

Evaluation of the Community Mental Health Navigator Pilot Programme

Final Report, May 2023

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1. Introduction

This is the final evaluation report for the Community Mental Health Navigation Pilot (CMHN Pilot), following on from the scoping report (March 2021) and interim report (April 2022). It begins with an overview of the project, its context and planned aims and outcomes ([Section 1.1](#)); followed by an overview of the evaluation questions, approach and methods ([Section 1.2](#)); consideration of evaluation limitations ([Section 1.3](#)); then an outline of the structure and scope of this report ([Section 1.4](#)). More details on the project context, aims, intended outcomes, proposed delivery and evaluation plan can be found in the scoping report, Theory of Change and NHS Ethics Application (see [Appendix 1](#)). The interim evaluation report can be seen in [Appendix 2](#).

1.1 Overview of the project: context, aims and planned outcomes

Mental Health UK is a partnership of four national mental health charities, based in each of the UK nations:

- England: Rethink Mental Illness (Rethink or RMI)
- Wales: Hafal (now Adferiad Recovery)
- Northern Ireland (NI): Mindwise
- Scotland: Support in Mind (now Change Mental Health)

The partners delivered the CMHN Pilot, with grant funding from Johnson & Johnson in the UK and the Johnson & Johnson Foundation, as a new model of care for people affected by mental illness. The approach, as originally conceived, was to create a new Community Mental Health Navigator (CMHN) post in each of the four nations to work within one local Primary Care Network (PCN).

The project was set up in the context of several systemic challenges and opportunities. NHS mental health services and healthcare services in general had a great deal of pressure and little spare capacity amongst clinical staff to engage in preventative care work. This meant that the non-clinical needs of people affected by mental illness were often left unmet, leading to deterioration in wellbeing and quality of life and potentially readmittance to care services.

In this challenging context, the emergence of the care navigation model was seen as a useful and person-centred approach to helping health service users with a wide range of needs. Previous research had found that care navigation has two types of benefits: benefits for the patient in terms of quality of life, and benefits for the health service in terms of free capacity and savings (e.g., Allen and Drabble, 2017). Learning from previous experience and research in different settings showed that care navigation is a beneficial and potentially cost-effective way to meet service user needs and free up increasingly limited health resources: by supporting people with non-clinical aspects of their lives this could also have a positive impact on the mental health of primary beneficiaries.

The navigator role had two main aims:

- to support the non-clinical needs of people experiencing mental illness (e.g., with housing, social integration, or employment), and thereby
- to reduce demands on the capacity of GPs, Mental Health Nurses, A&E, and other frontline health and care professionals.

It was intended to act as an early intervention, through attracting and accepting referrals, primarily from local primary care services (such as GP surgeries), which navigators would be based within. People referred would be supported to, for instance, get help from local

housing teams, engage with community activities provision, receive financial support, and/or access training or work. As a result, it was designed to help prevent escalations into crisis and the need for emergency care and, in so doing, release clinicians (secondary beneficiaries) to focus on the clinical needs of their patients. The expectation was that this support would result in improved mental health for the people supported, greater job satisfaction and wellbeing of healthcare staff and benefits for other people around the person being supported, such as family members or carers.

1.2 Overview of the evaluation questions, approach and methods

The Tavistock Institute of Human Relations undertook an external evaluation of the CMHN Pilot, between October 2020 and March 2023. It aimed to address the following research questions:

1. What were the impacts of the pilot on primary and secondary beneficiaries?
2. Were there different impacts for different sub-groups?
3. To what extent can changes be attributed to the pilot?
4. How was the pilot delivered?
 - How did actual delivery compare to intended delivery (i.e. fidelity)?
5. What are the improvement areas and what can be learned?
 - How did external factors influence implementation of the pilot? What can we learn from that?
6. What are the key success factors for this model?
 - What has been done in an innovative way?
7. What has been the ratio of costs to benefits?

A developmental and realist approach was used to evaluate the pilot, more detail of which can be found in the Scoping report (see [Appendix 1](#)). This helped guide the Theory of Change, evaluation protocol and tools ([Appendix 1](#)) and methods ([Appendix 3](#)). This report is based on data gathered through evaluation activities between June 2021 and March 2022, building on data presented in the interim report ([Appendix 2](#), covering April 2020 to January 2021). Monitoring data presented covers the period April 2021 to January 2022. [Table 1](#) provides an overview of evaluation methods employed.

Table 1 Evaluation components, methods and data gathered

Evaluation component	Contributing method	Data gathered for interim report	Data gathered for final report ¹	Total data gathered
Impact evaluation	Service user surveys (including SWEMWBS and EQ-5D)	36 – baseline surveys 10 – follow up surveys	60 – baseline surveys 37 – follow-up surveys 8 – 3-months follow-up surveys	96 – baseline surveys 47 – follow-up surveys 8 – 3-months follow-up surveys
	Service user case study interviews	4 interviews	3 interviews	7 interviews
	Healthcare staff surveys	11 baseline surveys	5 – follow-up surveys	11 – baseline surveys 5 – follow-up surveys
	Healthcare staff interviews	8 total	7 total	15 total (includes some staff)

¹ The counts of the service user surveys only include those cases we received signed consent forms for, it excludes duplicate cases (cases with the same unique ID) and it includes partially completed surveys (e.g., where SWEMWBS but not EQ-5D was completed). The number of 3-months service users follow-up surveys received excludes those who could not be matched with either the baseline or follow-up survey.

				interviewed at two time-points)
	Anonymised health service appointment data	Not returned	Not returned	Not returned
	Monitoring data	Aggregated quarterly returns received	Aggregated quarterly returns received (number of months vary per site)	Aggregated quarterly returns received (number of months vary per site)
	Diversity data	Aggregated data received for all sites (up to December 2021, though starting months vary)	Received as part of monthly aggregated monitoring data (for three sites and age and gender only)	More detailed aggregated data for all sites up to December 2021 and monthly diversity data up the July/Sept/Dec 2022 (for three sites and age and gender only)
Process evaluation	Service user interviews	4 initial interviews	3 interviews	7 interviews
	Health care staff interviews	8 total	7 total	15 total (includes some staff interviewed at two time-points)
	Navigator and MHUK stakeholder interviews	13 total	8 interviews	21 interviews (includes some stakeholders interviewed at two time-points)
Cost-benefit evaluation	Healthcare appointment data for service users	Not received	Not received	Not received
	Anonymised aggregated appointment data of comparison groups	Not received	Not received	Not received
	Service user surveys (EQ-5D)	36 – baseline surveys 10 – follow up surveys	60 – baseline surveys 37 – follow-up surveys 13 – 3-months follow-up	96 – baseline surveys 47 – follow-up surveys 13 – 3-months follow-up
	Health service staff surveys	11 baseline surveys	5 – follow-up surveys	11 – baseline surveys 5 – follow-up surveys

1.3 Evaluation limitations

Several factors combined to present challenges to the project and evaluation activity, affecting what could be achieved during the pilot. The main limitation was the relatively small amount of quantitative and qualitative outcomes data collected from participating sites. As [Table 1](#) shows, no healthcare appointment data was collected. In addition, although a comparison site was initially agreed, to better understand the differences between having a

navigator and not having one, overall challenges with gathering data meant that this became unfeasible. In summary:

- The COVID-19 pandemic hit the UK, leading to the first national lockdown approximately a week before the project was due to begin. It impacted on evaluation fieldwork, as beyond an initial scoping visit to the England site, no further physical site visits could be made by the evaluation team. It also presented challenges for the collation of consent forms and surveys.
- The NHS ethics approval process took longer than anticipated, partly due to the ongoing pandemic. No evaluation activity could start until the ethics process had completed. NHS ethics approval was gained for England and Wales in June 2021, with approval for Scotland and NI gained in December 2021, leaving less time for data collection.
- Despite gaining ethics approval, it was impossible to get data sharing agreements in place with the 4 sites, partly due to increased pressures on services and staffing and changing personnel within the sites and evaluation team. Therefore, no appointment data was shared and so could not be analysed against outcomes or for the economic evaluation.
- The CMHN Pilot was a small intervention, operating in four different countries, each with a different NHS system, MHUK organisational partner and in different social, political, health and geographic settings. This added to the challenge of getting proactive support from pilot sites with consistent data collection and of drawing general conclusions from the data received.
- As discussed later in [Section 4.2.7](#), navigators were required to report in different ways to different stakeholders as well as for the evaluation. Despite the evaluation team offering support to try and address challenges, and recommending greater streamlining of data collection, this did not seem to lead to any changes, partly related to other challenges reported here and in [Chapter 4](#).
- Linked to the above point, recommendations for improving data collection (e.g., increasing age categorisations), did not result in sharing of such data with the evaluation team, due to navigator workloads and administrative challenges (see also [Section 4.2](#)).
- Since the pandemic began, the social and economic context has become increasingly challenging, with healthcare staff increasingly stretched. Fewer have engaged with the evaluation than anticipated, and those that engaged in earlier stages struggled to engage later on.
- People being supported might not be well enough to engage in the evaluation. For instance, some people agreed to be interviewed but then withdrew because of their own circumstances. In addition, on top of other paperwork that needed completing, some people experienced the evaluation surveys as too much of an additional burden, which could generate additional unnecessary stress. This was clearly set out as an exclusion criterion for the evaluation, and it was appropriate that navigators did not continue asking these service users to complete forms.
- Finally, there has been a general drop in healthcare research within the NHS over recent years,² and one health service staff member told the evaluation team that they

² <https://www.theguardian.com/science/2023/feb/27/patients-losing-out-amid-slump-in-nhs-clinical-trials-warn-top-clinicians>

struggled to gather data internally and have it shared. Therefore, they thought it highly unlikely an external organisation would have success with this, particularly bearing in mind the context.

These factors contributed to making it very difficult to collect a greater amount of data, to gain a more detailed understanding about how well the CMHN Pilot operated in different circumstances. This in turn affected the evaluation's ability to assess whether there were different impacts for different sub-groups of service users. Caution is therefore needed when drawing conclusions from the data presented in this report.

1.4 *Structure and scope of this report*

This report is structured as follows:

- [Chapter 2](#) explores how the CMHN Pilot was delivered, including detail on its activities, referral processes, caseloads and who navigators worked with.
- [Chapter 3](#) describes the outcomes observed for primary and secondary beneficiaries, exploring how sustainable these outcomes are, to what extent they can be attributed to the pilot, and the cost-benefits of implementing a CMHN service.
- [Chapter 4](#) identifies key challenges in delivering the pilot, relating to the healthcare system, navigator capacity and pilot set up, as well as external factors, such as the COVID-19 pandemic.
- [Chapter 5](#) identifies key success factors of the pilot, including the navigator's profile and role, beneficiary characteristics and organisational factors, considering what has been innovative about the model and what is scalable.
- [Chapter 6](#) presents the report's conclusion, ending with some recommendations for future CMHN services.

The period covered within the report is primarily from October 2020 up to December 2022, with quantitative reporting for the period May 2020 to December 2022.

2. How was the CMHN Pilot delivered?

This chapter responds to the evaluation question of how the pilot was delivered, and how this compares to the intended delivery. It describes the CMHN Pilot activities ([Section 2.1](#)), covering how the individual navigation services worked ([Section 2.2](#)), the types of support provided ([Section 2.3](#)), and the characteristics of beneficiaries ([Section 2.4](#)). In the process, it provides an update on information shared in the interim report and seeks to understand what changed and why. It ends with key learning points from the process of delivering the pilot ([Section 2.5](#)). Data sources include:

- interviews with navigators, MHUK staff, local NHS health service staff and people supported by navigators (also called service users, patients or clients).
- survey responses from health service staff and service users/clients.
- aggregated monitoring reports of:
 - demographic data reported by navigators between May 2020 and December 2022.³

³ The exact reporting period differs per site and type of demographic data. More detailed aggregated data is available for all four sites up to December 2021 (from June 2021 for Northern Ireland and Scotland and from May 2020 for England and Wales). Aggregated monthly age and gender statistics are available for Northern Ireland between June 2021 and July 2022, for Scotland between May 2021 and December 2022 and for Wales between July 2021 and September 2022.

- referrals to, caseloads of, appointment attendances with and discharges from navigators between April 2021 and September 2022.⁴

The full breakdown of data that this report draws upon is listed in [Table 1](#).

2.1 What were the CMHN Pilot activities?

The CMHN Pilot was designed to provide one navigator each in one pilot site within each of the four UK nations. Navigators were expected to work with 60 people for up to six months each (a total of 240 people), over a two-year period. Posts were due to begin in England and Wales in April 2020, followed by Northern Ireland and Scotland in early 2021, before completion in all areas in December 2022. Navigators were managed by their respective Mental Health UK Partner organisation and based within a local NHS primary care setting.

The England navigator was based in the Meridian PCN, serving North-East Lincolnshire and hosted by NAViGO Health and Social Care CIC. The Wales navigator was based in The Princess of Wales Hospital in Bridgend, and the Royal Glamorgan Hospital in Rhondda Cynon Taf, serving the areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf, hosted by Cwm Taf Morgannwg University Health Board. The Scotland navigator was based in GP surgeries serving Stranraer, hosted by NHS Dumfries and Galloway. The Northern Ireland navigator was based in a GP surgery in Belfast, hosted by the West Belfast Federation of Family Practices CIC.

As [Table 2](#) shows, the actual delivery timeline differed from the original plan, due to the onset of COVID-19 and the first national lockdown which started just as the project was beginning. Delivery in Northern Ireland was further hampered by staffing challenges. Two people fulfilled the role of NI navigator during the project lifespan, with both individuals leaving the post prematurely. This, combined with sickness absences of other key staff, impacted on the partner's ability to recruit, and manage the navigation service. This resulted in gaps in service delivery and an early end to the NI service, contrasting with the expectation that NI would end its service at the same time as Scotland.

Table 2: Actual CMHN Pilot timeline

Date	Milestone
June to October 2020	England and Wales deliver a COVID-19 navigation service
October 2020 onwards	England and Wales begin delivering the CMHN Pilot
June 2021	Scotland and NI begin delivering the CMHN Pilot
July 2022	NI Service ends prematurely when navigator leaves post
December 2022	CMHN Pilot completes in England and Wales.
Summer 2023	Scotland navigation service is due to complete.

2.2 Referrals to and caseloads held by navigators

Each site had different levels of access to the local healthcare system and different mechanisms for referral. These included:

- referrals via the primary care case management system.

⁴ For Wales and England, monitoring data was available for previous months and not all sites reported continuously between April 2021 and September 2022, however, for most of this time, complete data exists.

- triaging by a mental health clinician who referred on eligible patients that had been referred to them by GPs.
- informal emails and phone calls from healthcare staff to the navigator.
- referrals during team meetings that the navigator attended.

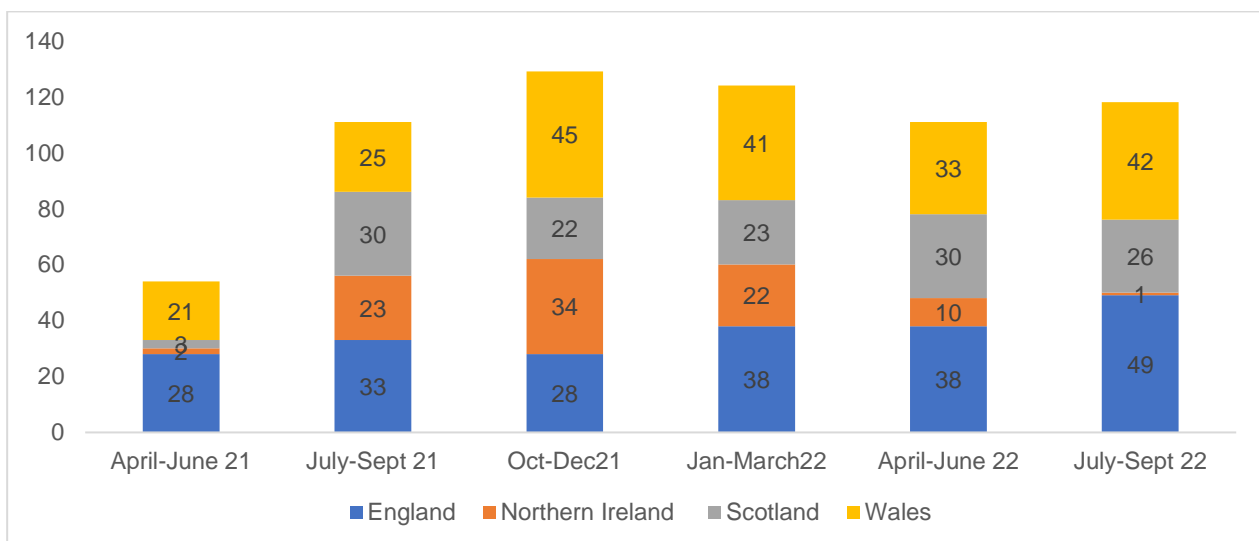
Since April 2022, the referral process in England changed, in response to the large number of referrals, as well as part of a wider mental health services transformation. It moved from referrals coming through the IT system, to referrals being triaged by a mental health clinician. This was a similar approach to Scotland, which seemed to have been working well.

2.2.1 Number of referrals received

[Figure 1](#) shows the number of new referrals to the navigation service, reported by quarter and site, between April 2021 and September 2022. England and Wales started receiving referrals in May 2020, NI and Scotland in June 2021. Based on the data reported, it seems that there were 305 new referrals between February and September 2022, since the 342 referrals between April 2021 and January 2022. This total of 647 new referrals in the period reported indicates that the actual number of people referred over the lifespan of the navigation service was a lot higher than this. The total number reported represents a 270% increase from the anticipated 240 people, although it is not known if all these people received support, or for how long. However, the assumption, based on discharge and interview data is that most referred people were contacted by navigators and offered support.

The data also shows that referral numbers, on average, increased (despite the lack of reported data from Northern Ireland for four months in 2022), from an average of 34 referrals per month in total between April 2021 and January 2022, to an average of 38 referrals per month across the four sites between February and September 2022. [Figure A2](#) in [Appendix 4](#) displays the number of referrals by month and site which shows that the number of referrals in the period (April 2021 to September 2022) ranged from 2 to 24 new referrals by month. The average number of monthly referrals ranged from 7.1 (NI), and 8.1 (Scotland), to 11.5 (Wales) and 11.7 (England) respectively. [Figure 1](#) below displays the referral numbers per quarter and site, highlighting that October to December 2021 and January to March 2022 had the highest number of referrals (i.e., 129 and 124 respectively) as all sites received more than 20 referrals during those quarters.

Figure 1 Number of referrals by site and quarter between April 2021 and September 2022



Note. N=647; Source: Monitoring data provided by each site.

2.2.2 Navigator caseloads

Caseloads remained relatively steady following an initial build-up period, with an average of 31 people being supported by a navigator per month. The average was 22 in Northern Ireland, 23 in Scotland and 40 in England and Wales. This difference is partly due to England and Wales having taken on referrals before April 2021, therefore their caseloads had already built up at that stage. There were two main peaks for Wales and NI (51 and 40, respectively) which occurred following increases in referrals. Apart from one peak of 72 in March 2022 for Scotland, caseload numbers in Scotland and England seemed otherwise relatively stable (see [Figure 2](#) for an overview of monthly caseloads held by navigators between April 2021 and September 2022 or

[Table A1](#) in Appendix 4).

