organisational and professional identities, building relationships to support boundary spanning, designing boundary spanning care, skills needed, training requirement, and organisational management of workforce integration (Gilburt, 2016). Future research should consider studying the value of current navigation roles using this framework. This may apply particularly well to social prescribing link workers as their role spans clinical and non-clinical care, primary care and the VCSE sector, the psycho-social and the biomedical.

#### Recommendations for future research

There are a number of areas in which further research would be useful:

- a. Extending the current map outside of primary care and to the international literature to capture a greater range of navigator roles across different contexts. Such investigation should consider grey literature as central to the process.
- b. A systematic review of the health outcomes of navigator schemes: this may examine the health and social outcomes for service users across primary care and beyond and internationally to capture other models.

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## 9 Appendices

### 9.1 Appendix 1: Search strategy

#### **Databases**

The following are first choices from the options available to the UEL:

Medline/Pubmed

Cochrane Library

Cinahl

PsycInfo

Social Care Online

Second choices if insufficient material found:

Ovid

Scopus

Science Direct

Wiley Online

Zetoc

However, the following may be more appropriate, if I can get access to them elsewhere:

ASSIA

Web of Science

IBSS

Embase

Social Policy and Planning (but note that with this one, the download facility is so terrible that I will need to select items personally. My strategy would be: anything about social prescribing that fits the other criteria – or they are unspecified – and doesn't self-declare in the abstract to be any other category except research.)

#### **Search terminology: Pubmed**

Social-prescri\* or signpost\* or system-navigat\* or community-navigat\* or system-coordinat\* or system-co-ordinat\* or care-navigat\* or patient-navigat\* or care-coordinat\* or care-co-ordinat\* or wellbeing-program\* or well-being-program\* or well-being-co-ordinat\* or wellbeing-co-ordinat\* or well-being-coordinat\* or wellbeing-coordinat\* or community-referral\* or non-medical-referral\* or nonmedical-referral\* or health-coach\* or health-trainer\* or community-matron\* or link-worker\* or close-loop-prescribing or closed-loop-prescribing or occupational-therap\* or linking-scheme\*

OR

Mesh: Patient navigation or occupational therapy

AND

Primary-care or GP or GPs or general practitioner\* or general-practice\* or pharmacy or pharmacist\*

OR

Mesh: Primary health care or Primary care nursing or Physicians, primary care or Pharmacy or pharmacist\*

AND

England or Britain or UK or "United Kingdom"

Or

Mesh: United Kingdom

AND

Publication year: 2009-

Total: 284 hits.

Search terminology: CINAHL and PsycInfo

Ti,ab,su: Social N1 prescri\* or signpost\* or system N1 navigat\* or community N1 navigat\* or system N1 coordinat\* or system N1 co-ordinat\* or care N1 navigat\* or patient N1 navigat\* or care N1 coordinat\* or care N1 co-ordinat\* or wellbeing N1 program\* or well-being N1 program\* or well-being N1 co-ordinat\* or wellbeing N1 co-ordinat\* or well-being N1 coordinat\* or wellbeing N1 coordinat\* or community N1 referral\* or non-medical N1 referral\* or nonmedical N1 referral\* or health N1 coach\* or health N1 trainer\* or community N1 matron\* or link N1 worker\* or close\* N1 loop N1 prescribing or occupational N1 therap\* or linking N1 scheme\*

AND

Ti,ab,su: Primary N1 care or GP or GPs or general N/1 practitioner\* or general N/1 practice\* or pharmacy or pharmacist\*

AND

Geographical terms and date restriction as in PubMed

Total: 506. Excluded magazine articles and non-English: 497. Deduplicated: 440.