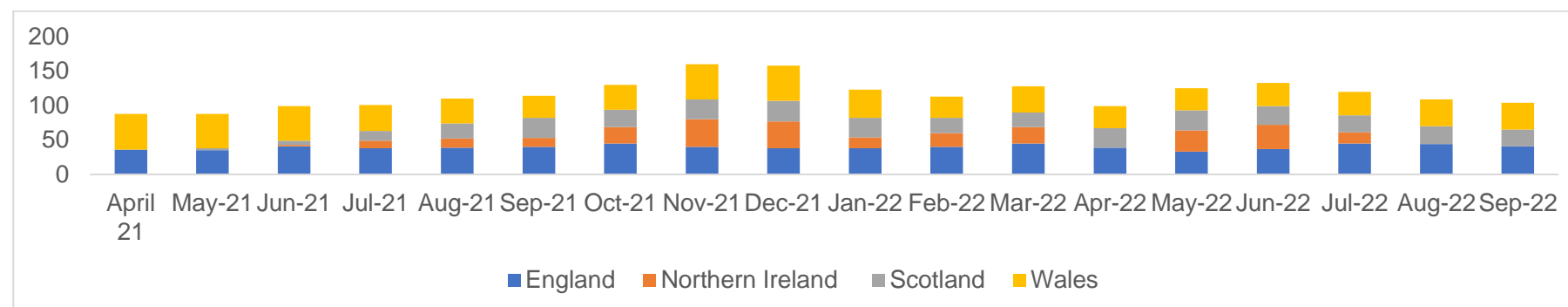
2.2.3 Appointments with navigators offered, attended, and not attended

Between April 2021 and September 2022, there were 5785 appointments offered, of which 4926 were attended (85%) and 859 not attended (DNAs). Quarterly figures can be seen in [Table 3](#), with the monthly breakdown detailed in [Appendix 4, Table A2](#). More appointments continued to be offered and attended in Wales and England than in NI and Scotland. For example, the highest number of appointments offered in Wales in one month was 224, compared to 35 in NI. The highest number of appointments offered in one month in England and Scotland respectively were 157 and 80. There was some fluctuation between months and quarters in the number of appointments offered, especially for Wales, which can be partly explained by the higher caseloads in months with high number of appointments (as further described below).

The challenges with staffing the NI navigator post seem most likely to have affected the numbers of people offered appointments there. This is because when a navigator was first in post, it attracted a similar number of referrals to other areas (see [Appendix 4, Figure A1](#)), and for some of the period, the caseload was similar. From interview data as well as from the monitoring data shared, it seems that England and Scotland had a more consistent and coordinated approach to attracting and managing referrals, with a more manageable caseload overall than in Wales. Here, referrals seemed to come through a variety of routes, many of these informal, and direct to the navigator. This perhaps explains the much larger caseload held, and number of appointments offered, by the Wales navigator. Backed up by interview data, it seems that this became overwhelming quite quickly and was perhaps, without a more standardised referral process, challenging to manage. However, having said this, England also seemed to have an overwhelmingly high number of referrals and caseload, and this was occasionally also the case in Scotland.

[Figure 3](#) provides a visual representation of appointments offered per site, which further highlights the variability of numbers of appointments offered within and between the four sites.

Figure 2 Caseload by site between April 2021 and September 2022



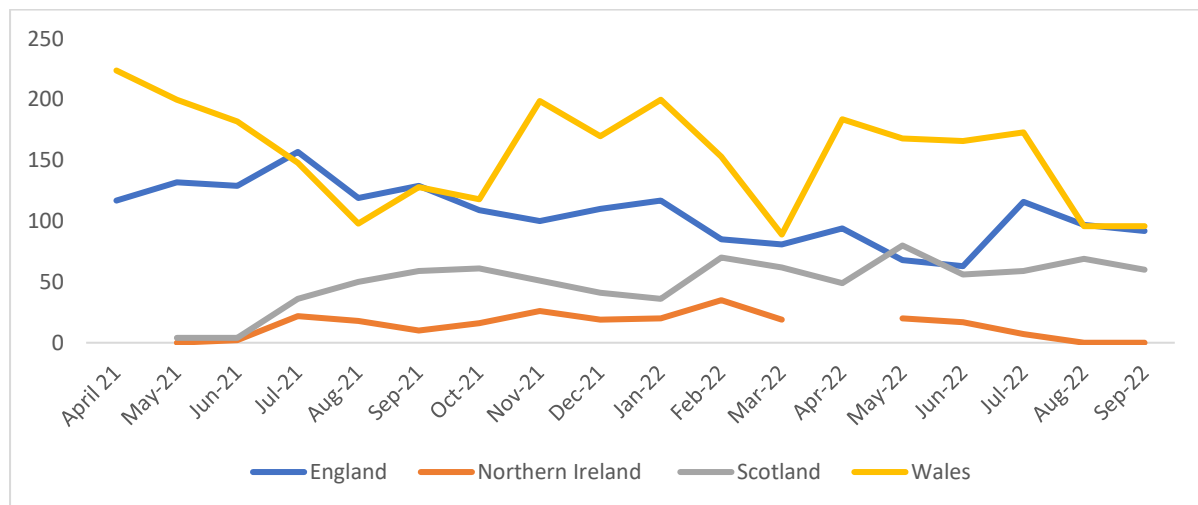
Note. Source: Monitoring data provided by each site.

Table 3 Navigator appointments offered, attended and not attended by site and quarter between April 2021 and September 2022

		April-June 21	July-Sept 21	Oct-Dec21	Jan-March 22	April-June 22	July-Sept 22	Total
England	Appointments offered	378	405	319	283	225	305	1931
	Appointments attended	332	344	264	237	181	249	1607
	Did not attend appointment	46	61	55	46	44	56	308
Northern Ireland	Appointments offered	2	50	61	74	37	7	231
	Appointments attended	1	30	51	65	28	7	182
	Did not attend appointment	1	20	10	9	9	0	49
Scotland	Appointments offered	8	145	153	168	185	188	847
	Appointments attended	7	117	135	138	165	168	730
	Did not attend appointment	1	28	18	30	20	20	117
Wales	Appointments offered	606	374	487	442	518	365	2612
	Appointments attended	538	329	396	383	456	305	2407
	Did not attend appointment	68	45	91	59	62	60	385
Total	Appointments offered	994	974	1020	967	965	865	5785
	Appointments attended	878	820	846	823	830	729	4926
	Did not attend appointment	116	154	174	144	135	136	859

Note. Source: Monitoring data provided by each site.

Figure 3 Appointments offered by site between April 2021 and September 2022

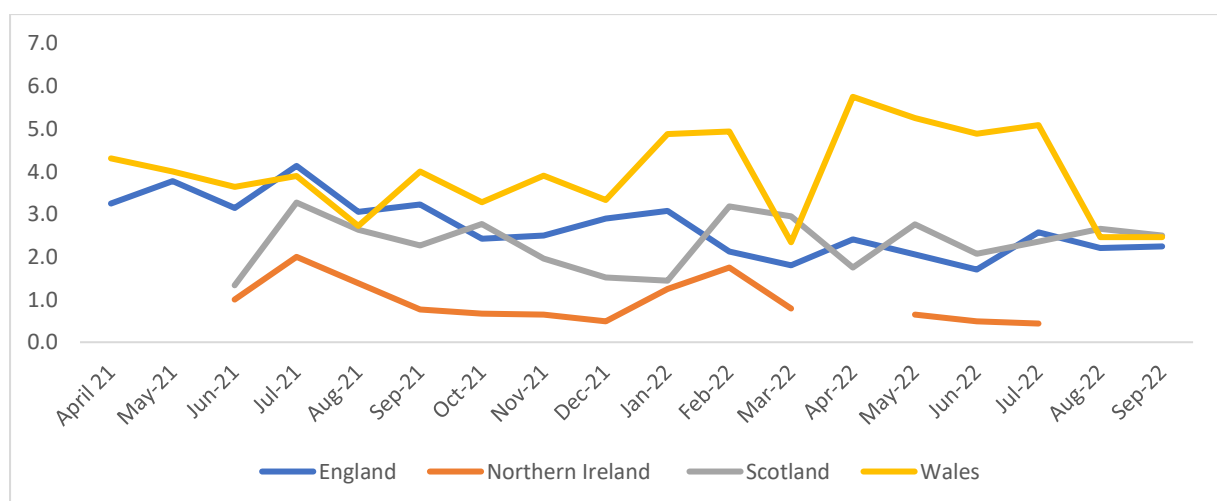


Note. N=5785; Source: Monitoring data provided by each site.

Appointment rates

A comparison of the number of appointments offered with the monthly caseloads shows that the appointment rate per person (or case) supported also differed per site. On average, Wales had the highest average number of appointments offered per case (4.0), and NI, the lowest (0.9). For England, the average number of appointments offered per case and month ranged from 1.7 to 4.1, in Northern Ireland from 0.4 to 2.0, in Scotland from 1.3 to 3.3 and in Wales from 2.3 to 5.8 (see [Figure 4](#) for an overview). Across all sites, the average number of appointments offered per case within a month was 2.9. Bearing in mind the challenges experienced in NI, if these figures are taken out, it appears that there were on average 3.1 appointments per person per month. Without raw data identifying the specific number and length of appointments each person supported by a navigator received, it has not been possible to analyse the range of appointments provided and identify the level of support required for different needs. As the report goes on to explore, the support could look vastly different for each person.

Figure 4 Appointment rate by site between April 2021 and September 2022



Note. Appointment rate = Number of appointments / caseloads; Source: Monitoring data provided by each site.

Length of support

Monitoring data shared with the evaluation team did not provide detail about the length of time navigators supported people. However, data from a small sample of service users in Wales (n=22, representing 11% of referrals within the period), shows a wide range of engagement periods from 1 month to over 7 months, and an average of 3.5 months engagement per person. Interviewees reported that support could range from a few weeks to over a year, though only a few people would receive support for this long.

2.3 Types of support offered

The most common types of support that navigators reported providing continued to be ongoing mental health support and financial stability support. [Table 4](#) shows the six forms of support which were consistently reported from most to least common between February to September 2022. The table also includes an indication of the change in rank since the interim report (covering April 2021 to January 2022). This shows that there were only small changes in the ranking of support types.

Table 4 Most common forms of support provided to clients between February and September 2022

	England		Northern Ireland		Scotland		Wales	
1	Financial stability/ support	=	Ongoing mental health support	=	Ongoing mental health support	=	Ongoing mental health support	=
2	Ongoing mental health support	+1	Social groups & activities	=	Social groups & activities	=	Financial stability/ support	=
3	Substance misuse support	-1	Financial stability/ support	=	Financial stability/ support	=	Accommodation/ housing support	=
4	Social groups & activities	+2	Employment support	+2	Accommodation/ housing support	=	Social groups & activities	=
5	Accommodation/ housing support	=	Substance misuse support	-1	Employment support	=	Employment support	+1
6	Employment support	-2	Accommodation/ housing support	-1	Substance misuse support	=	Substance misuse support	-1

Source: Monitoring data provided by each site.

In England, for example, proportionally fewer people required employment support and in Scotland, there was no change in ranking of support.

Unsurprisingly, bearing in mind that the pilot was designed for people presenting to local healthcare services with mental health issues, ongoing mental health support represented much of the work undertaken. Together with data on beneficiary characteristics, presented in the [next section](#), this highlights that navigators were supporting the target population for this intervention. And, together with the reported level of referrals and caseloads, it indicates that this type of support was needed.

One navigator pointed out that there were two levels of support required in general. For instance, while some people simply needed to be given information relevant to their issues and directed towards an appropriate service, there were others who needed a much higher level of support. One person might need help with a range of issues, such as accessing benefits advice, joining a local community group, and ongoing emotional support. The importance of having the navigator to support those

with a greater level of need was emphasised by a member of health service staff, who suggested that signposting to services can be less effective for people with mental ill health. This is because it relies on them having the motivation to independently contact that new service. In contrast, the navigator can support individuals directly by helping them make or even accompanying them to appointments.

For some people, the navigator supported them to regain employment, receive benefits and sell property. One navigator commented that they made the most referrals to the Money Advice Service. Another navigator talked about how they had supported people to access food banks, which in turn meant they then had the necessary funds to pay for transport or fuel.

[Table 5](#) presents service users' responses around the follow-up support they accessed with the help of the navigator. Firstly, the table shows that different types of further support were more common than others, as indicated by the number of 'not relevant' responses. Support with finances appears to be the most popular, followed by housing or accommodation, and then, support with other treatments. Secondly, those who responded to the survey believed that they accessed this support because of the navigator's help. The proportion of respondents who agrees with each of the items ranges between 60% and 100%, indicating that navigators helped people access relevant services, and again that it was needed.

“Even though at times you could not help me, sometimes you put me in the right direction and you were there for me to guide me” Service user

Table 5 Responses to the question “As a result of seeing the navigator, the services I have accessed are helping me to address problems I have with...”

	Disagree	Neutral	Agree	Not relevant
Alcohol or substance misuse / addiction	0	0	3	22
Employment, work, or occupation	2	0	6	17
Training and / or education	1	1	3	20
Housing or accommodation	1	2	11	11
My financial situation (debt, access to benefits/income support etc.)	1	1	17	6
Parenting or caring responsibilities	0	2	7	16
Social, cultural, or spiritual needs	1	4	10	10
Personal care, physical well-being, or medical treatment	1	3	10	11
Other forms of treatment I am receiving (including psychological ones)	1	2	11	11

Note. N=25; site = Wales and Scotland; The categories “Strongly disagree” and “Disagree” were merged into “Disagree” and the categories “Strongly agree” and “Agree” were merged into “Agree”.

Survey results were also supported by interview data. For example, one interviewee mentioned specific social groups that the navigator had signposted them towards, through which they were able to make new friends and get their “*life back on track again*”. One navigator highlighted how important these referrals to social groups were, particularly for men, because of very limited opportunities for socialising and discussing mental health in an informal environment (See also [Section 3.1.6](#), which explores access to social/community activities).

“It’s an opportunity for people with mental health issues to be in an environment where people understand.” Navigator

Service users interviewed highlighted how having the navigator sit next to them, while they turned on their laptop or made a phone call, made an important difference in increasing their confidence to tackle activities they found anxiety-provoking:

“She actually came, bless her, and sat beside me while I put on the laptop and while I made phone calls and I needed that level of support at that time.” Service user

As we go on to explain, many people supported might be facing significant struggles with their mental health. Therefore, this type of support, not available elsewhere, was key to helping them address practical needs, access further help, resolve difficulties that might be exacerbating mental ill health and make improvements in a number of areas, as explored in [Chapter 3](#).

2.4 Characteristics of beneficiaries

This section gives an update on the characteristics of primary beneficiaries ([Section 2.4.1](#)) and secondary beneficiaries ([Section 2.4.2](#)). Despite the interim report highlighting demographic monitoring data gathering as an area for improvement, this unfortunately was not addressed. Since the interim report, only some data on gender and age categories were shared by NI, Scotland and Wales. Interviews and health and wellbeing scales completed at baseline by a further 59 people indicate an overall drop in health and wellbeing of those people seeking help from navigators, as this section goes on to discuss.

2.4.1 Demographics of people supported by navigators (primary beneficiaries)

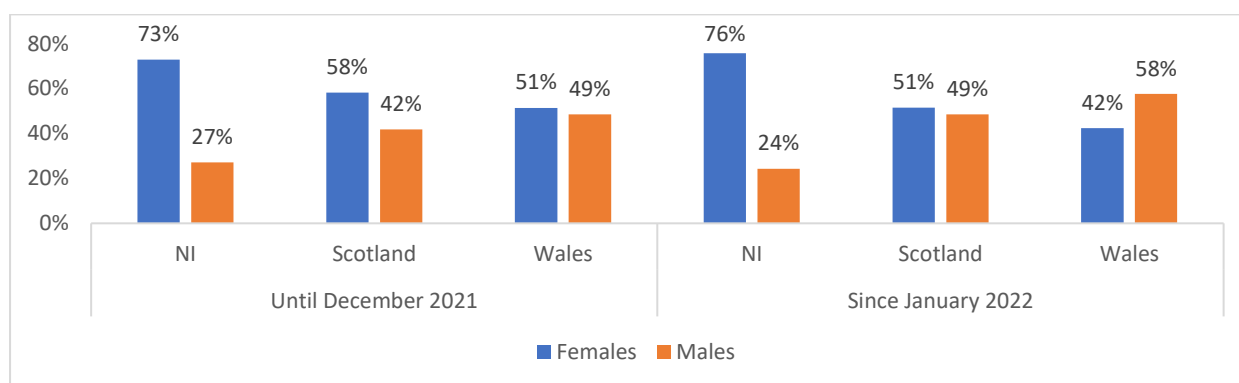
Due to limited demographic data collated by navigators and/or MHUK partner organisations, it is not possible to comprehensively update on the overall demographics of the population being supported by navigators. Demographic data from the 520 people shared in the interim report represents the best picture of what is known at a quantitative level. To recap, from the period June to December 2021 for NI and Scotland, and May 2020 to December 2021 for Wales and England, this is as follows:

- In all sites, the proportion of females was higher than for males (ranging from 55% to 68%).
- Most participants were White British (88% across all sites).
- The most common primary mental health diagnoses were depression and anxiety disorder; the client profile regarding mental health diagnosis was slightly different in Wales with higher proportions of clients with Psychosis and Schizophrenia.

In addition to this data, some further gender and age monitoring data for 226 people (for the period January 2022 onwards) were shared by NI, Scotland and Wales for all new referrals received. However, with age categories monitored only covering the age ranges of under 20 and over 20, it is not very meaningful to share, as support was not provided for young people under 18 years.

Comparing the gender distribution for the time periods until December 2021 and from January 2022, Scotland and Wales supported a higher proportion of males in the second part of the pilot. For Wales, the proportion of male service users was overall higher than females. NI continued to support a higher level of females seeking support (see [Figure 5](#)).

Figure 5 Gender distribution in Northern Ireland, Scotland and Wales



Note. N=184 and N=226. *Source.* Monthly monitoring data provided by each site. Northern Ireland covers June 2021 to July 2022; Scotland June 2021 to December 2022 and Wales July 2021 to September 2022.

Whilst demographic monitoring data was not received from the England site, interviewees reported that extensive demographic data was being collected as part of NHS monitoring of patients. However, getting consent for collating and sharing this data for the purposes of this evaluation was experienced as an additional burden for people receiving support and for local staff.

It is also worth noting that some internal work was undertaken by Rethink’s policy team on behalf of MHUK (Access for All report, January 2023), to better understand the ethnic diversity of people supported by navigators, considering barriers to access in relation to ethnicity and making some recommendations. Unfortunately, this was not shared with the evaluation team at the time but could provide some useful information in relation to addressing health inequalities and access to navigation services for Black and minoritised people in future.

Before reporting on the health and wellbeing demographic data reported at baseline by people who consented to engage in the evaluation, some interviewees reported that, since the interim report:

- levels of anxiety of people seeking support seemed to be higher than in earlier stages of the pilot, partly perhaps due to increased financial difficulties relating to the cost-of-living crisis.
- some people may have previously been living satisfactorily with existing mental health conditions, such as bi-polar. However, their mental health had taken a downturn due to, for instance, a redundancy, housing issues and/or financial

difficulties. Some of these changes were reported to be an impact of the COVID-19 pandemic.

- the England navigator reported continuing to see a high number of people with substance misuse issues (in the interim report, this was 30% of the supported population). Likewise, there was one report of a higher population of sex workers than had been anticipated as well as people experiencing domestic violence.
- in Wales and Scotland, there were reportedly several people referred who were waiting for other healthcare services – e.g. for diagnosis around potential ADHD and/or Autism. However, waiting lists for these services were so long, the navigator was providing practical and emotional support in the meantime.
- there were a few reports of people seeking support who were living with the impacts of trauma, including childhood trauma.

Health and wellbeing baseline demographic data - SWEMWBS & EQ-5D

People supported by navigators were asked to complete two psychometric measures as part of their baseline questionnaire. These were the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) and the EQ-5D, to assess participants' health-related quality of life.

- **SWEMWBS** is the short version of the Warwick–Edinburgh Mental Wellbeing Scale. The scale consists of seven items, each to be rated on a 5-point Likert-scale. Scoring involves summing up the scores of each item to a sum score ranging from 7 to 35, and then transforming the raw score to a metric score, with higher scores indicating higher levels of wellbeing.⁵
- **EQ-5D** is a standardised measure of health-related quality of life developed by the Euroqol group. Three different versions of the measure exist: EQ-5D-5L, EQ-5D-3L and EQ-5D-Y. The EQ-5D-3L was used in this evaluation and measures five dimensions of health: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression on three levels: no problems (Level 1), some problems (Level 2), and extreme problems (Level 3). An additional scale measures patient's self-rated health on a scale from 0 (worst health) to 1 (best health), which is called the EQ VAS.⁶

Of the 95 survey respondents that completed the SWEMWBS at baseline, the average score was 15.8 (SD=4.28). The lowest wellbeing being score was 7 and highest 25. This is significantly lower than the SWEMWBS population norms of 23.6 according to the health survey for England ($p<.001$).⁷ Comparing this to the average score reported in the interim report (based on 34 responses), shows that the average

⁵ <https://www.corc.uk.net/outcome-experience-measures/short-warwick-edinburgh-mental-wellbeing-scale-swemws/#:~:text=The%20SWEMWBS%20is%20a%20short,aim%20to%20improve%20mental%20wellbeing>

⁶ <https://euroqol.org> ; EuroQol Research Foundation (2021). EQ-5D-3L User Guide - Basic information on how to use the EQ-5D-3L instrument.

⁷ Ng Fat, L., Scholes, S., Boniface, S., Mindell, J., & Stewart-Brown, S. (2017). Evaluating and establishing national norms for mental wellbeing using the short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS): findings from the Health Survey for England. *Quality of Life Research*, 26, 1129-1144.

baseline wellbeing score has slightly decreased from 17.8 (SD=7.9) to 15.8 (SD=4.28). This supports the feedback from navigator interviews.

Regarding the EQ-5D, only 4 of the 92 people who completed the questions about four of the dimensions reported no problems across all four dimensions (the last dimension has been excluded from the analysis due to only partial data being recorded on this). This means that most respondents had at least some problems in at least one area. More than one-third (36%) reported having at least some problems in all four areas. Comparing these proportions to those in the interim report (based on 36 responses) shows fewer reports of no problems in each of the areas. Furthermore, all 52 respondents who completed the dimension ‘anxiety/depression’ reported to be at least moderately anxious or depressed (see [Table 6](#)).

Of the 95 survey respondents who completed the EQ VAS at baseline, the average health score was 33.8 (SD 22.42) with a range from 0 to 87. This mean score was significantly lower than the average for the general population (82 for females and 83 for males) according to the population survey in the UK ($p<.001$).⁸ This was also slightly lower than the interim report average of 36.1 (SD=22.81).

Overall, the profile of patients seemed to have slightly changed, though limited demographic data prevents a comprehensive assessment of this. However, as with SWEMWBS, this is supported by interviewees who felt that the health and wellbeing of the people being referred seemed to have worsened over the pilot’s lifespan.

Table 6 EQ-5D-3L results for five dimensions at baseline

	No problems			Some problems		A lot of problems	
	N	n	%	N	%	n	%
Mobility	95	43	45%	38	40%	14	15%
Self-care	92	44	48%	35	38%	13	14%
Usual activities	94	9	10%	44	47%	41	44%
Pain/discomfort	94	28	30%	30	32%	36	38%
Anxiety/depression	52	0	0%	21	40%	31	60%

2.4.2 Characteristics of healthcare staff (secondary beneficiaries)

Fewer health service staff took part in the second round of surveys and interviews since the interim report (see [Appendix 2](#)). This can be seen to reflect the increased pressures on the healthcare system, with some people who were contacted for interviews being off with ill-health, others had changed job roles or were otherwise unavailable. In addition, when the pilot was designed, it had been anticipated that a larger number of healthcare staff would have knowledge of and contact with the navigation service. As it transpired, the identified group of people for receiving

⁸ Kind, P., Hardman, G., & Macran, S. (1999). *UK population norms for EQ-5D* (No. 172chedp).

surveys or to be contacted for interviews was much lower, making any statistical analysis of this population non-viable.

2.5 Learning points from CMHN Pilot delivery

As can be seen from the monitoring data reported in this chapter, navigators received a high number of referrals, with a high number of appointments offered and taken up. Interview data suggests that there was an ebb and flow of referrals, and therefore in caseloads and numbers of appointments offered.

“You get a couple of quiet weeks and you think ‘ohh what’s going on? I’ve not had many referrals’ and then all of a sudden you get like 5 in a week”

Navigator

Overall, it seems that a considerably higher number of people were supported than had been anticipated during the project design. It is not possible to understand in detail what this support looked like in relation to length of appointments, or how much time support might take for specific needs. Interview data indicated that the overall timespan of support was more varied than expected, ranging from a few weeks to over a year. This variability in time spent with different people perhaps partly explains how navigators were able to support a significantly higher number of people than planned. It also indicates the flexibility of the service which is further explored in the next section. Interviews and quantitative data suggest though that the CMHN Pilot has been a popular referral and support route for primary and secondary beneficiaries.

The overall health and wellbeing of those that completed surveys at baseline was lower than the general population and there is some evidence that the health and wellbeing needs of those referred increased since the interim report. From what can be seen from the demographic data recorded, the target population of people for this intervention has been successfully reached. As predicted, navigators provided people with support for a range of non-clinical needs, as well as offering ongoing emotional support that healthcare staff such as GPs and mental health nurses would not have time to provide.

In summary, the navigators seemed to fill a gap in supporting people with mental health diagnoses, or who were experiencing deteriorating mental health, with their non-clinical needs. The demand for support however, and the possibility that navigators were being referred some people who might have needed healthcare attention from a clinician, is explored in later sections. Likewise, the level of demand is a concern in relation to navigators’ health and wellbeing, as discussed in [Section 4](#).

First, however, the report goes on to explore the outcomes reported for people receiving navigator support.

3. What outcomes were achieved by the CMHN Pilot?

This chapter reports on outcomes observed since the start of the CMHN Pilot, in response to the following evaluation questions:

- What were the impacts of the pilot on primary and secondary beneficiaries?
- To what extent can changes be attributed to the pilot?

- What was the ratio of costs to benefits?

The original intended aim of the evaluation was to provide a deeper understanding of whether the CMHN Pilot was effective at:

- reducing the number of non-clinically solvable primary care appointments and attendances.
- improving service users' mental health and helping them to access the support they needed.

However, as explained in [Section 1.3](#), it was not possible to gain healthcare appointment data from hosting sites and therefore it is not possible to say whether non-clinically solvable appointments were reduced because of navigator support. Due to the lack of demographic data shared, it is also not possible to comment on potential different impacts for different sub-groups. However, as [Appendix 1](#) shows, the Theory of Change identified a range of medium and long-term outcomes, leading towards the ultimate impacts expected due to implementing a CMHN service. Evaluation methods and tools were designed to capture any evidence that would indicate that these outcomes and progress towards impacts were being met.

This chapter begins by exploring the outcomes observed for primary beneficiaries – the people supported by navigators ([Section 3.1](#)); followed by outcomes for secondary beneficiaries – healthcare staff ([Section 3.2](#)); going on to consider the sustainability of outcomes observed ([Section 3.3](#)); the extent to which any changes can be attributed to the pilot ([Section 3.4](#)); and ending by exploring the ratio of costs to benefits of delivering a CMHN service ([Section 3.5](#)). It builds on insights described in the Interim report, and is based on the following data:

- interviews with MHUK staff, local NHS health service staff in England, Wales and Scotland (including follow-up interviews) and people supported by navigators.⁹
- survey responses from healthcare staff at baseline and follow-up.
- survey responses from service users at baseline (towards beginning of support), follow-up (towards end of support) and at three months following the end of support.

As mentioned in [Section 1.1](#), the Northern Ireland CMHN Pilot completed prematurely. Therefore, there is no interview or survey data from NI since March 2022.

3.1 *What outcomes were observed for primary beneficiaries (people supported by navigators / service users)?*

The Theory of Change ([Appendix 1](#)) outlines the anticipated medium and long-term outcomes and ultimate impacts for people being supported by navigators. This section presents data analysis which indicates that the following medium-term outcomes were successfully being achieved for primary beneficiaries.

⁹ No-one contacted in Northern Ireland was available to be interviewed.

- The non-clinical needs of people experiencing mental illness were better met ([Section 3.1.1](#)).
- Beneficiaries had decreased anxiety/ exacerbation of health or mental health conditions due to non-clinical needs and wider social/economic issues ([Section 3.1.2](#)).
- Improved health outcomes over a longer time period, including physical and mental health, and quality of life ([Section 3.1.3](#)).
- Better engagement in and maintenance of positive health behaviours ([Section 3.1.4](#)).
- Better adherence to clinical and non-clinical treatments ([Section 3.1.5](#)).
- Access to and engagement in social/community activities ([Section 3.1.6](#)).

It updates on qualitative analysis presented in interim report and integrates quantitative evidence from follow-up survey data, which was limited in the interim report due to the small sample size at that point. However, caution is needed when interpreting data presented, due to the small sample of people interviewed and survey responses. It is also worth noting that whilst explored separately, each of these different outcomes are in some cases connected with each other, as anticipated by the [Theory of Change](#). For instance, someone whose non-clinical needs are being better met may experience a positive impact on their mental health, which in turn may impact on their ability to engage in more positive physical health behaviours and/or better engage with other treatments and access more social and community activities.

3.1.1 The non-clinical needs of people experiencing mental illness were better met

Interviewees continued to report that navigators helped people in addressing non-clinical needs. Some interviewees commented that this kind of support had not previously been available. In addition, the proactive nature of the support, more than just signposting people, seemed to be of particular benefit to people experiencing mental illness.

Healthcare staff who responded to the evaluation survey all agreed that the CMHN service was an effective model to manage people's non-clinical needs, with two responding with 'probably' and three with 'definitely'.

“So as opposed to service users having to navigate really quite a complex system, [navigator's] role has helped people [...] get the right service for their needs.” Health service staff

This takes us onto the next outcome, which shows how this type of help could make a difference to people's mental health and wellbeing.

3.1.2 Beneficiaries had decreased anxiety/exacerbation of health or mental health conditions due to non-clinical needs and wider social/economic issues

The interim report shared evidence that service users reported feeling less anxious around social issues because of the help received with non-clinical needs. These positive reports have continued, with interviewees giving examples of how navigators

supported people with a range of non-clinical needs, which positively impacted their physical and mental health.

“I was able to do things that I hadn’t been able to do by myself, and that then impacted on my mental health, actually being able to do the things that were causing me extreme distress.” Service user

Health service staff emphasised the importance of the navigator in helping to relieve the social stressors and practical issues faced by service users that were contributing to their mental ill health. When discussing the non-clinical needs that the navigator had helped them meet, all interviewed service users talked about how this had had a knock-on impact on their mental health, particularly in relation to:

- improved mental health and wellbeing e.g., improved confidence, self-worth and purpose.
- improved physical health and quality of life.

Many examples were given of the different ways in which the navigator had directly supported people around issues such as physical health, finances and social activities.

Vignette 1: How a navigator’s support with non-clinical needs helped improve a person’s anxiety

Since losing his job, Terry was struggling financially, with stress and anxiety levels growing to the point that they became difficult to manage. When he first met the navigator, they worked around Terry’s needs, visiting him in his home, because anxiety prevented him from meeting in unfamiliar venues. The navigator supported Terry to apply for benefits, sitting next to him while he made the necessary phone calls. They also encouraged Terry to apply for increased Personal Independence Payment benefits, which he hadn’t considered before. The navigator explained that Terry was entitled to this support and helped with the application.

In addition, the navigator signposted Terry to a local service that taught employment skills. When Terry felt able to apply for jobs, the navigator looked for jobs that might be of interest and sent them to him. At other times, they would phone an employer on Terry’s behalf to explain, if he felt he needed to withdraw an application because of anxiety. This extra support reduced the stress and pressure that Terry felt. Lowered anxiety levels meant that Terry was able to sleep a lot better than he had before receiving navigator support.

Improved mental health and wellbeing

Service users who were interviewed reported that their outlook on life and their sense of wellbeing had improved as a direct result of interventions by the navigator targeted at improving their mental health. This data was supported by responses from service users who completed the SWEMWBS measures at the beginning and end of their engagement with the navigation service.

Comparing the SWEMWBS metric baseline score with the follow-up score, showed an increase in the average from 15.4 (SD=4.09) to 19.9 (SD=4.45) for the 42 individuals who completed both surveys. This difference is statistically significant

($p < .001$). The effect size Cohen's d , a measure of the magnitude of the mean difference, equates to 1 which can be interpreted as large according to conventions (Cohen, 1988). This difference was not statistically significant in the interim report due to the small sample size at that point. At 19.9, the average score at follow-up is still significantly lower than the UK population mean ($p < .001$). However, it is much closer to the average than the baseline value.

Looking at the individual change score of service users, the vast majority (89%, $n=37$) had a higher wellbeing score at follow-up than at baseline. Two did not show a change and only three service users showed a decrease in their wellbeing score. Furthermore, health service staff (3 out of 5) who completed the follow-up survey also reported that the navigator helped to improve their patients' quality of life and mental health, at least to a moderate extent.

“The navigation service and support in [site] has been crucial for my mental health wellbeing and should not be underestimated. They deal with the fallout of the unseen mental and unseen wounds which can be more debilitating in some cases than a visible physical disability.” Service user

Vignette 2: An experience of improved mental health due to navigator support

Kim had been in and out of mental health services for a long time and had a sense of not achieving very much in life. After being referred to the navigator, Kim felt she had found someone who gave her the emotional support she had always needed. The navigator would call Kim a couple of times a week to check that she was okay and helped convince her that any task, no matter how small, was an achievement. This helped Kim build self-worth. In addition, the navigator asked Kim to keep a diary of what she did and how she felt during the day, so as to identify what the triggers might be for 'down periods', to help put things in place to manage these. Kim felt she had gained more control over her life, due to knowing where her triggers were coming from and how to adjust to them. As a result of the navigator's support, she also now felt much more comfortable talking about her mental ill health with her friends and family, which meant that they were now able to support her at times when she was feeling low.

One service user even attributed the navigator's support with prevention of a further crisis in their mental health. The navigator's help in talking through some of the person's difficulties gave them hope:

“It probably saved my life. If not for [navigator] I don't know what I would have done or where I would be.” Service user

Improved confidence, self-worth and purpose

Two service users attributed their work with the navigator as having helped them to accept and come to terms with their mental ill health, and one talked about exercises they had been given to improve their confidence. Service users also reported a greater sense of self-worth after being taught to value everyday achievements like getting out of bed and cleaning teeth:

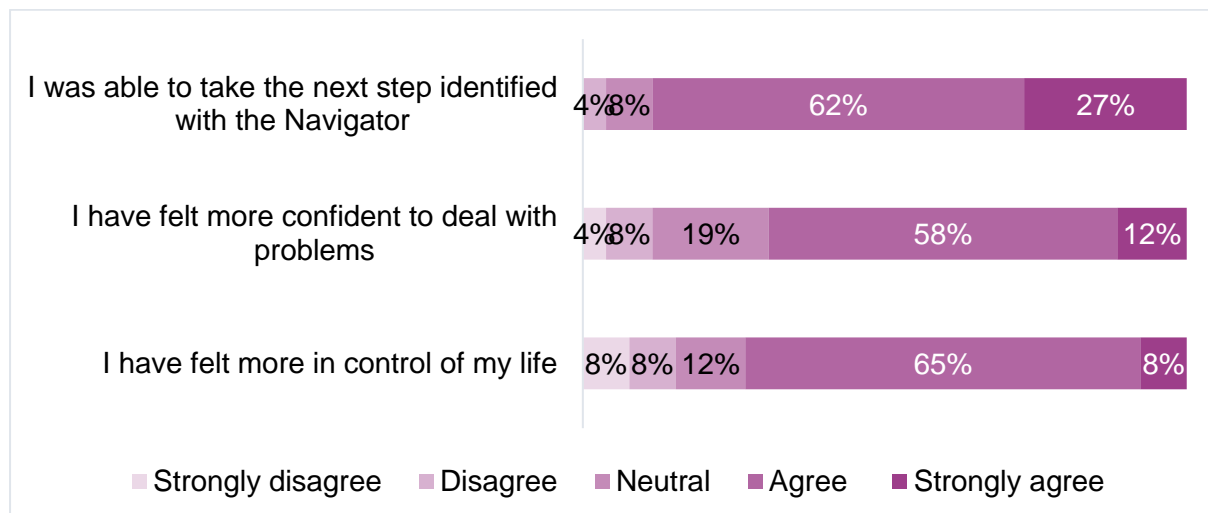
“Just reassurance that actually I was achieving and that what I was doing was actually fine, it was enough.” Service user

This outcome of increased confidence and self-worth is also supported by survey data. Responses to the follow-up survey of services indicated that about 7 out of 10 people felt they had more control of their life and felt more confident to deal with their problems (see [Figure 6](#)). The vast majority of the 26 follow-up respondents (88%, n=23) further stated that they were able to undertake the next steps identified with the navigator.

“It has been an amazing help. Before using the navigation service I barely left the house, had no motivation or hope about the future. Now I am applying for jobs, volunteering and feeling a lot more optimistic about my future.” Service user

Most responses (4 out of 5) from the healthcare staff follow-up survey also reported that the navigation service had given people more confidence to manage their health.

Figure 6 Responses to the question “As a result of seeing the navigator.”



Note. N=26; Site=Wales and Scotland; Source: Service user follow-up survey.

Stakeholders also said they believed that an important impact the navigator had was giving people “*direction ... meaning and purposefulness*” by setting goals and helping them to feel that their problems were going to be solved. One project stakeholder agreed that the ability of the navigator to give service users “*some hope that something can help them*” was an important aspect of the service. They felt this was particularly important during COVID-19 lockdowns because of increased mental health needs during this time. One navigator reported feeling that they had an indirect impact on a person’s mental health, through conversations which led to the realisation that there was important information, previously undisclosed to healthcare staff. The navigator, with the person’s permission, got in touch with the relevant healthcare professional, which led to the service user being reassessed.

Improved physical health and quality of life

In addition to mental health improvements, service users who completed the EQ-5D at the beginning and end of their engagement, reported improved physical health and quality of life. [Improved health](#) outcomes over a longer time period, including improved physical and mental health and quality of life.

There is some, although very limited, evidence on mental and physical health outcomes being sustained over a longer period. The repeat of the service user survey three months after the end of support from a navigator, shows that an improvement in wellbeing (SWEMWBS) as well as overall health (EQ-VAS) was sustained for the six or seven individuals who completed the scales at all three time-points ([Table 7](#)). For SWEMWBS there was a slight reduction in the average wellbeing score at three months, following an initial significant increase at follow-up. For the self-reported health score, a small increase at three months was measured after a sharp initial increase at follow-up. The difference in the wellbeing scores was statistically significant ($p < .05$), whereas the difference in the health scores was not ($p = .14$).

Table 7 SWEMWBS and EQ-VAS descriptive statistics for baseline, follow-up and 3-months follow-up

	Baseline			Follow-up		3-mths follow-up	
	N	M	SD	M	SD	M	SD
SWEMWBS	7	15.4	2.12	20.6	3.46	19.8	3.43
EQ-VAS	6	24.8	28.20	47.0	28.07	52.8	8.73

Note. N=6 and N=7. M refers to the mean and SD to the standard deviation; Source: Service user baseline, follow-up and three-months follow-up survey.

One navigator pointed out though that the sustainability of these improvements in mental health would be different from person to person since some people “*will always have an element of anxiety and low mood*”. They had experience of successfully supporting some people who then returned to the service a year later when their circumstances had changed. For these individuals, the navigator saw their role as being more about helping them to manage their triggers rather than necessarily providing long-term solutions. This point is returned to in Section 3.3.

shows the change in the number and proportion of service users reporting problems regarding their mobility, their ability to undertake self-care and usual activities, their pain and anxiety levels. Improvements were found in all five areas, meaning that the proportion of individuals reporting at least some problems per area decreased from baseline to follow-up completion of the EQ-5D scale. The largest reduction was found for the anxiety dimension, with a 23% decrease in service users reporting problems. The smallest improvement was found for self-care and mobility, a 4% change in the number of people reporting any problems.

Table 8 Numbers and proportions for the five dimensions of the EQ-5D-3L comparing baseline and follow-up responses.

	Mobility		Self-care		Usual activities		Pain/discomfort		Anxiety/depression	
	T0	T1	T0	T1	T0	T1	T0	T1	T0	T1
No problems	22 (48%)	24 (52%)	20 (44%)	22 (48%)	4 (9%)	12 (26%)	13 (28%)	18 (39%)	0 (0%)	6 (23%)

Some problems	19 (41%)	18 (39%)	17 (37%)	17 (37%)	22 (48%)	22 (48%)	14 (30%)	16 (35%)	10 (38%)	12 (46%)
A lot of problems	5 (11%)	4 (9%)	8 (17%)	6 (13%)	20 (43%)	12 (26%)	19 (41%)	12 (26%)	16 (62%)	8 (31%)
Total	46 (100%)	46 (100%)	45 (100%)	45 (100%)	46 (100%)	46 (100%)	46 (100%)	46 (100%)	26 (100%)	26 (100%)
Reporting at least some problems	24	22	25	23	42	34	33	28	26	20
Change in N reporting problems	2		2		8		5		6	
% change	4%		4%		17%		11%		23%	

Note. N=26-46. T0 refers to the baseline completion and T1 to the follow-up completion of the scale;
Source: Service user baseline and follow-up survey.