Search terminology: British Nursing Index, ASSIA and IBSS

ASSIA

Ti,ab,su: Social N/1 prescri\* or signpost\* or system N/1 navigat\* or community N/1 navigat\* or system N/1 coordinat\* or system N/1 co-ordinat\* or care N/1 navigat\* or patient N/1 navigat\* or care N/1 coordinat\* or care N/1 co-ordinat\* or wellbeing N/1 program\* or well-being N/1 program\* or well-being N/1 co-ordinat\* or wellbeing N/1 co-ordinat\* or well-being N/1 coordinat\* or wellbeing N/1 coordinat\* or community N/1 referral\* or non-medical N/1 referral\* or nonmedical N/1 referral\* or health N/1 coach\* or health N/1 trainer\* or community N/1 matron\* or link N/1 worker\* or close\* N/1 loop N/1 prescribing or occupational N/1 therap\* or linking N/1 scheme\*

AND

Ti,ab,su: Primary N/2 care or GP or GPs or general N/1 practitioner\* or general N/1 practice\* or pharmacy or pharmacist\*

AND

Loc=United Kingdom

Source: Dissertations, scholarly journals.

IBSS

As ASSIA

Instead of Loc=, AND ab: England or Britain or UK or "United Kingdom" or Scotland or Ireland or Wales. (There were no Loc entries; system collapsed every time I tried to use the large geographical set).

Source: Books, dissertations, scholarly journals

British Nursing Index

As IBSS

Source: Scholarly journals

Deduplicated total for ASSIA, IBSS and BNI: 110

Cochrane Library

Searched Mesh term Patient Navigation. Not possible to combine with other concepts, so selection made from 91 hits. One downloaded.

Searched for "social prescribing", "social prescription", "care navigation", "health coach", "health trainer", "community referral", "non-medical referral", "close loop prescribing", "closed loop prescribing", "linking schemes". Two items downloaded.

Some terms, e.g. Occupational therapy, produced too many results to scan.

Followed link from a poster to Glasgow Deep End Link Worker evaluation and downloaded four documents.

OpenGrey

Searched for "social prescribing", "social prescription" (discipline – health services, medicine), "care navigation", "health coach", "health trainer", "community referral", "non-medical referral", "close loop prescribing", "closed loop prescribing", "linking schemes". 1 item found.

Google Scholar

Searched "social prescribing". First five pages checked and research reports not already found were recorded. 6 hits.

Total of all databases, deduplicated: 698.

Websites

**Mind.** Check About Us: Our Policy Work: Reports and Guides, sections 'Primary Care' and 'Our Research'; also Our Information. Found no relevant original research.

**Age UK.** Searched Our Impact: Publications: Reports and briefings: 0 relevant papers. Also Evaluation Reports: these were all evaluations of services, not referrals to those services.

**Health Education England:** Has produced a care navigation competency framework; a health coaching quality framework (downloaded for background).

**Sport England:** Run a series of projects called Get Healthy Get Active, to which people can be referred. However, the evaluations don't address the role of social prescribing.

**London Sport:** Focus is on provision of services, not referral to them. Report *Moving More, Aging Well* recommends a National Activity Therapy Service that would see signposting to physical activity opportunities and practical advice on how to be more active feature in every contact between carer professionals and patients. The service would also see specially trained exercise professionals embedded into GP practices. Report is not research, but does contain some case studies.

**Work Foundation:** *Social Prescribing: A Pathway to Work?* Downloaded. Contains case studies

**King's Fund:** Downloaded *Innovative models of general practice; Adoption and spread of innovation in the NHS; Reimagining community services; Supporting integration through new roles and working across boundaries; Co-ordinated care for people with complex chronic conditions;*

**Health Foundation:** Searched Reports and Journal Articles. Downloaded *Making it happen: Practical learning and tips from the five Realising the Value local partner sites*

**Nesta:** Searching impossible so used Google: site:nesta.org.uk "social prescribing" Downloaded *Tempo: Time Credit Social Prescribing Pilot; More Than Medicine*

**Joseph Rowntree Foundation:** Searched Google: site:jrf.org.uk "social prescribing", signposting; health coach; health trainer; care coordination. Found nothing.

**Wellcome Trust:** followed internal link to Social Prescribing Network and report by Polley et al.; *Making sense of social prescribing* (useful bibliography)

## 9.2 Appendix 2: List of shortlisted document

Ahluwalia S, de Silva , D , Kumar S, Viney R, and Chana N. (2013). Teaching GP trainees to use health coaching in consultations with patients: evaluation of a pilot study. *Education for Primary Care*, 24(6), pp.418-426.

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