In addition, the average health score, which represents service users' own assessment of their health on the day of completion, showed a further improvement from baseline to follow-up. For the 46 service users who completed the scale at both time points, the average increased from 33.1 (SD=22.76) to 52.7 (SD=25.67). The difference of 19.6 is statistically significant ($p<.001$) and indicates a medium effect according to Cohen's conventions (Cohen's $d = .76$). The average health score at follow-up is still significantly lower than the population average ($p<.001$), though, as with the EQ-5D, in terms of actual difference considerably closer to the population average. Looking at changes for individuals yields an improvement in the health score for the majority of the 46 service users (82%, $n=38$), although five showed a lower health score at follow-up and the score for three people showed no change.

3.1.3 Improved health outcomes over a longer time period, including improved physical and mental health and quality of life.

There is some, although very limited, evidence on mental and physical health outcomes being sustained over a longer period. The repeat of the service user survey three months after the end of support from a navigator, shows that an improvement in wellbeing (SWEMWBS) as well as overall health (EQ-VAS) was sustained for the six or seven individuals who completed the scales at all three time-points (see [Table 9](#)). For SWEMWBS there was a slight reduction in the average wellbeing score at three months, following an initial significant increase at follow-up. For the self-reported health score, a small increase at three months was measured after a sharp initial increase at follow-up. The difference in the wellbeing scores was statistically significant ($p<.05$), whereas the difference in the health scores was not ($p=.14$).¹⁰

Table 9 SWEMWBS and EQ-VAS descriptive statistics for baseline, follow-up and 3-months follow-up

	Baseline			Follow-up		3-mths follow-up	
	N	M	SD	M	SD	M	SD
SWEMWBS	7	15.4	2.12	20.6	3.46	19.8	3.43
EQ-VAS	6	24.8	28.20	47.0	28.07	52.8	8.73

Note. N=6 and N=7. M refers to the mean and SD to the standard deviation; Source: Service user baseline, follow-up and three-months follow-up survey.

One navigator pointed out though that the sustainability of these improvements in mental health would be different from person to person since some people “*will always have an element of anxiety and low mood*”. They had experience of successfully supporting some people who then returned to the service a year later when their circumstances had changed. For these individuals, the navigator saw their role as being more about helping them to manage their triggers rather than necessarily providing long-term solutions. This point is returned to in [Section 3.3](#).

¹⁰ Due to the small sample size a non-parametric test was conducted as assumptions for a parametric test were not met.

3.1.4 Better engagement in and maintenance of positive health behaviours

Most commonly, service users reported improved engagement in positive health behaviours, that might impact on their mental and/or physical health. For instance, one service user described how the navigator had encouraged them to go for walks, swim, and go to the gym. These activities not only improved their fitness but also helped “*take [their] mind off things*”. The navigator would also check in with them to help ensure that they were eating properly and encouraged them to start cooking. Not only did the person achieve a healthier weight than before, but through cooking they also enhanced their opportunities for social interaction: “*When I cook, I usually invite people round. I’m looking forward to them coming round*” (Service user). This links to the outcome of having access to and engagement in social/community activities ([Section 3.1.6](#)).

3.1.5 Better adherence to clinical and non-clinical treatments

There were some suggestions that the CMHN Pilot led to a better adherence to clinical and non-clinical treatments by service users, although this evidence was limited. For instance, one person reported that since receiving support from the navigator, they now engaged with other professionals and did not “*just hang the phone up on them*”. In addition, one navigator reported that helping arrange GP appointments or suggesting a medication review, increased service users’ engagement with health services. Another navigator commented that they believed that the people they supported were more engaged in medical treatment because of this support.

“I think [suggesting a medication review] encourages a lot of people to go back and do that, when they perhaps wouldn’t normally do anything because they think they’re wasting the GP’s time.” Navigator

This proactive approach to seeking medical help indicates the potential of a navigation service to reduce crises and the need for emergency care. Healthcare staff follow-up survey responses (4 out of 5) also reported that navigators helped service users engage more with other treatments.

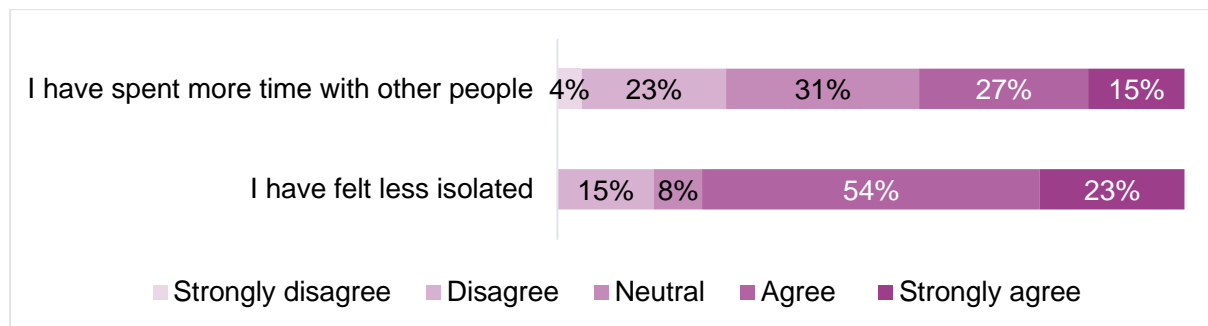
3.1.6 Access to and engagement in social/ community activities.

All service users interviewed said that they were engaging more with friends and family compared to before receiving navigator support. Responses to the follow-up service user survey also indicated a positive effect on connectedness with others (see [Figure 7](#)). More than three-quarters (77%, n=20) agreed that they felt less isolated because of the navigation service, although a smaller number of respondents thought they had spent more time with others as a result of the navigator’s support (42%, n=11). Most responses (4 out of 5) from the healthcare staff follow-up survey also agreed that the navigation service had reduced patients’ social isolation. As the quote below suggests, navigators were fulfilling the aspect of their roles around supporting people to access other activities, potentially helping reduce isolation. [Section 2.3](#) provides additional data on support with accessing social and community groups, which supports this reported outcome.

“The navigation service has helped me because I am going out during the week when I can to go to a couple of places to do some voluntary work.”
Service user

However, it may be that, for some, reductions in social isolation may have been due to other factors, possibly the interaction with the navigator themselves.

Figure 7 Responses to the question “As a result of seeing the navigator...”



Note. N=26; Site=Wales and Scotland; Source: Service user follow-up survey.

3.2 What outcomes were observed for secondary beneficiaries (healthcare staff, family members/carers)?

According to the [Theory of Change](#), intended medium and long-term outcomes, and ultimate impacts for secondary beneficiaries included:

- reduced pressure for GPs, mental health nurses and A&Es.
- increased job satisfaction of healthcare workers.
- reduced pressures on family members and carers.
- improved integrated working across health, mental health, and community providers.

The interim report highlighted some evidence that the first three outcomes were being achieved. Interviews with and survey responses from healthcare staff indicated that they were spending less time on non-clinical needs of patients and having higher levels of job satisfaction. As mentioned previously, it has not been possible to quantify the impact on healthcare appointments due to being unable to access NHS appointment data. Likewise, no family members or carers were interviewed. Some service users did suggest family members that might be happy to speak but it was not possible to get hold of contact details to follow these up. In addition, while one stakeholder did reflect that they felt it was likely pressure did reduce for people around service users, without further data it is not possible to explore the impacts for this potential group of beneficiaries.

However, staff and stakeholders did continue to report positive impacts of the pilot on healthcare staff, and the potential for positive effects at a system-wide level, including improved partnership building. This section shares data analysis on these outcomes, as recorded since April 2022.

3.2.1 Reduced pressure for GPs, mental health nurses and A&E's

A key intended outcome of the CMHN Pilot was a reduced burden on healthcare staff, in the number of patients seen and time per patient spent. One stakeholder interviewed talked about how admissions had increased greatly over the previous three years, and a healthcare worker from the same area said that the work of the navigator “took the burden from” nursing staff who now felt able to discharge

patients even though they knew they needed other (non-clinical) support, because the navigator could support with these issues:

“Having a navigator was helpful for the healthcare staff to concentrate on other things, on seeing patients and working with medical referrals.”
Health service staff

One staff member interviewed gave the example of one individual who, before receiving navigator support, was regularly calling paramedics and going into primary care. After seeing the navigator, who supported them with their housing and other non-clinical concerns, even the ambulance service had commented to the interviewee that this individual had stopped calling them.

Generally, survey data supports these experiences of navigators helping reduce pressures. According to service user follow-up surveys completed, 58% (n=15) of respondents thought that they needed to access their local GP, A&E and/or other mental health services less as a result of the navigation service. However, 16% (n=4) did not think so and 27% (n=7) were neutral. This is in line with responses to the healthcare staff follow-up survey, where four out of the five survey respondents stated that they spent less time working with their patients to address non-clinical needs, at least to a great extent, because of the navigator support.

Bearing in mind the point about higher admissions, and with increasing pressures on NHS services widely reported in recent years, it is perhaps not surprising that when comparing staff survey responses from baseline to follow-up, there is limited evidence of a navigator’s positive effect on other health care professionals’ time. As presented in [Table 10](#), the extent to which survey participants agreed to the three statements about their time taken up by non-clinical issues only changed for a small number. However, for these reasons (see also [Section 4.1.5](#), which explores workload and service demand pressures), and the low number of responses, this result needs reading with caution.

Table 10 Comparison of first and second health care staff survey responses to items related to their time uptake.

	Change in opposite direction	No change	Change in expected direction
I see many patients who present with primarily non-clinical mental health needs	0	3	1
I receive many repeat visits from patients with non-clinical needs	0	2	2
Much of my time is taken up by visits from patients with mental health needs that are not clinically solvable	0	4	0

Note. N=4. Source: Baseline and Follow-up healthcare staff survey.

Additionally, healthcare staff reported that the unique knowledge and perspective of the navigator was beneficial in giving a “*different optic*” to assessments, and one healthcare worker stated that the best thing about working with the navigator from their perspective was that they no longer felt pressured to keep up to date with the

developments and availability of external services since the navigator would hold that knowledge:

“I don’t know what’s there from day to day. But [navigator] will have more of an insight.” Health service staff

This finding is supported by the healthcare staff follow-up survey, where two out of the five respondents felt less aware of other services compared to at the beginning of the CMHN Pilot, with three respondents reporting no change.

3.2.2 Increased job satisfaction of healthcare workers

Though there was no difference reported in the job satisfaction of the five survey respondents who completed the healthcare staff follow-up survey, all but one thought the service had helped them fulfil their role. Three responded that this had definitely been the case. Health service staff interviews further highlighted that there was no general change in job satisfaction because of the pilot. Linked to the point about pressured healthcare, this is again perhaps no surprise. However, as shown in [Section 5.5.2](#) on gaps in NHS services, staff felt confident that they could refer people to the navigator, as a specialist service rather than a generic advice service, which seemed to give greater peace of mind. This is supported by one interviewee reporting that lots of people who were referred to their navigator did not meet eligibility criteria for secondary mental health services. This meant that these services could not support such patients:

“They can only discharge people back to the community. Or maybe to the GP. And it would leave [these staff] with a lot of concern, worries, stress, thinking ‘Oh gosh, I’ve just had to discharge that person. What is it that I can now do? How do I know they’re going to be OK?’ But the [...] navigation service [...] would pick those people up [...] that would be a safety net then for those professionals because they know somebody is there to support that person [...].” Stakeholder

3.2.3 Improved integrated working across health, mental health, and community providers

The CMHN Pilot also saw indications of impacts for the wider system within the sites which it was located. One key outcome was the improvement in building partnerships beyond the healthcare sector, particularly with organisations in the third sector (see more on related success factors in [Sections 5.4.2, 5.5.2 and 5.5.3](#)). One navigator said that a combination of ‘word of mouth’ from service users as well as their own presence at community mental health fora meant that they had been noticed by a third sector organisation who got in touch to find out more about the service. Another member of health service staff said that the navigator’s efforts in actively working with the voluntary sector helped connect these services together, demonstrating how statutory and third sector services can collaborate:

“It’s been a foot in the door for the discussion with the voluntary sector and really building those relationships and our partnership working, which is going to be absolutely crucial as we move forward over the coming years.” Health service staff

Because navigators were employed by MHUK partners, they were perhaps in a good position to make links between different health and community sector

providers. However, it is worth noting that third sector organisations are also experiencing funding and staffing pressures.

“Just kind of made me a lot more stretched and maybe couldn't give as much to the team as I would like to.” Stakeholder

3.3 *Can these changes be sustained?*

One ultimate impact of the CMHN Pilot has been that it has continued and expanded within two of the sites, leading to the greater likelihood that outcomes reported will be sustained for a larger population of people. Because of the experienced success of the pilot in England, NAViGO and Rethink collaborated to appoint three more people into navigator roles during the project's lifespan, so that they could extend this support to other Primary Care Networks. In addition, once the initial funding for the CMHN Pilot in England ended, the local Primary Care Network continued to fund the CMHN Pilot post.

Similarly, in Wales, the team managed to secure further funding through *“utilising and explaining the holistic person-centred approach that is the social navigation model”*. This means that there are now three navigators sitting under and funded by the Cardiff and Vale University Health Board, two navigators funded by Merthyr Tydfil Local Authority, and seven navigators funded by the Welsh Assembly Government. These are reported to work to the same model as the CMHN Pilot (though titled 'social navigators') and continue to be successful, with considerable numbers of referrals. The fact that these posts were created before the end of the pilot, is a sign that local health providers could see its benefit, acting on this successfully before the service ended. There have been reports that partners in Scotland are also trying to identify further funding for a CMHN service to continue, at the time of writing.

There were, however, differences in perception between regions when it came to potential sustainability, with one stakeholder commenting that they felt the pilot had gained more traction in England and Wales than in other areas. Further exploration would be helpful to understand why that may have been. It seems that the service stopping in NI before the pilot's end, was due to staffing challenges, rather than the concept not working. This indicates a need for workforce development, but other factors may also have been involved.

Sustainability was a concern raised by one person who commented:

“The worst one is that it's gonna shut in a year. That's the worst, cause that's been well good [...] I think it's a brilliant service.” Service user

Another stakeholder commented that a difference in outcomes was to be expected with UK-wide projects, as different national contexts and devolution meant that different approaches and services might be needed and might work differently, or not at all, dependent on the environment. This is something that would benefit from further testing.

Overall, the success of the CMHN Pilot has led to plans being developed by Rethink Mental Illness for the role to be extended and embedded across England, with aspirations to embed a navigator in each of its 1,250 Primary Care Networks. It is being viewed as a *“golden thread”* running through the various elements of their new

five-year strategy, which includes areas such as accommodation, employment, social connectiveness and physical health.

3.4 *To what extent were these changes due to the pilot?*

The interim report stated that interview data provided a good level of evidence that changes for service users and staff were attributed to the CMHN Pilot. In line with this, service users interviewed for this final report were all certain that the outcomes they had experienced in terms of their improved mental health, as well as other non-clinical needs, were the result of the support they had received from the navigator.

For the people who had joined new groups or services, they reported that they did not know that those services existed before they were signposted towards them by the navigator. One service user said that it was through the navigator and their work that they started to be more socially active. A repeated theme throughout interviews was the idea that this type of support was not available anywhere else. There was a strong narrative that the navigator filled a gap that could not be addressed by healthcare staff like GPs, mental health nurses or psychologists.

“It was that practical support from a non-medical practitioner which was exactly what I needed. That level of support was not available to me from any other source.” Service user

This view was generally supported by health service staff, with most attributing outcomes reported to the pilot. However, there was occasional reticence expressed, with some interviewees reluctant to state their opinion on impact made for service users, or to attribute a contribution of the navigation service to positive outcomes seen. In one area, there was some questioning of the value of contributing to the evaluation without “*baseline*” figures. It is possible that this may be more to do with workload pressures and perhaps a lack of understanding around mixed methods evaluation.

As mentioned [above](#), a number of interviewees reported that further funding and an expansion of the model in England and Wales, was specifically because the success of the CMHN Pilot was clear to see. It is hoped that this report helps in the continued development of these and other potential new services, taking account of challenges identified ([Chapter 4](#)), success factors ([Chapter 5](#)) and recommendations ([Chapter 6](#)). First though, this section concludes by exploring the calculated ratio of costs to benefits of providing a CMHN service.

3.5 *What are the potential cost benefits to healthcare services from implementing a CMHN role?*

For the economic evaluation of the CHMN Pilot, a cost utility analysis was conducted comparing the costs with the benefits of the service by using quality-adjusted life years (QALYs). Quality-adjusted life years combine the expected quality as well as the quantity of years into one single measure. We used EQ-5D to assess quality of life as recommended by the National Institute for Health and Clinical Excellence (NICE)¹¹. More precisely, cost utility analysis compares the improvement in QALYs with the incremental cost of an intervention.

¹¹ Sculpher, M. (2008). NICE's Methods Guide: sensible consolidation or opportunities missed? *Pharmacoeconomics*. 2008;26(9).

To determine the QALYs, the health profile of each respondent was first translated into a 5-digit health profile (e.g., 21232 meaning some problems for mobility, no problems for self-care, some problems for usual activities, extreme problems for pain/discomfort and some problems for anxiety/depression). In total, there are 243 possible health states.¹² The health profiles were then converted into values according to a value set. Value sets have been created for different countries in various studies by using specific methods to estimate the value of each health state. We used the UK estimates for the EQ-5D and converted health profiles of all respondents into this one single value.¹³ The same scale as the EQ-VAS is used to estimate the value of the different health states (i.e., 1 perfect health and 0 worst health).

[Table 11](#) shows the descriptive and inference statistics of the value score when comparing baseline and follow-up completion. For the 26 respondents who completed the full scale at both time-points, the average value increased from .08 to .28 which equates to a statistically significant improvement ($p < .05$).

Unfortunately, only eight respondents completed the EQ-5D-3L at three-months follow-up and only two of those also had a valid EQ-5D-3L at baseline and follow-up. Therefore, this could not be used to determine if the positive effects were sustained following the intervention. The average value score of the eight participants who completed the EQ-5D-3L at three-months follow-up was .23 (SD=.48) and therefore close to the .28 at follow-up across the 26 respondents. Furthermore, as reported in [Section 3.1](#), the EQ-VAS score was sustained for the small number of people who completed it at all three time points. However, this reasoning can only be seen as anecdotal evidence that effects were sustained.

Table 11 EQ-5D-3L value score statistics for baseline and follow-up

	N	Mean	SD	Mdiff	SDdiff	T	df	p
Baseline	26	.08	.37	-.20	.36	-2.781	25	.01
Follow-up	26	.28	.46					

Note. N=26. Source: Baseline and follow-up service user survey.

The values in [Table 11](#) can be used to identify the QALYs (1 Year of Life \times 1 Utility = 1 QALY). Here, we assumed respondents' health was sustained for three months, as this was when the second follow-up survey was sent out and results indicated the level of health improvement being constant over that period (with caution as described above). Normally, this calculation is based on a control group, but as the evaluation did not include a comparison group, we used the baseline and follow-up scores instead.

To calculate the average costs of navigator service per service user, we used the staffing costs for the navigator according to PSSRU unit costs¹⁴ of a Band 5 health professional which includes the following costs: salary (£27,350), salary oncosts (£8,239), overheads (£21,653), and capital overheads (£4,471). This annual cost of

¹² EuroQol Research Foundation (2021). EQ-5D-3L User Guide - Basic information on how to use the EQ-5D-3L instrument.

¹³ Kind, P., Hardman, G., & Macran, S. (1999). *UK population norms for EQ-5D*. (Discussion paper 171, centre for health economics).

¹⁴ <https://www.pssru.ac.uk/pub/uc/uc2020/2-communityhcstaff.pdf>

£61,713 per navigator was multiplied by four for the four sites and by 1.5, to account for the 18 months of monitoring data collected (April 2021 to September 2022) across all sites, giving a total cost of £370,278. This equates to an average cost of £572 per client across the four sites (based on 647 new referrals recorded for the period).

The actual overall cost of the service for the two years was £880,000. However, as this was a pilot project, the amount included various other costs such as project set-up, evaluation and management (including a more complex form of management due to the MHUK partnership, involving four different charities in four different countries and different NHS legislation at play), which were not included in this calculation. The reason for this is that we restricted the economic evaluation to a 'business-as-usual' delivery.

Comparing the change in QALYs with the costs for the service shows a cost per QALY of £11,446 (see [Table 12](#)). This was based on the average change of .05 QALY when comparing the follow-up score with the baseline score. To yield one QALY, one would need to spend 20 times the cost for the .05 QALY. The cost per QALY is below the threshold of £20,000 per QALY according to NICE for England and £30,000 for Wales.¹⁵

It should be noted that this is likely a conservative figure as:

- we used three months to calculate the QALY, however it is possible that positive effects could be sustained for a longer period. It is also worth reiterating that we used the three months even though we did not have data from all service users at the three months follow-up stage to indicate that health improvements were sustained.
- we have not added any potential cost savings of having a navigator, for example through time savings of other health professionals.

Qualitative evidence from interviews and quantitative evidence from service user follow-up survey responses suggest that service users had to access GP, A&E and other health care appointments less because of the work of their navigator. Qualitative data also indicated the preventative nature of the service, with some service users not meeting the threshold for mental health services in secondary care. The engagement with navigators potentially prevented escalation of mental ill health (which could have resulted in higher costs for mental health support), which might have meant these people became eligible, needing more costly support. Cost savings for primary care has been shown in other evaluations of navigation services. For example, the evaluation of Community Navigation in Brighton & Hove estimated a cost saving of £1500 per patient per year.¹⁶ If the CHMN evaluation had found similar cost saving effects, the cost savings would have outweighed the cost of the navigators. On the other hand, there is also evidence from this evaluation that service users engaged with health services as well as other services because of the support of the navigator.

¹⁵ <https://www.gov.uk/guidance/cost-utility-analysis-health-economic-studies>

¹⁶ Farenden, C., Mitchell, C., Feast, S., & Verdenicci, S. (2015). Community navigation in Brighton & Hove. Evaluation of a social prescribing pilot. *Hove, UK: Brighton and Hove Impetus*. Available at: <https://ihub.scot/media/1656/cn-full-evaluation-nov-2015.pdf>

Unfortunately, as discussed in [Section 1.3](#) (Evaluation limitations), we were unable to access healthcare appointment data. However, this would have needed a control group of people with similar characteristics who had not received support through the navigator to undertake a robust cost-benefit analysis. This was discussed with all sites and was part of the evaluation approach that was approved through the NHS ethics application (see [Appendix 2](#)). Initially, one site agreed to provide healthcare appointment data from a different PCN, however, agreements were not finalised.

Table 12 Cost-Utility based on QALYs

	Utility	QALY	Cost
Baseline (no service)	0.08	0.02	£0
Follow-up (service)	0.28	0.07	£572
Increment	0.2	0.05	£572
Incremental cost/ Incremental Outcome	£11,440		

Note. N=26; *Source:* Baseline and follow-up service user survey.

Generally, this cost utility analysis shows that the service can be viewed as cost-effective, based on the limited data available to the evaluation and the limitations of the design (i.e., no control group and only 3-month follow-up). Bearing in mind the high number of patients supported (see [Section 4.2.3](#)), if one was to reduce the number of people navigators worked with, to 70% of the 647, it would still show a cost per QALY under £20,000. This indicates that a lower caseload could still offer a cost-effective intervention.

This analysis was restricted to QALYs and did not include other potential direct costs savings such as a reduction in GP appointments, wider costs savings from service users' potential integration into the labour market, or potential future savings due to a reduction in utilisation of secondary mental health care. This links to some of the challenges that the evaluation and the service faced, to be discussed in the next section.

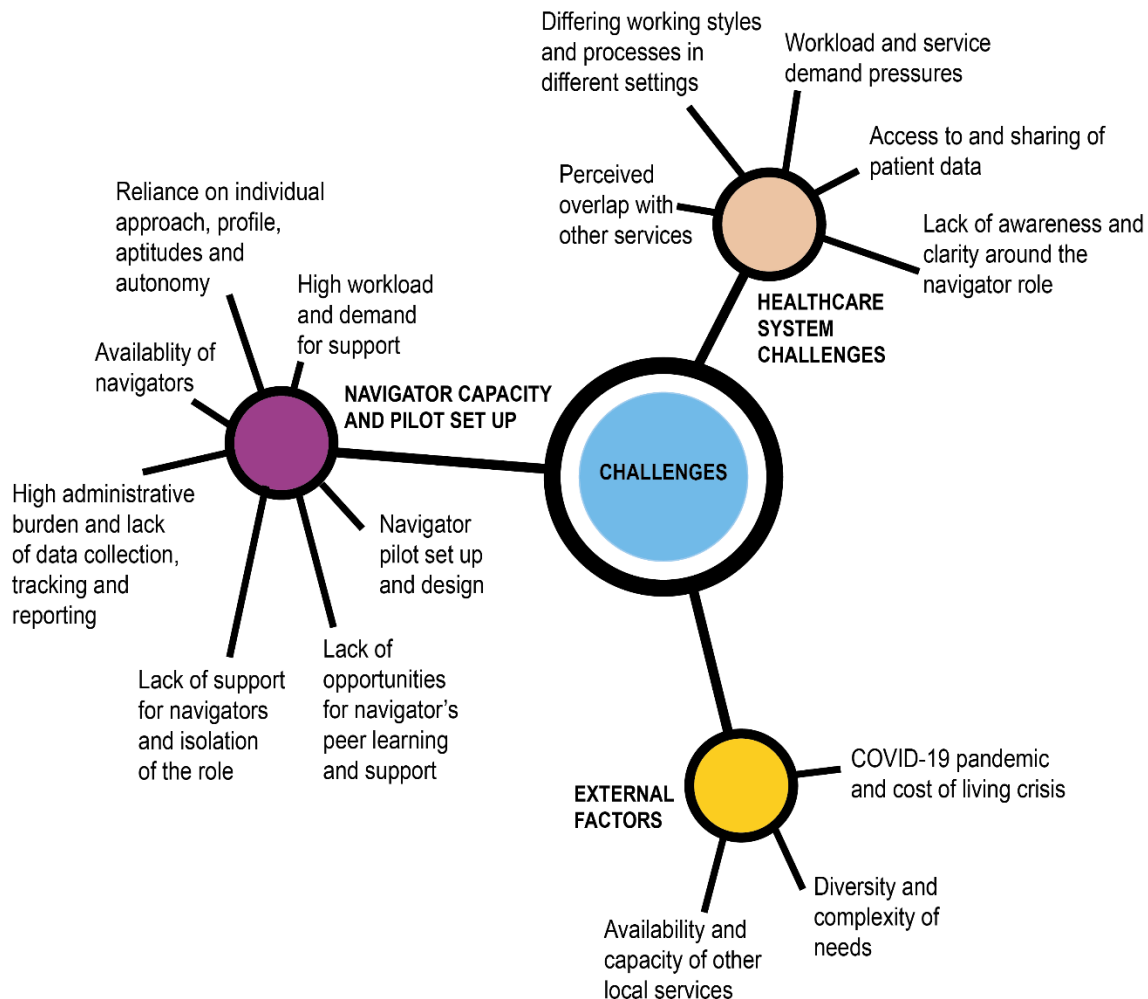
4. Key challenges in delivering the CMHN Pilot

As with any project, there were challenges faced during delivery of the CMHN Pilot, some of which were ongoing. Throughout, people supported by navigators gave overall positive feedback during interviews and in survey responses. The main feedback from this cohort was the desire for more navigators to be available in their area or for the service to continue. Challenges reported here have therefore predominantly been drawn from interviews with navigators, MHUK staff, local NHS health service staff and from the observations of the evaluation team, since April 2022. As can be seen from this chapter and [Chapter 5](#), some challenges can also be strengths, depending on the perspective held and/or depending on the context and other influencing factors. Therefore, it is important to bear in mind that a challenge does not mean the approach is completely wrong, and vice versa with a strength. Key challenges are explored under three broad categories and illustrated in [Figure 8](#).

- Healthcare system challenges – such as working styles, data access and perceptions of the navigation services.

- Navigator capacity and pilot set-up in sites – including the reliance on the individual navigator, workloads and reporting burdens.
- External social and economic factors – for instance, availability of local services and the diversity of needs.

Figure 8 Challenges faced by the CMHN project since the Interim report



4.1 Healthcare system challenges

This section explores some of the challenges faced:

- when implementing the CMHN Pilot in healthcare systems.
- by navigators in working across and within local healthcare systems.
- by staff within those systems around the navigator role.

4.1.1 Differing working style and processes in different settings

Whilst a key feature of this project was the hosting and testing of a navigation service in one site in each of the four nations, this presented challenges. To set up the navigator roles required working with four different NHS systems, in four settings, each with their own political, social and organisational systems, each one having

their own mechanisms for how work was managed, delivered and reported on. Whilst perhaps giving some insights to what might work in these different contexts, it meant that each navigator's experience might be very different, in part affected by their different national and organisational context. This made some of the logistics and communication challenging.

Likewise, how referrals were made differed dependent on the NHS contexts people were within, and their level of access to staff, physical spaces, and IT systems. For instance, in one site a navigator had physical access to one venue where patients were seen, but not another. Also, the 'front door' for patients might look different in different settings, with some having, for instance, a streamlined 24-hour phone line, whereas another might have different phone numbers a person could call, making referral pathways to and from a navigator more diverse and less clear. Whilst it was expected there would be contextual differences, understanding what was due to more local or social contexts and what was due to the larger systems within which navigators were based has been challenging.

At a local level, navigators worked across different settings within a PCN or across hospitals, again each with their own systems, working styles and communication needs. One setting might include the navigator in team meetings whilst another would only communicate via email or phone, making it more difficult to build relationships and ensure appropriate referrals were being made. One health service staff member interviewed acknowledged the differences in working practices between GP surgeries in the same PCN, including how roles like the CMHN were understood and engaged with. Navigators needed to work and understand these differences and find ways to adapt their approaches.

4.1.2 Access to and sharing of patient data

Navigators' access to patient data held by local healthcare systems varied, with some being able to receive information via IT systems and others not. Limitations were experienced that might be barriers to getting necessary information, even with access to IT systems. For instance, to access and capture patient data might require knowledge of a person's date of birth. However, if this hadn't been given by a healthcare worker or the patient themselves, then it was not possible to either find or store information. This may link to [Section 4.2.4](#) (around availability of navigators) and [Section 4.2.7](#) (navigator's high administrative burden). If data access was better enabled for navigators, two-way communication might be easier for all involved in a person's care. This also links to challenges with data gathering, outlined in [Section 1.3](#)).

4.1.3 Perceived overlap with other services

Some interviewees explained that it could be difficult to know what the difference was between the navigator role and other roles that could look quite similar, for example, social prescribers, care coordinators, and other programmes offered by charities and community organisations. This point is also addressed in [Section 5.6.2](#), which gives examples of how a navigator might work successfully with these other roles. However, for some interviewees they overlapped, and some staff were unsure about who to refer a person to. In one site, another NHS mental health support service was better known by healthcare staff. Because it was seen as a more internal service, staff were more likely to refer here than to the navigator, particularly when they perceived that the same service was being provided, even if this wasn't

the case. Particularly in one site there seemed to be a general perception that there were several services with a similar offer. This links to the next point.

4.1.4 Lack of awareness and clarity around the navigator role

Some interviewees raised the issue that people struggled to understand exactly what the navigator role involved – whether a member of the public or a healthcare staff member. This links to the above challenge, with people sometimes struggling to distinguish the difference between the navigator role, and a social prescriber, for instance. It also links to pressures faced by staff within healthcare services who perhaps lack time to explore the differences and clarify for themselves what this role might offer that a social prescriber might not, and therefore who it might benefit most.

“I feel the role could be communicated and marketed better within services as they are extremely valuable.” Healthcare staff

The issue of a lack of understanding of mental health services within primary care, raised in the interim report, was not mentioned in later interviews. However, it is worth noting that there have been a range of changes in mental health services (e.g. with Increasing Access to Psychological Therapies) in recent years, together with the development of more social prescriber and navigator-type roles and with increasing staffing challenges, this can add to the communication challenges. Those who were closer to the navigators were more able to clearly articulate what was different about this role and why it was needed. Therefore, the simpler and clearer the communication, to describe and explain what a navigator can do, the better it will help inform those who may not be as closely involved. However, ensuring that communication is proportionate to the service on offer is key, to avoid generating demand that cannot be met (see also [Section 4.2](#)).

4.1.5 Workload and service demand pressures

Workload and service demand pressures continued to increase during the lifespan of the CMHN Pilot. This was partly exacerbated by COVID-19 and the increased pressures this created on healthcare services. Additionally, the cost-of-living crisis, broader economic pressures on healthcare services, traditionally lower levels of investment in mental healthcare services, increasing mental health needs and staffing vacancies have all been part of the background context to this project. In part, these issues perhaps add to the argument for posts like the navigator role. However, these challenges can present a barrier for services and staff, who may struggle to find the time and energy to understand, appropriately refer to and engage with the navigator.

4.2 Navigator capacity and pilot set up

The many success factors in relation to this area are considered in both the [interim report](#) and below in [Section 5.2](#), and should be read alongside this section, which considers some of the reported challenges.

4.2.1 Navigator pilot set up and design

Some interviewees reported that they didn't think there had been a formal set up of the CMHN Pilot in their sites. This included gaps in the plan for a navigator's initial training, and in local relationship building (however, other interviewees reported this as a [success factor](#)). There was some feedback that core training, such as counselling skills, safeguarding training, suicide prevention and mental health first

aid, would help navigators better prepare for the role. Bearing in mind reports of navigators working with people experiencing domestic violence, this might be another core area of training needed. As a pilot project, this has perhaps been the opportunity to identify the types of core training required for scaling out such roles and it is understood that a comprehensive induction booklet and training plan has now been introduced. However, it is worth monitoring how such plans are implemented at a local level, to check how these plans work in practice.

Healthcare staff from different areas reported they did not hear much from the pilot organisers, suggesting that communication could have been better. And from some in different sites, there was criticism that that pilot was overly centred on the England setting. For instance, there were some reports of little contact between MHUK partners, given their healthcare systems and funding were different. There were also perceptions reported that decision making around the pilot was done mostly by the England partner and a sense of aggrievement from some interviewees that an online launch of the 'Navigator Good Practice Guide' seemed particularly England-focused. This was because of the lack of good practice examples from the devolved nations shared at the event and a perception that NHS England was the audience being spoken to.

"I sat in there and watched it, thinking what the hell am I doing sitting here watching about England? It's not relevant to me and the information that was being given wasn't relevant to me. Now I think that out of fairness, there should have been an individual launch set up and managed and orchestrated in the same response as England, in Wales, Scotland and NI." Navigator

As Rethink Mental Illness was the largest organisation of the MHUK partners, leading the pilot overall, including reporting to the funder, it is understandable that this could increase perceptions of the project being focused on England in preference to the devolved nations. It is also worth noting that the evaluation team were not aware of the Good Practice Guide being a part of the CMHN Pilot and so this may have been an independent initiative, outside of the CMHN Pilot. However, this may also have been down to a lack of communication. The impact of such developments, when working in partnership, is worth considering in relation to the impact on working relationships and power dynamics between partner organisations and individuals within the overall system. Interviews with different people across all nations acknowledged that there had been a disconnection between sites, with each trying to push for the pilot in their own area, to ensure the service worked well and that they could secure funding to continue it.

Finally on the pilot set up and design, the process of referring cases to the navigator depended on how each local health setting worked and, in some places, there wasn't a formal process in place for at least a few months until they decided to review this.

4.2.2 Reliance on individual approach, profile, aptitudes and autonomy

The approach, profile, aptitudes and autonomy of the navigators in each area were clearly key to the success of the CMHN Pilot delivery, as explored in more depth in [Section 5.2](#). However, this reliance also represented a challenge.

"I do get concerned sometimes that she's taken on too much because she works really, really hard and she does a lot. And I think we would really

struggle to replace that because I don't think we'd find anyone who's as motivated as her." Health service staff

As indicated above, the role set-up in each area relied on navigators' initiative to introduce themselves and explain what their role would be. Since each navigator began their role with different background skills and work experience (although all had some level of mental health experience), they each identified their own training needs in addition to mandatory training such as safeguarding. Reliance on the individual perhaps contributed to the difficulties with staffing the post in NI and was raised as a potential future challenge in interviews.

There is perhaps more learning needed as to the core competencies, training needs and potential development routes for people within a navigator role. This may help people interested in such a job to better understand what may be gained from taking on a role, and how they might be supported to develop and progress professionally. This might help build a bigger workforce who could fulfil this role, without solely relying on the individual aptitudes – a difficult balancing act.

4.2.3 High workload and demand for support

The success factors explored further on in this report help explain why the service has been so popular. However, this success helped create the challenge of a high workload and high demand. This in some cases left navigators feeling overwhelmed. The high number of referrals that needed managing, the complexity of people's situations that navigators were supporting, and working across more than one setting in primary care all appear to have contributed to this. Likewise, wider pressures on healthcare services, as mentioned above, perhaps meant that navigators were being asked to 'hold' patients who might have needed specific clinical attention that just wasn't available.

"Sometimes I can't manage the workload. There's just too much to do. There's never a quiet day, I'm never up to date with my work because it's constant." Navigator

Related to the previous challenge, the navigators' motivation and 'can-do' attitudes also perhaps meant they were taking too many referrals, feeling the pressure of wanting to help people. Healthcare colleagues also seemed to rely on navigators more as the pilot evolved. Many health service staff interviewed and surveyed felt that the navigator had too much work and too many cases to manage. This seems to be backed up by the quantitative monitoring data of referrals and caseloads, shared in [Section 2.2](#).

"It's a good service and it has grown. But I have to kind of put it on hold. It's expanding rapidly but I can't meet the need." Navigator

This is supported by the evaluation team's observations. For instance, during a 20-minute interview with a navigator (undertaken by an evaluation team member), nine referrals were received. Although the interim report recommended more administrative support for navigators, and it seemed that resource was made available, it wasn't necessarily taken up. Again, it seems this might have been due to those at a local level being caught up in trying to meet excessive service demands. This raises the question of whether the support structures around navigators were adequate, particularly when there was just one navigator in a service, leading to the potential for isolation and over-burden. Having one navigator available also limited

capacity, with some interviewees perceiving that there was greater need and higher demand than the service could cope with.

“It would probably be a bit better if there was more than just [one navigator] [...] there are people who could do with support and help who aren’t able to get it because [the navigator] has limited capacity.” Service user

Having only one navigator available also represented additional challenges to manage during sickness or annual leave, since there would be no one else (available or suitable) to replace them. In one area, both healthcare staff and the navigator thought they could have had another navigator or member of staff actively engaging in this role, as they had to juggle between attending meetings and working with referrals. The fact that two sites have taken on more navigators also adds to the evidence that one navigator in a service could soon become over-stretched, and that there is a need for more than one staff member.

Finally, on this point, interviewees reported that the ending of the pilot felt abrupt and rushed. Even though it was known this was a pilot, the end date came as a surprise to many, since there had been no reminders or ongoing communication. Staff noticed this sudden ending caused anxiety and stress for navigators, who had to wrap up cases and ensure their job was finished. The ending of the pilot left staff with the impression of *“one day we were told it was coming to an end and the next week she was gone”*. There wasn’t any handover from navigators, since there was no replacement to hand over to, and the intention was not to overload healthcare staff. This underlines how pressured the roles were up until their finish points, for those that ended.

4.2.4 Availability of navigators

Several healthcare staff reported some limitations around availability of a navigator and in their ways of working. This included the number of days that they might be physically present at a site or available for calls/queries around referrals. Linked to the above point, the pressure on navigators may have been part of the cause for this. However, building on insights in the interim report, it seems that following COVID-19 lockdowns, there were some challenges with some navigators either not having a space from which to work at primary care locations, and/or primarily working remotely. This made it more difficult for healthcare staff to locate the navigator when needed, or for the navigator to speak with people when they were present on site.

“The setup we wanted initially it was for me to go into the [primary care setting], have a bit of a like a clinic thing, and they would book some people in to come and see me. The only trouble is they have not always got offices...” Navigator

In other cases, the days a navigator might be on site would change on different weeks, and some interviewees commented they would like the navigator to have been present more often. Additionally, when working remotely in areas of poor mobile phone reception, it wasn’t always possible to reach a navigator when it was felt a conversation, rather than email, was needed. However, if navigators were visiting people in their homes or supporting them out in the community, it is understandable that there might be some inconsistencies in relation to their physical

presence at healthcare sites, further supporting the argument for more staff within a navigator service.

Unfortunately, this lack of presence led to some healthcare staff reporting that they felt disconnected with a navigator's work, preventing greater collaboration and contributing to uncertainties about what specific work a navigator might be undertaking with people referred to them. This lack of visibility also led to some healthcare staff forgetting about the navigator role or feeling that they needed to exert more effort to liaise with them than they felt was necessary. The fact that all navigators seemed, despite this, to hold large caseloads is another indication of the potential demand for the role.

4.2.5 Lack of support for navigators and isolation of the role

Linked to the above three challenges, whilst navigators reported feeling supported by their direct supervisors (based within MHUK partner organisations), they didn't always feel supported by the wider CMHN Pilot management structure and could feel quite isolated within the pilot and their local healthcare settings. Following the interim report, one interviewee reported that reflective practice sessions had been set up for navigators. However, there were also reports that monthly catch ups set up to bring navigators together were then cancelled for different reasons. Across all partners involved in the CMHN Pilot, local and national, there seemed to be challenges in supporting the navigators because of widespread workload pressures.

"The challenge we've got now it's not to do with her [navigator], it's to do with the organisation I work for and the lack of managers and support I have to be able to support her." Stakeholder

This contributed to the isolation sometimes felt by navigators, particularly as there might not be similar roles locally that they could connect with and a lack of peer support available. For instance, despite some reflective practice sessions being reported for navigators, there seemed to be very little opportunity for navigators to come together and share learning. This is supported by the evaluation team's experience of trying to bring all navigators together for focus group sessions, which ultimately proved impossible. It was perhaps a loss for the navigators and for learning opportunities from the pilot as a whole. When two navigators did come together for a joint evaluation interview, they expressed appreciation in being able to share experiences with each other. Likewise, one navigator interviewed did report that whenever they had met with the other navigators, it had been a valuable experience, both enjoyable and helpful to share ideas and approaches.

As a project working across the four UK nations, it could be argued that this provided good opportunity to explore and share learning across the UK. However, this also generated some challenges (see also [Section 4.1.1](#) and [Section 4.2.1](#)), and may have made relationship building across sites more difficult.

4.2.6 High administrative burden and lack of data collection, tracking and reporting

Linked to the above point, in all areas, there was feedback that those referring people to navigators did not receive information on what happened following referrals. There was reported to be a lack of information shared with more senior managers and other colleagues, including MHUK partners, around the number of cases a navigator was managing, what type of work was being undertaken and progress being made with service users.

“I did not receive feedback if a referral has been accepted or regarding any work undertaken [...] I would like to be aware of an accepted referral and any plan in place. I would also like more information on what the role entails.” Health service staff

“...what happens next [after the referral], how she [navigator] works with them, it's a bit of the unknown.” Health service staff

Each navigator had different local NHS monitoring procedures they needed to follow as well as their own organisational procedures, and the external evaluation team's and funder's reporting requirements (see also [Section 1.3](#) and [Section 6.1.5](#)). Navigators reported that they were capturing different types of KPIs and diversity monitoring data to present to different stakeholders in different report formats. For instance, one might capture the number of referrals received, number of cases closed, and broad age categories, whereas another navigator was also capturing mental health diagnoses and additional diversity data, such as ethnicity. Monthly caseload figures may be reported to the funder but not to the local healthcare services. This perhaps did not help with referral and caseload management. Navigators, using their own initiative, created their own databases with referrals' start and discharge dates for their own reference. One navigator created their own survey, asking discharged people to give feedback by completing it. This additional work was perhaps felt to be needed by the navigator, but generated more work for them, without adding to this evaluation.

“We're trying to work between three [stakeholders] really and meet everybody's needs and that juggling act can be difficult at times. I probably am [sending the same information] to my own employer in a sense, but not as much. They use different documents and different methods of collecting that information [...] You can use the same data, but you've got to log that in different ways.” Navigator

These multiple requirements were noted in the interim report and attempts were made to liaise with navigators, MHUK partner organisations and healthcare partners to see if reporting requirements could be streamlined, simplified and therefore more manageable. But it seemed due to everyone's workloads, these efforts did not result in changes. The overall structure of the project, with different partners and systems involved, added to the difficulty in addressing this. Whilst there may have been a wealth of data collected, it seemed there was little consistency in collation and reporting, including to the evaluation team, who spent time offering support, and chasing, but to little avail. All of this indicates a lack of knowledge and skills, understandably, around monitoring and evaluation, which perhaps could be addressed as part of training plans. In the event, this way of working represented missed opportunities to make the navigator role more efficient for everyone involved, and to make the most of all of the data that was being collected.

However, at a local level, one health service staff interviewee reported that they began asking their navigator for feedback halfway through the project. Since then, they felt more informed and used it as a benchmark, for when service users may return for further support.

4.3 External factors

4.3.1 Availability and capacity of other local services

Whilst there were some reports of navigators identifying other services and supporting people to access them as needed (see [Section 5.5.3](#)), in other cases, adequate support services were not available for onward referral. For example, autism or ADHD diagnostic support and some more general community-based activities might have very long waiting lists or offered very short-term support. This led to navigators trying to support some people for longer if they felt able to and not always knowing when or how to discharge people if the support needed was not available. This links to the next challenge as COVID-19 led to a wide range of support services stopping or reducing capacity.

“The problem we have is care services have got a long waiting list. So that has an impact then on navigators because in some respects we're kind of turning into a bit of a babysitting service which isn't what we were set to be. The role was to navigate but it's not as simple as that because you can't do that because you've got that risk of mental health.” Navigator

4.3.2 COVID-19 pandemic and cost-of-living crisis

As mentioned in the interim report, GPs and clinical staff brought up the limitations of starting the pilot during the pandemic, in undertaking in-person activities, meetings and visits, as well as its impact on the overall set up of the pilot during this time. This links to challenges identified in [Section 4.2.1](#), and affected the ability of navigators to shadow healthcare staff when they first began.

Even following national lockdowns, the impacts of the pandemic continued, as remote working sustained, and restrictions continuing around in-person meetings. This may also have been an additional contributing factor to the difficulty in establishing the service in NI. As mentioned in the previous challenge, there were longer waiting times for services during the pandemic, some services had to shut down, were reduced or the availability of staff changed, given they were working from home. And some of this has still not returned to business as usual, with impacts continuing to be felt. On the other hand, new temporary services did set up to meet this need, including the navigation service.

“I've tried ringing [a support group] and there's no answer from there, so my assumption is they closed. There's less opportunity for us to refer to services. But then we found others that have popped up to meet others, and that's amazing. So we are still looking and we're always sharing [with the team] what we've found.” Navigator

However, this also links to [Section 5.5.3](#), which identifies that, despite some disruptions, COVID-19 also perhaps contributed to some of the pilot's successes. Overall, though, it was a significant disruptor to the project as initially envisaged.

The cost-of-living crisis is another contextual factor which may have increased the number of people needing support and could potentially lead to the worsening of people's mental health. It presents a challenge for services and perhaps also highlights the ever-increasing need for the type of practical support that navigators can offer.

4.3.3 Diversity and complexity of needs

Exacerbated by the pandemic and cost-of-living crisis, navigators are working with an increasing diversity and complexity of needs. In cases where they might have expected a person not to need further support, this was not always the case. As wider social and economic challenges are unlikely to improve soon, it is likely that navigators will be seeing more people with various difficulties and needs. This links to [Section 5.2](#), around navigators' profile and role, and [Section 6.1.3](#), which makes some recommendations about navigator workloads.

Having considered challenges experienced during the CMHN Pilot, the report now goes on to consider its success factors, before making some recommendations within the conclusion.

Vignette 3: Being able to return for further support

Since his marriage broke down, Al had started to drink excessively, wasn't eating regularly, and didn't see much of his friends anymore, staying at home alone. As well as helping Al to put steps in place to limit his drinking, one of the key changes the navigator made to Al's life was encouraging him to start cooking socially, which had multiple benefits for him as it took his mind off thinking about his separation, improved his diet and meant that he started seeing his friends again.

Whilst Al completed his sessions with the navigator after a couple of months, at that point feeling a lot better, he found a few weeks later that he had another 'blip' and was able to self-refer to the navigator to ask if he could have more sessions for some extra support. The navigator spent time finding more ways to help Al. Upon the navigator's encouragement, Al started painting, which was new to him, and which he found he had a talent for. Al has now given one of his paintings to the navigator to say thank you for supporting him and helping him get through hard times.

5. Key success factors of the CMHN programme

Despite challenges outlined in the [preceding chapter](#), the success of the CMHN Pilot is supported by evidence presented in [Chapter 3](#). Survey results strongly supported the qualitative impacts reported, with standardised measures for both mental wellbeing (SWEMWEBS) and for health-related quality of life (EQ-5D) having statistically significant increases and a large effect size. These outcomes were triangulated by qualitative data which suggests that patients and other services were impacted positively by the service. The question for this section, then, is less 'what was successful about the service?' and more 'why was the service successful?' Key success factors are explored in this chapter, under the following headings:

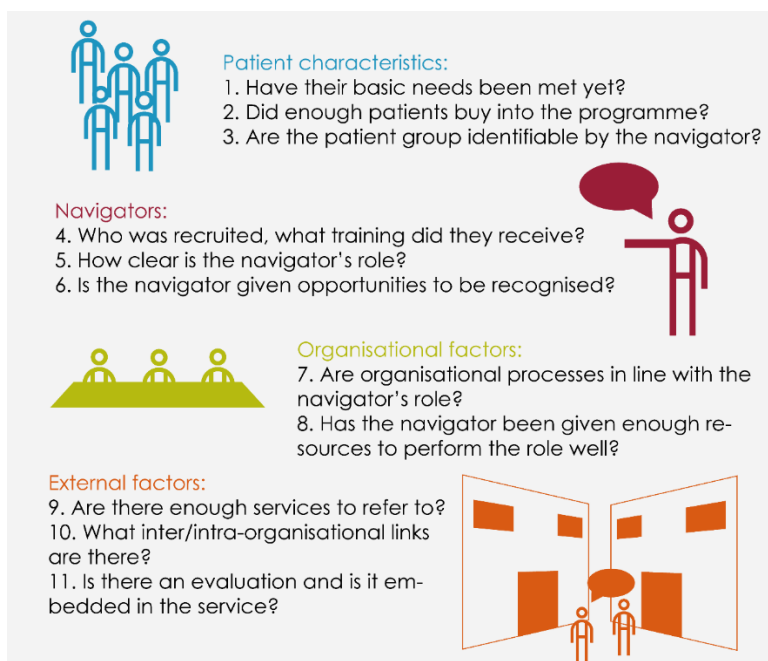
- Success in care navigation pilots ([Section 5.1](#))
- Navigator's profile and role ([Section 5.2](#))
- Beneficiary characteristics ([Section 5.3](#))
- Organisational Factors ([Section 5.4](#))
- External factors ([Section 5.5](#))

The section ends by discussing what has been done in an innovative way ([Section 5.6](#)) and considering what is scalable in this model ([Section 5.7](#)).

5.1 Success in care navigation pilots

Success factors for navigation projects in recent years can be understood in terms of what 'ingredients' a navigation service requires to be successful. This is shown in work such as Valaitis et al (2017) which identified eleven dimensions that indicate a well-functioning navigation model: patients who already have basic needs met, sufficient patient flow, identifiable patients, navigator profile and training, clear role for navigator, opportunities to recognise navigator, aligned organisational processes, sufficient resources, sufficient services, sufficient inter/intra-organisational links to navigator, and an embedded evaluation. These are factors selected based on a review of all research available on navigation programmes at the time to understand what makes a successful navigation project. Figure 9 shows these dimensions clustered and turned into questions related to patient characteristics, navigators, organisational factors and external factors.

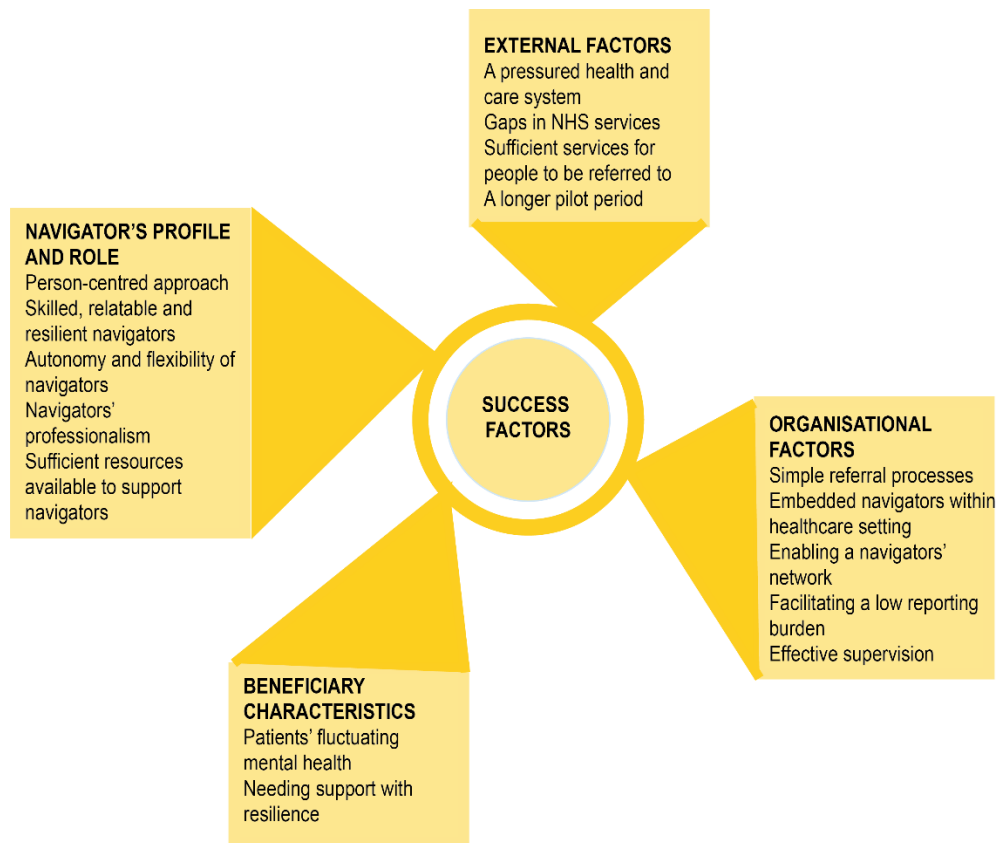
Figure 9 Questions for successfully designing a navigation programme in primary care settings



However, whilst these questions are of interest, a straight application of these to the CMHN model would not be particularly enlightening, given that a) the CMHN model applied had several innovative features which would be lost with a straight comparison of validated dimensions, and b) the programme appears to have been successful and so it would be more useful to examine what made it successful according to interviewees, rather than applying a model. Where relevant, previous literature and research will be brought in to explain different factors.

Following the review of navigation services by Valaitis et al (2017), four categories of factors were identified as important to successful navigation: patient characteristics, the navigator's profile and role, organisational factors and external factors. These categories were used to guide the analysis of the CMHN Pilot, with success factors under each category presented in Figure 10 and explained further below. As mentioned in Chapter 4, sometimes success factors might also present challenges, hence the overlap in some areas.

Figure 10 Success factors identified from analysis of interviews



5.2 Navigator's profile and role

The interim report goes into some detail about the navigator's profile and role, including how the time spent at the early stages of the CMHN Pilot in building relationships and researching local services was seen as key to its initial success. This section adds to learning shared there.

5.2.1 Person-centred approach

One of the most important aspects of the navigator role was the person-centred approach that was taken in each area. In practice this meant that the navigator's approach shifted depending on each individual client: their needs, their relationships, their phase of life etc. Rather than the clinical diagnosis-based approach, the ethic of the CMHN was to combine the "*right core value base to be able to treat everybody as an individual and respect everybody's rights*" but also to "*have the experience of being a reliable person with people at different points and different circumstances and crisis in their life*" (Health service staff). This approach was commented upon by clients:

"it was pretty much agreed between us in terms of what we felt my needs were at the time. When it was really bad, she'd speak to me or see me a couple of times a week if that was what I needed, or we would just do it once a week, very much dependent on how I was managing at the time type of thing.... I also knew how to get in touch with [the navigator] so if

anything changed, I could contact her and change when the next contact would be." Service user

This flexible approach was helpful and necessary given the client base. Navigators could not be *"very fixed in their approach in delivering this model to people because everybody [...] being referred to the service will be very different"* (Health service staff). A question worth considering then is how did a person-centred approach arise and how was it sustained throughout the programme? The data suggests that four aspects were crucial to allowing a person-centred approach: the profile and attitudes of navigators, navigators' autonomy, professionalism, and resources.

5.2.2 *Skilled, relatable, and resilient navigators*

The navigator selection process was a crucial aspect of the model's success. Navigators would be working, semi-independently, with some of the most vulnerable people in society. This meant that the navigators hired were resilient and experienced. It was suggested that the competence of the navigator *"comes from experience more than training"* (Health service staff) as the situations that navigators had to handle were often difficult and unique, which some felt made handbook guides less applicable. In addition, a few of the navigators also had *"lived experience of mental health which gave more context to the role"* (Stakeholder).

As well as experience, the quality of service provided by navigators was seen as important to the delivery of the model: *"The quality of the navigator was critical, the navigator was outstanding, the role was such a blend of culture, understanding and experience"* (Stakeholder). It is likely that the combination of being able to navigate services, empathise with clients and draw upon experience in the way navigators did in a new service is rare.

It was suggested by those interviewed that the navigators each had a likable personal style which could raise spirits: *"They make you laugh some days when you were feeling a bit crap. She's very cheery. She's got a cheery voice"* (Service user). Another interviewee suggested this positivity meant that they were able to identify and overcome obstacles together:

"She was always positive right from the start even though I was down. She'd find out the trigger and then say 'right I want you to do this now'. She pushed me into a different path and put things in place so I could make that step." Service user

This positivity also meant it was easier to operate in the healthcare system as a colleague, making connections between services: *"She was likable and nice to work with, liked across staff and patients"* (Health service staff).

Finally, interviewees commented that navigators were highly suited to the roles: *"She's really quite unique. I think as an individual, she's absolutely perfect for the role"* (Health service staff). This suitability was seen as a combination of sensitivity and practicality: *"Very empathetic but also practical, very understanding. Very gentle but also very matter of fact. Absolutely, definitely very suited"* (Service user). To be successful the navigators were required to give practical advice, for instance on PIP applications, as well as emotional support:

“She’d give you some advice as well, she’s not trained for PIP but she just gave you some tips or something, but she was there for support for like emotions.” (Service user)

This combination of practicality and care is perhaps not rare, yet in the context of a new role, working between different services, it required individuals with high confidence and resilience to be successful:

“one of the reasons why it has been so successful and I think for me, you know it has to be someone that’s very resilient but also very kind of confident and willing to go out and have those discussions and forge those relationships not only with the service users, but also with professional partners” Health service staff

5.2.3 *Autonomy and flexibility of navigators*

The strong profile of navigators leads to another reason the person-centred approach worked well: a great amount of autonomy was given to navigators to network, support clients and connect services. Navigators commented that they felt lucky and fortunate to have few guidelines, and with permission to develop their own service:

“I’m fortunate and... I know how lucky I have been to be able to do this in the way that I’ve developed. There’s been guidelines in terms of the holistic needs assessment but essentially, I’m lucky to have been left to get on and do it.” Navigator

Navigators were able to explore what worked best for their clients in terms of the level of flexibility in the support offered. One of the most obvious ways that this autonomy was used was in arranging appointments. Often clients, due to anxiety, finances and/or transportation limitations, were unable to go to a health centre for an appointment. The navigators used their freedom to arrange appointments in a way that best met client needs:

“I didn’t want to meet her though at the start.... I just remember saying, ‘I’m not coming down to the centre,’ and she said, ‘I can come to you.’ And I just thought, oh this is absolute mega, that was class.” Service user

From the navigators’ perspective, the ability to meet anywhere and for any length of time was crucial to building relationships and supporting clients with their conditions, especially for initial meetings:

“Flexibility is crucial without a shadow of a doubt for both the navigator in their job role and the individuals using the service. You have the opportunity to spend time with somebody when they actually need time.... Not all initial meetings are two hours long, the majority of them can be a lot quicker. But if you have that base structure of giving somebody initial time... And for follow up meetings, I can’t do it in less than an hour, I could never do a 15-minute slot meeting, it isn’t possible.” Navigator

The flexibility was in combination with a strong duty of care, and the navigators showed strong self-motivation to continually check-in with service users: for one client, who is now *“not too bad”* in terms of mental health, *“[Navigator] checks in every now and again to make sure I’m OK. She doesn’t have to do that but she*

does” (Service user). Regular communication was seen as crucial, with the mode of communication depending on different people’s preferences:

“I used to see her sometimes weekly, and if I never see her in person, I would text her, just to have a chat.” Service user

“[What’s the best thing about the service?] She comes to you. That’s the nice thing.” Service user

This flexibility extended to being able to ‘hold’ clients whilst waiting for other support. One navigator gave the example of someone who remained with the navigator for several months whilst on a waiting list for other services, so that the navigator could check in with the person and offer emotional support if needed. The navigator believed it was crucial for that person that they had not been discharged, with the implication being that it prevented escalation of mental ill-health because the person knew they had not been forgotten:

“You may not actually see value for the time spent with her or him but that contact on the phone to say ‘hi, how are you doing?’ was massive.”
Navigator

In addition to flexibility with clients, the navigators were also notable for building relationships with other services and professionals. This included promoting the navigation service, and connecting it, to local healthcare and community services. This required a significant amount of time, resilience, and confidence on the navigators’ behalf:

“she was so confident to go out, put herself out there, put the role out there, build those relationships, build those understandings of what other services are out there and how she could work with them and particularly support service users to access those services [...]” Health service staff

The self-motivation displayed by navigators shows that the autonomy, flexibility and freedom given to the navigators was appropriate for the role and for the individuals hired, in part due to their experience and personality traits:

“her previous experience of being in mental health services, working in [the local area] and understanding the wider kind of system, what’s available were really important, but also her personality, as I said, in terms of being so determined and confident in putting herself out there, going and having those discussions with GPs or other colleagues, she wasn’t put off by that at all.” Health service staff

5.2.4 Navigators’ professionalism

Another factor supporting a person-centred approach was the navigators’ professionalism. Their helpful and friendly attitudes were predicated on operating in a professional capacity, giving respect and impartiality to service users:

“she was really nice and very professional, and she listened and don’t talk over you and, just nice.” Service user

“She is supporting in a professional capacity rather than as a friend, I believe that this is an important distinction, as there are some issues that I would not be comfortable discussing with others and I would not be

comfortable asking for intense support from a friend. The professional relationship is very important as I can be assured that positive input is impartial” Service user

This experience was also reported by healthcare staff interviewees, indicating trust in the professional skills and attitudes of navigators:

“[Health staff] had a feeling it would be dealt with, even if you didn’t hear back. So there was that peace of mind.” Health service staff

5.2.5 Sufficient resources available to support navigators

The final success factor related to navigator characteristics were some of the resources available to navigators. For instance, professional development opportunities were identified by navigators (a further sign of their autonomy) and could be accessed due to the financial support available for courses that could improve a key skillset (however, this was also a challenge identified in [Section 4.2](#)). This might be in using the holistic needs assessment tool, helping people in crisis or understanding social services. One navigator reported that they appreciated the ability to identify and address their own needs:

“Freedom to identify what you need in the role and find training courses that are appropriate and be able to do them in work hours.... If you can show the value in that you can show that it’s relevant to your work, you can do it. Last week I went to a suicide prevention training that was organised through the NHS and third sector. I’d done suicide prevention training before but for me it’s important that I do this as well as it was expanded and relevant. The following day I was doing one on mental health first aid training. It’s important that you get the ability and flexibility to be able to identify the training.” Navigator

Whilst administration support was made available, it was not always accessed (see also [Section 4.2.6](#)). Having this support in place might increase success of the role, relieving some of the administrative burden on navigators. This point also links to [Section 5.4](#), which discusses some of the organisational factors, including supervision and peer network resources that can support a navigator’s success in their role.

5.3 Beneficiary characteristics

In essence, the CMHN Pilot has demonstrated that specialised navigation for people with mental ill health can work well. This section goes onto explore aspects of beneficiary characteristics that navigators could support with, which helped ensure success: Patients’ fluctuating mental health and needing support with resilience.

5.3.1 Patients’ fluctuating mental health

Linked to the navigators’ profile and role, the main success factor identified in interviews regarding beneficiary characteristics, was that the service was a good match for patients with poor mental health. This is because navigators had the understanding and ability to support with things that might be more of a struggle for people with mental health issues or illness. For instance, having the self-efficacy and motivation to independently access (or chase) a service can be more of a challenge for this population. A more standard or generic healthcare navigation or social prescribing service might guide or sign-post people to different services, but they do

not necessarily provide hands-on support to help people (actually or metaphorically) get through the front door. The variety of needs, triggers and crises experienced by navigators' clients, meant a generic approach was unlikely to fit well with their needs. The fact that some social prescribers referred people to navigators underlines this.

Many people supported by navigators had a wide range of needs, which were unpredictable, requiring extensive meetings to explore. This meant that the autonomous, person-centred approach of navigators, specialised in mental health, enabled relationships to develop organically, at the pace of the individual, ensuring a good fit between the model and the population group.

Patients were often close to or experiencing mental health crises, and the navigators' approach of long exploratory meetings and consistent follow up was suitable and very useful. The navigators took the approach of collaborating with service users to identify needs, and build a plan together to address these issues:

"We discussed what I felt I needed and is there something you can help me with... So we would identify what was causing the stress because I needed to address it, and then both discuss how we'd address it and we'd, basically, a kind of action plan." Service user

"she could find out what was triggering my downward spirals. So she could put things in place so that when I felt like that, I would do something else. She was giving me things to do to combat my depression." Service user

As these quotes demonstrate, this approach was felt to make a positive difference to people's mental health. It appears to have given the navigators credibility and was experienced as refreshing compared to usual care in the NHS. Allowing people the time they needed, even if this took several hours, was unique:

*"My first meeting was only meant to be for an hour. I was there for two hours. I cried, broke down. Basically she got me to shape my life.... It didn't seem like two hours, it went by like a flash. I'd said 'do you want to stop?' and she said 'no we'll stay here till you're finished'. I was like *surprised noise*. She was great."* Service user

Likewise, unpredictable patient needs meant that if there had been a strict protocol, for instance restricting home visits, then a large cohort of people would not have accessed the service and their needs may not have been met. For one patient who struggled to leave their house:

"[The navigator] telephoned me and she came to the house because at that time I wasn't comfortable leaving the house." Service user

It is important to note therefore that part of the success with this model is ensuring that navigators are referred people with mental health needs (who of course, also have non-clinical needs). However, the level of mental health need seems not to be so important if the person is receptive to help. This means people do not necessarily need to meet NHS secondary care thresholds, in keeping with the preventative aims of the service, and as their health fluctuates a navigator can be more, or less, proactive. However, some form of mental health need is important, to retain the unique and specific focus of the role.

5.3.2 *Needing support with resilience*

The navigator would often support the building of patients' self-knowledge and resilience, so that after discharge, they had better self-understanding, internal and external resources to draw upon:

"She was just so understanding. She was able to talk me through each process and talk through each day. She's shown me where the triggers were coming in and how to adjust so I stay on the good path." Service user

Over time, clients grew emotionally connected and even attached to their navigators who could be seen as reliable points of contact and comfort. It was noted in one area that *"People got attached and the navigator is being missed now"* (Health service staff). This highlights perhaps how navigators themselves supported clients' resilience at times of difficulty, helping people feel not as alone as they otherwise might. However, this needs careful balancing to ensure that navigators don't promise more than they can realistically offer.

5.4 *Organisational factors*

5.4.1 *Simple referral processes*

One feature of the model that seemed to work well was that quick and simple referral processes were implemented. Quantitative data suggested that referrals quickly led to appointments. This is reflected in the interview data, with reports of first appointments being given within *"days"* or a *"fortnight"* of referral. One factor that made this process quick and efficient was that patients could self-refer; another was that healthcare staff did not need to complete time-consuming referral forms:

"When the navigator was there, it was more likely for the health staff to refer someone to her because it's simple and easy – just sending her a quick email. Before, the staff had to think when they were doing the paperwork, to which places they could refer patients to, and that took up a lot of time. Ease of referring to her rather than other places or services doing it themselves. With [the navigator] it was one email. So it wasn't adding to the workload. They had a feeling it would be dealt with, even if you didn't hear back. So there was that peace of mind." Health service staff

A third factor seemed to relate to relationships being well established with primary care and other relevant services. After these were established, navigators needed to balance the opening of referral routes wide enough so that the service could prove its worth, with ensuring that appropriate people were coming through and that demand did not become overwhelming (see also [Section 4.2.3](#) on workloads and demand for support).

5.4.2 *Embedded navigators within healthcare settings*

One important factor in the success of navigators was their hosting by NHS healthcare providers. Whilst employed and managed by one of the MHUK partners, who each had connections and credibility with mainstream healthcare services, each navigator 'sat' within existing NHS provision. This meant that navigators could draw upon the knowledge, resources and support of their employers, retaining some cultural and institutional independence from mainstream NHS services. At the same

time, they were part of local NHS healthcare teams, giving navigators a strong platform from which to build local relationships, referrals and day-to-day connections for the benefit of their clients. This was further enriched when navigators had previous experience with such colleagues:

“When [the navigator] joined the role she had previously had experience of working with [NHS Provider], with [MHUK partner] and working in the local community. And you know... it's not what you know, it's who you know, and it is it's having those contacts out there in the community to really understand the range of services that are out there and to build those relationships.” Health service staff

Being strongly embedded in local care networks and having working relationships in primary care was a starting advantage. However, where this was not the case, navigators were able to use connections in their organisation and, over time, the reputation they built became helpful in attracting referrals: *“the service was so well received and we in fairness, I suppose we already have very good working relationships with a lot of those professionals and that [NHS Service] in particular”* (Stakeholder). Navigators were not expected to only rely on existing networks and their reputation to create appropriate referral pathways, but to proactively create new connections with other professionals in an entrepreneurial fashion:

“she's done a great job at building relationships with a whole host of professionals and colleagues... She's not afraid to go out there and put her name out there and talk to people. So, you'll often hear her talk about how she's met with primary care colleagues, be it GPs, advanced practitioners and practice nurses, everyone within the primary care team.” Health service staff

Building connections with professionals was a key part of embedding the role for navigators *“to make sure you're getting referrals from appropriate services, so you don't have to spend time triaging the people that come into your service”* (Navigator). Having a regular supply of appropriate referrals also allowed navigators to spend more time supporting clients.

A final aspect that supported the embedding of navigators was a commitment to and shared belief in the value of the navigation service by the host NHS provider:

“we both absolutely believed in the pilot and the project and what it was aiming to achieve [...] colleagues really got it and were really enthusiastic about introducing the role and I believe... it was so successful because everyone was so kind of committed and enthusiastic about it.” (Stakeholder).

5.4.3 Enabling a navigators' network

Despite its challenges (as discussed in [Section 4.2.5](#)), the network of the four UK navigators was mentioned as a useful sounding board and support for the role: *“it was helpful that they kind of had that peer network arrangement with the navigators elsewhere around the country. So they had that peer support”* (Stakeholder). During the earlier days of the pandemic, some social calls were reported to have been set up, as well as later opportunities for sharing learning being introduced. However, there seemed to be different perceptions from different interviewees as to how frequent or embedded these were. During interviews though, navigators

demonstrated knowledge of one another and expressed understanding of the different circumstances as well as the common challenges they faced. This included comments around specific challenges faced by the NI Navigator, indicating some knowledge of the local circumstances in that setting.

Whether or not navigators experienced having good enough opportunities to network with each other, it seems that interviewees all agreed on the value of having such mechanisms in place, and so underlining how such networks can be important contributors to the success of a local service.

5.4.4 Facilitating a low reporting burden

Another helpful factor that was highlighted was that reporting by CMHNs could be 'queued' until the navigators had spare capacity. This was useful as navigator meetings with service users could take many hours and yet not create an immediate task for the navigators:

"the reporting requirements obviously are just once a month. So that works really well. I've had first meetings that are three hours. Luckily that I've not had anything afterwards, as you then have to put that information into a holistic needs assessment and that can take a good hour. Then you then transfer them over to a contact note. So, essentially, it's a double initial contact for me." Navigator

However, this success factor needs taking account of alongside the overall administrative burden and data challenges reported in [Section 4.2.6](#). Perhaps what is important to note from this is the flexibility needed in relation to when and how navigators report, so that this doesn't negatively impact on the attention being given to people receiving support.

5.4.5 Effective supervision

The final organisational success factor was related to navigator supervision. Having supervisors, based within the MHUK partner organisation, was reported as a distinct advantage for the navigators. This line management support seemed to complement other support provided by host NHS providers, such as "*clinical support and peer support*" (Stakeholder). Even where navigators were working in a relatively independent and self-authorized way, they could swiftly check in for support as needed:

"I've been able to double check that a decision I have made (e.g. discharging a [service user] if they're not engaging) is appropriate before I actually take it." Navigator

However, the MHUK supervision support wasn't experienced consistently across all areas, and where it was experienced as "*quite loose*", there was feedback that "*I would have liked more direction*" (Navigator). There is a delicate balance needed to enable navigators to have autonomy and flexibility, whilst providing adequate support, particularly to help manage workloads and prevent burnout. If CMHN services continue to develop, this will be an area for development, as proposed in [Section 6.1.4](#).

5.5 External factors

In terms of external success factors, four were identified in the analysis: pressure in the health and care system, NHS service gaps, sufficient services for onward referral and the COVID-19 piloting period.

5.5.1 A pressured health and care system

As is generally recognised, health and social care systems across the UK have been under pressure with insufficient resources to deliver a timely and holistic care service.

“some of the comments for instance that we'd have from team managers within the NHS and staff themselves was for them dealing with people at crisis. They were having so many people that were for instance stated and they were suicidal or they were on their way to being suicidal.”

Stakeholder

The navigator role, offering transitional support from clinical services, and helping address basic needs and provide emotional support, was received well by healthcare staff. For instance, as [Section 3.2](#) explores, mental health nurses were at capacity and navigators helped relieve pressures on them. Likewise, staff working in crisis teams reported that they would have liked more of their navigator's time because of how useful they found this in supporting patients' non-clinical needs.

Navigators did not only help at times of crisis though, they also worked to build capacity in both the individual to recognise triggers, and to build networks and resources for service users before another crisis could occur. The ethos of the CMHN has a strong preventative element which is often missing in mainstream services:

“For us, the strength of this is the preventative model. Why within society do we wait that late for people to get help? Where if we can support people early enough, we're supporting them in the point where they have poor mental well-being, not a mental illness and then we reduce the need and hopefully the future possibility of them ever needing support around their mental health again because they they're equipped and they're empowered to deal with those social circumstances as a result of this.”

Health service staff

As well as increasing wellbeing and quality of life, preventative models for people with mental ill health also save NHS primary and secondary care resources by avoiding repeat GP visitations, emergency admissions etc. Such preventative models are notoriously difficult to implement within UK healthcare systems because of the ways in which funding and services have traditionally been set up. However, reports from those involved in the CMHN Pilot have supported the argument that navigation services bring direct benefits to pressured systems (despite related challenges as reported in [Section 4.1.5](#)). This is backed up by concerns expressed by one of the healthcare services which no longer has access to their navigator now that funding has stopped. Perhaps, the fact that systems are so pressured, means that they might more immediately feel the benefit of having navigators, and linked to the next point, can see more quickly how it fills gaps in provision. This also links to [Section 4.3.2](#), because the arrival of COVID-19 created a healthcare emergency,

which perhaps created opportunities for innovative and helpful services to more likely be embraced than if it had perhaps been business as usual.

5.5.2 Gaps in NHS services

In addition to relieving pressure in services, the navigators also provided a unique service which filled a gap in NHS services. Numerous interviewees opined on the navigator service: *“All this is great. This is the service we need”* (Health service staff). This positivity seemed to a large extent to stem from the fact that navigators were often assisting a cohort with mental ill health who either required support but would not have been eligible for secondary services or were ready for discharge from secondary services but because of their non-clinical needs, would not have been discharged without a navigator to support them. This is because it was perceived that there would be nowhere else to go. One clinician reported that 40-50% of patients they worked with needed support like this. Whilst a few had social workers and some needed secondary mental health services, many would be left out *“and [the navigator] would fill this gap”* (Health service staff). Other interviewees reported similar stories, as described in [Section 3.2.2](#) on increased job satisfaction.

Navigators also provided a link *“between GP and third sector, volunteering organisations”* (Health service staff). Whilst social prescribers might signpost, a navigator actively brokered support with other organisations, supporting closely people with mental ill health to transition towards accessing community support. In some cases, before the CMHN Pilot was implemented, referrals could be made to other organisations such as the Citizens Advice Bureau. However, it was felt that the navigation service garnered more confidence because staff knew a navigator was *“...doing something for the patient, they would be assisted and helped to identify problems”* (Health service staff). This meant healthcare staff would refer to the navigator in preference to other services. Another gap in NHS services filled, as noted in [Section 5.4.1](#), was a simple and efficient referral process, notable because of its difference to most healthcare services in terms of ease of referral.

5.5.3 Sufficient services for people to be referred onto

On balance, whilst there were some challenges in the availability and capacity of services that navigators might refer people onto (see [Section 4.3.1](#)), navigators seemed to work well in supporting people to access further services that could offer help relatively immediately. This may be linked to how embedded navigators were: *“connections with your local authority, understanding what’s happening around you, you need to ensure that you are working with all third sector agencies”* (Navigator). In addition, if there were issues with onward referrals, navigators could continue support until another service stepped in.

Overall, though, navigators and beneficiaries interviewed spoke of accessing advice, support and activity groups, without many issues raised. It may be that challenges with external services, raised more prominently in the interim evaluation report, lessened as more services opened up following COVID-19 lockdowns. One navigator reported that although some services had closed, new ones had developed in their place. Navigators were able to keep more up to date with what other support and services were available at any one time, because of this aspect of their role.

“I have no knowledge, well I do have some knowledge, but I don't have a great knowledge of the availability of services with what I do because they change so often – the names change and the funding can get pulled. I don't know what's there from day-to-day. But [the navigator] will have more of an insight. So I do see [them] very much as a point of referral to link into [...] what's available.” Clinician

As reported in [Section 5.5.1](#) and the interim report, this underlines how navigators can support overall service efficiency, due to saving clinical time that might otherwise be spent researching other services.

This area of work would benefit from further exploration, to understand how navigation services ensure appropriate and timely move-on of clients, particularly in an ever-changing landscape. It may link to [Section 5.2.2](#), which indicates that skilled and relatable navigators may play a part, through appropriately identifying and referring patients to agencies who were able to respond, and in brokering support with organisations on their clients' behalf.

5.5.4 A longer pilot period than planned

Finally, the COVID-19 pandemic, which hit at the start of the piloting period, was difficult to manage and a challenge, whilst also a contributing success factor, partly due to it leading to a longer pilot period. Having almost three years for the national pilot allowed the team to capitalise on success and refine roles over time. In Wales and England, the introduction of a 'COVID navigator' role for six months prior to a delayed start of the CMHN Pilot helped these navigators establish themselves at a time of great need. In implementing the role during social distancing, this allowed a useful and sustained technological infrastructure to develop:

“And actually what we know is now the virtual platforms being a good addition to our service model because there are some individuals, some service users that will prefer to engage with the service like this as opposed to coming in or over the phone. So I think we've worked around it and actually used it to our advantage” Health service staff

This longer period is worth highlighting because care navigation pilots tend to be shorter, and this can mean patients and staff are less willing to integrate them into their lives and work. Even in this case, the temporary nature of the CMHN Pilot appears to have caused some anxiety:

“The worst one is that it's gonna shut in a year. That's the worst 'cause that's been well good. Cause you've got a hospital, mental health, and you wait ages.” Service user

An even longer pilot period might be desirable, to further test this approach, using the learning so far to inform adaptations and improvements, and continuing to build the data for understanding the processes and factors that help achieve the best outcomes for different population groups and increasing the evidence of outcomes for patients, professionals, wider networks and health and care systems more generally.

Whilst a CMHN service has not yet been sustained in all countries, the pilot has led to CMHN services being taken up in England and Wales more permanently. However, there have been some changes made and it would be of great benefit if

learning from these experiences could be evaluated and shared more widely, to help build knowledge and improve practice and outcomes.

5.6 What has been done in an innovative way?

It is worth prefacing this discussion by noting that in several ways, care navigation has been an ongoing concern for the MHUK subsidiary organisations for several years. In England, for instance, care navigation had been trialled elsewhere outside of primary care (e.g. RMI’s Sheffield Crisis House and mental health navigator services):

“Within Rethink, care navigation is a function. In our criminal justice programmes, we have mental health navigators in pre, during and post release. We’ve been able to place navigators in different environments. We’ve been adapting that [...] into primary care settings” Stakeholder

This pilot, though, represents a change in the status quo of care navigation within primary care. Innovation can be seen by making two comparisons: to previous pilots of primary care navigation, and to the mainstream social prescription model in the NHS.

5.6.1 Contrast to previous primary care navigation models

When care navigators began gaining currency in the 2010s, role differentiation was common, often depending upon the initial job role of the navigator. For instance, the National Association for Primary Care’s navigation pilot programmes focused on training receptionists at GP surgeries and assistant chemists at pharmacies to navigate patients with long-term conditions to appropriate services (Allen and Drabble, 2017). Using Health Education England’s tiered competency framework (Figure 11), this model used a large network of navigators in the ‘essential’ skills strand, who signposted to local services under supervision.

Figure 11 Overview of the tiered competency framework (HEE, 2016)



The CMHN Pilot used a model of navigation, based on RMI navigation models within acute mental health and criminal justice settings. It is more like care navigation given to armed forces veterans in primary care, funded by the Forces in Mind Trust (Drabble, Allen & Child, 2019). The navigator had a blend of ‘enhanced’ and ‘expert’ skills, with independent working, service development, the capacity to deal with complex cases and advanced communication skills. In the case of the armed forces

navigator, the project was not sustained as the navigator was alone, not embedded within a primary care organisation, and worked with a population of service users who were difficult to identify. This was due to poor coding records identifying the population in primary care at the time that made the target population largely invisible to the navigator.

The CMHN Pilot represents a successful innovation upon previous primary care navigation pilots. Having four navigators across the UK meant that:

- a peer network could start to develop.
- the programme could test assumptions about where care navigation works best (for instance in urban areas).
- 'failure' in one site would not mean the whole programme was unsuccessful.

In addition, navigators being based within primary care settings, rather than as a freelancer or a GP surgery employee, enabled sufficient resources, networks, connections, and credibility to the navigator whilst not limiting the navigator to a single GP surgery. Supervision, clinical support and approval procedures were generally efficient as the navigators were embedded in both a primary care organisation and the MHUK partner.

The profile of the navigators in the CMHN Pilot was also different from previous primary care navigation projects, so as to work with the specific population group identified. Navigators had relevant health and/or social care knowledge and experience, whether having trained as a GP, worked in care or mental health specifically. Having knowledge of the mental health sector was seen as particularly valuable, including one navigator who was a qualified counsellor. Navigators engaged in further training such as suicide prevention and health coaching as needed, to enable targeting of their approach to the people they supported, all of whom would have had some level of mental health need. In short, hiring experienced professionals, with skills in supporting people with mental ill-health, who had the capacity to self-manage, develop a service, handle complex needs and continuously improve, then giving navigators autonomy and authorisation to deliver person-centred care, was vital to the success of the pilot.

5.6.2 Contrast to social prescription models

The CMHN model also stands in contrast to the social prescription model in England. Social prescribers are stated to work particularly well for people who have one or more long term conditions, who need support with low level mental health issues, who are lonely or isolated, and who have complex social needs which affect their wellbeing (NHS, 2023). Like the CMHNs, social prescribers offer personalised care in some ways, for instance by creating personalised plans, and linking to appropriate services depending on their needs. The CMHN however was innovative in several different ways, such as through:

- offering a service that was more appropriate for those with complex needs and varied mental health needs, from low-level through to more severe and enduring mental ill-health.
- brokering connections to and engagement with services, through proactive support with making phone calls, completing applications, arranging appointments and/or attending appointments, activities, and groups.

- checking in with people, even following discharge, to check how they were doing and if any further support was needed.

“The NHS [in England] are very much behind the social prescribing model, and [...] we have to work within that model, and we can direct PCNs to appoint navigators. We do so much more, we’re constantly upskilling [the navigators], the plans we have are in mental health coaching, and they can do community mapping, they’ll drive you etc. It’s tailored and bespoke care, the social prescribers will just give addresses and phone numbers.”
Stakeholder

There were some examples of a CMHN receiving referrals from social prescribers and sometimes working alongside them, suggesting that navigators and prescribers can co-exist, and complement each other, within the UK health and care system:

“She’s gone out with the social prescribing team and have actually done a joint assessment to determine who’s most appropriate to support that individual or what services are most appropriate.” Health service staff

The different service quality offered by the navigators seems to have been due to an innovative care approach by navigators which:

- provided a holding environment for patients with complex needs.
- offered emotional support and advice to support people’s mental health.
- supported navigation and access to other services whilst providing a caring and nurturing relationship which was sustained over time.

This presents a significant contrast to the social prescription model, which can be seen as more light-touch, short term and less proactive. Therefore, contacts with the navigators themselves were perhaps more responsible for the reported improvements in quality of life than the services users were navigated towards.

5.7 What is scalable in this model?

In terms of scalability, the CMHN model appears suitable for geographical expansion, whether alongside social prescribing link workers or in their absence. Even within the sites that navigators operated in, there was evidence that increasing the number of navigator roles would be necessary to meet current needs:

“[during the pilot] there’s only one person who’s on a limited project and there are people who could do with support and help who aren’t able to get it because [the navigator] has limited capacity.” (Service user)

This view is supported by the high levels of referrals and much higher number of people seen by navigators than anticipated, the fact that additional navigators were recruited in England and Wales, and as shared in this report, that there were indications of navigators becoming overwhelmed and isolated, without being part of a navigation team. Based on the evaluation of the CMHN Pilot, it seems that it would be desirable for the model to be scaled up within the pilot sites as well as in other areas across the UK. This would better meet demand, better enable peer support for navigators, and help relieve the increasing pressures faced by clinical services because of non-clinical needs of patients, which seem to have increased as a result of the COVID-19 pandemic and cost-of-living crisis.

The areas that were consistent across all pilot sites and which seem particularly scalable within this model were:

- the focus on people having a mental health need, alongside non-clinical needs, to be eligible for support.
- navigators working with the full range of mental health needs – from low level to severe and enduring.
- navigators having some specific experience and knowledge related to mental health before starting in the role.
- navigators being placed within a primary care network/setting, so that they can receive referrals from patients self-referring as well as from a range of professionals and primary care providers; be directly connected to GP surgeries and multi-disciplinary teams, with access to ad-hoc clinical support and advice.
- simple and quick referral processes – using light-touch administrative processes, avoiding detailed referral forms, ensuring a clear, transparent route to referral, with rapid follow-up by a navigator (within weeks as a contrast to most healthcare services).
- a mixture of generic induction and training for navigators as well as the ability for navigators to access training suitable for their individual needs.
- navigators to have flexibility and autonomy in how their time is used, to enable work to be person-centred and adaptable to their local geography, healthcare systems and clients.
- navigators' time to include meeting with and attracting referrals from a variety of local professionals, identifying and building relationships with other services that clients could be supported to access, as well as the time spent directly with clients and on the administration and reporting needs around this.

5.7.1 Areas for further consideration when scaling up the model

To successfully scale-up the CMHN model across the UK, three areas in particular may present a challenge and would need further work to ensure that these factors do not hinder scalability.

- Finding appropriate people to fulfil the navigator roles.
- Considering whether navigators should be managed by independent mental health charities (as in the case of the pilots) or taken on as NHS provider employees.
- Protecting the focus, boundaries and workload of navigators to avoid overwhelm, burnout and expansion of scope beyond competency, because of gaps that should be filled by other professionals.

This section now goes on to explore each of these in some more depth.

Finding appropriate people to fulfil navigator roles

Many interviewees mentioned the 'uniqueness' of the navigator who was hired in each area. This related to their blend of experience, independence, humane care, diligence, and professionalism. There were some early challenges with recruitment, and in NI with retention of navigators, indicating the difficulty in finding the right people that meet the job profile. The CMHN model also relied on giving the navigator

autonomy, with the navigator thriving on working between the gaps in services and building connections with diverse professionals, services and individuals seeking support. This was supported by one navigator who stated:

“I'm not being big-headed, but what I'm saying is a lot of people wouldn't feel comfortable in doing that and having that amount of free reign. Luckily, I do and it's something that perhaps was picked up at interview, I don't know.” Navigator

Therefore, ensuring that there are effective methods for recruiting appropriate people and/or developing the workforce to undertake this specialist role within a scalable model will be key to its success.

Line management/supervision of navigators

All navigators in the CMHN Pilot were managed by their respective MHUK partner, which overall was reported to have worked well. Whilst embedding navigators in primary care-based settings is recommended for scalability, this does not necessarily mean they would be best served by being employees of the local primary care provider. Interviewees highlighted the value of navigation services being a ‘stand-alone’ service, which might support its autonomy and flexibility.

“Ideally, if there was a structured system in terms of a management role and navigator management role, then that could be appropriate, and the referral routes could be opened up further. That probably is important as well especially if the navigator service itself is going to prove to be an effective support for statutory services, which is what it needs to be. It needs to be a standalone support, but it does need to sit alongside those services.” Navigator

However, if the management structure is too distant from the navigators, this might be detrimental, potentially leaving gaps in the oversight of and support for individuals fulfilling the role. This connects to some of the challenges outlined in [Section 4.2](#), where navigators could become overwhelmed with demand and feel isolated. However, a benefit might be the ability to connect navigators in different areas/regions/countries, provide specialist navigation line management and supervision, and better connect navigators between NHS and voluntary and community sector partners.

Likewise, if navigators are employed by local NHS providers, particularly if there are only one or two posts, the same overwhelm and isolation could occur, with the potential for individuals to get ‘lost’ within the overall healthcare system, and the danger of role drift occurring. A benefit though might be an easier connection to and liaison with health service staff through IT systems and easier access to triaging and other clinical support. This is an area that would benefit from further exploration.

Protecting the focus and boundaries of navigators

This point is connected to the previous consideration. Protecting the focus of the navigator role and its boundaries will also be key to its success as a scalable model. With reports of some perceptions of overlap with other services and a lack of clarity around the navigator role (see [Section 4.1](#)), it is vital that wider pressures within the overall healthcare system, linked to the likely pressures on navigators to support as many people as possible, do not lead to unhelpful changes in focus and boundaries.

These might otherwise dilute the uniqueness of the role or lead to navigators working beyond their competencies. This is another area for further exploration.

In summary to the question of scalability, it seems that the model could be successfully scaled out and be a valued additional resource for healthcare systems and eligible individuals across the UK. However, as the CMHN Pilot only involved four funded posts, it remains unclear whether the MHUK partners or other organisations have sufficient capacity to host roles if this model was expanded throughout the four nations of the UK. Working out capacity requirements and whether enough potential CMHNs exist will be key to successful expansion. This is particularly highlighted by the short duration and difficulties experienced in embedding the NI navigator.

It is understood that MHUK has developed processes, procedures and a Good Practice Guide (MHUK, 2022) to support the recruitment, line management and training of navigators, as well as delivery of a mental health navigation service. Using this guide could help maintain a high quality of service and ensure appropriate support is put into place for people fulfilling such roles. Finally, a mental health focus appears particularly suited to this care navigation model, as evidenced by the high number of referrals, low dropout rates, improvements in quality of life and wellbeing, and testimonies of patients.

6. Conclusion

This chapter begins with some final reflections to conclude the evaluation report, before ending with some key recommendations based on learning from the implementation of the CMHN Pilot.

6.1 Final reflections

This evaluation of the CMHN Pilot has provided evidence that the concept of a community mental health navigation service within primary care settings is needed, can work well and be of value to the wider healthcare system and individual patients. There were some challenges around awareness and understanding of the navigator role within healthcare services. However, it seems that the experience and knowledge of navigators in supporting people experiencing mental ill health, with their non-clinical needs, is a unique and much needed service that could prevent escalation into mental health crises, preventing the need for more intensive and expensive healthcare support.

The mental health navigator role does appear to offer something different to existing non-clinical roles, such as social prescribers and care coordinators. And there is evidence that these different roles can complement each other to best meet the needs of local populations. To continue improving the ability of navigation services to meet people's needs, it is recommended that support structures, administration needs, data collection and reporting mechanisms are addressed, as identified in the report, and highlighted below. And there is room for further research and evaluation to understand what works, for whom, in what context.

At a time of over-stretched services and wider social and economic pressures for individuals and communities, it seems that a CMHN service is one potentially cost-effective way to support people and may be more needed than ever, as

demonstrated by continuing and expanded investment in CMHN roles in England and Wales.

Finally, the importance of having a service that is open to people who may not meet criteria for secondary mental health services, and that keeps an open door for people to return to, were key strengths of the CMHN Pilot. This will perhaps be important to maintain, so that it can be preventative for people who may experience challenges with their mental health for the first time due to non-clinical needs. It can also support people living with ongoing mental health diagnoses and conditions, to help prevent deterioration because of non-clinical needs. However, the development needs, workloads, health and wellbeing of navigators needs continued attention to avoid overwhelm and burnout, and to support the continued professionalisation of the role, whilst maintaining the person-centred focus.

6.2 Recommendations

Key recommendations from the evaluation of the CMHN Pilot are presented under the following headings:

- Communications, liaison and referral routes between navigators and healthcare services
- Induction training and support for navigators
- Navigator workloads
- Administration and supervisory support structures
- Monitoring and evaluation – building the evidence

These are each now explored in turn, although there are links between the different areas.

6.2.1 *Communications, liaison and referral routes between navigators and healthcare services*

- **Clarify and agree referral routes** that, where possible, include some form of **triage by a clinician** who clearly understands the navigator role, and can assess individual needs of patients. This will help ensure appropriate referrals and prevent navigators becoming overwhelmed with too high a demand.
- **Ensure clear, frequent and multiple communication routes** are used to explain what the navigator role is, who it is appropriate for, and what makes it different from other, possibly more familiar, roles such as care coordinators and social prescribers. Communication should be tailored to both professionals and potential clients.
- **Address data sharing needs of both navigators and referring clinicians**, to help enable easy access for both sets of professionals to share and receive necessary patient information. Improved access to IT systems will help navigators gain important information once a patient is referred, to avoid patients needing to repeat stories and potentially saving clinician time. Additionally, enabling navigators to update patient records on support given, onward referrals and any other outcomes, will help clinicians and other health service staff be better informed about patients' progress with navigation support.
- However, regardless of access to IT records, it will be important for navigators to continue **attending team meetings and other events, to build trusting relationships with other professionals**, promote the service, and

demonstrate visibility and reliability. This visibility might usefully extend to finding ways to communicate when a staff member from a navigation service, is or will be available, for professionals and/or patients, to 'drop in' to find out more.

6.2.2 Induction training for navigators

There seemed to be different perspectives on how thorough induction processes were for navigators, and all navigators began with a lot of relevant existing professional knowledge, experience and in some cases, connections within local geographies. Therefore, a **review of induction processes is recommended** to ensure that learning from the pilot is incorporated into future induction plans for CMHNs, as necessary. As with the pilot, any induction plan would need to include **generic training such as Health and Safety, GDPR, Safeguarding and other standard organisational induction procedures**. However, alongside these, it seems that navigators would benefit from opportunities during induction that include:

- **shadowing of and meeting with other navigators and potential referring professionals**, to gain an insight into how the local system works, the types of needs people may present with and how the navigator might work in partnership with others.
- **health coaching** and/or basic counselling skills training.
- **suicide risk management** and prevention training.
- **specific mental health training** – depending on likely population groups being supported.

In addition, specific activities and training specific to individual navigators and their local contexts also need identifying, an approach which seemed to work well in the pilot. Ongoing training and development can then be managed and arranged as the role develops. This includes **supporting navigators to be part of a CMHN network/professional forum**, to enable peer support and learning, reflective practice, helping build navigator skills, the professionalisation of the role and the infrastructure around it.

6.2.3 Navigator workloads

- **Review and better monitor navigator caseloads**: Establishing a quick reporting process with regular check-ins between line manager and navigator to oversee the number and complexity of referrals taken, being worked with, and completed.
- **Establish some form of cut-off point**, beyond which no new referrals can be taken, to avoid the overwhelming number of referrals and caseloads that navigators were sometimes holding. A caseload of, on average, 30 people, per month has been suggested and may be a useful guide. However, **more testing and evaluation of this is needed**, alongside better monitoring around length of support for different population groups, to understand better the level of support different people may need and therefore, what that means for navigators' capacity.
- **Avoid hiring a single navigator within a service** – consider how a navigation team might be established so that services do not become overly-reliant on one individual, building resilience into the service. As the pilot has demonstrated,

the introduction of a navigator can quickly lead to a high demand, high burden and potential for burnout, which needs considering during set-up.

6.2.4 Administration and supervisory support structures

- **Implement administrative support** for navigation services, to support liaison with healthcare colleagues, management of referrals and collating and reporting monitoring data.
- Ensure **supervision balances support for navigator autonomy** alongside checking that **navigators are not working beyond their competency and capacity**. Without sufficient support, it is possible that navigators find themselves filling clinical gaps in mental health services that they are not necessarily trained or equipped for.
- As CMHN services develop, there is the potential for **senior navigator roles** to be created. These could offer supervision of navigator teams, support the assessment and triaging of referrals, and oversee/support training and development needs.

6.2.5 Monitoring and Evaluation – building the evidence

Monitoring and evaluation activities are key to building the evidence for the wider rollout of CMHN services. It is recommended that:

- stakeholders **agree reporting requirements** and **streamline** these, so that navigators can report consistently to all stakeholders, minimising reporting burdens.
- partners confirm **data sharing agreements** between relevant services at the earliest opportunity to simplify information sharing processes.
- **administration, data collection and reporting** are explicitly a part of navigators' and navigation services' workloads, with time given for these tasks. Identify **lines of accountability** for ensuring monitoring and evaluation is undertaken and is everyone's responsibility.
- further monitoring and evaluation **helps build the evidence base** of the value of such navigation services, and, particularly, where and with whom it can provide most benefit. This evaluation has shown the large positive impact that community navigation can have for people with mental health conditions, yet the paucity of patient survey data has meant that specific lessons cannot be confidently drawn on which settings and which service user types are most suited for this support.
- as CMHN posts continue, based within NHS settings, **healthcare appointment data** and **any cost benefits** of the service are further assessed. However, **ongoing qualitative and mixed methods evaluation** is also recommended, to help continued learning about what works and what doesn't, as appointment data alone will provide a partial view on the value of navigator services.

7. Appendices

7.1 *Appendix 1: Scoping Report, Theory of Change Map and NHS Ethics application*



CMHN_scopingreport_TIHR.docx



ToC - CMHN.pdf



Submitted IRAS form_updated 1.3.20

7.2 *Appendix 2: CMHN Interim Evaluation Report*



MHN Pilot Interim Report_Final.pdf

7.3 *Appendix 3: Evaluation methods*

7.3.1 *Quantitative methods and analysis*

This section describes the analysis of all quantitative data: service user surveys, healthcare staff surveys and project/monitoring data. Generally, all case-level data (i.e., service user and staff surveys) were analysed in IBM SPSS and figures were created in Microsoft Excel. All data were prepared and cleansed, which included the assignment of missing values, deletion of irrelevant variables, recoding of items, and variable type changes. Project/monitoring data were analysed in Microsoft Excel.

Service user surveys

Data completion and preparation: Service user surveys were either completed directly on the online-survey platform Qualtrics or on the existing data system of the service. Completion differed between self-completion of the service user (either at home or within a health-care setting), completion with the assistance of staff or care/family completion. Service user surveys were completed at three time points: Close to the beginning of the engagement with the navigator, close to the end and three months after the end. All three surveys included the two validated psychometric scales to measure mental wellbeing and quality of life: SWEMWBS and EQ-5D. In addition, the two follow-up surveys included further questions. The follow-up survey included questions about a) experience with the navigator service and b) outcomes experienced because of the navigator service. The 3-month follow-up survey further included questions about outcomes achieved as matrix questions as well as a couple of open-response questions. All three surveys included a unique code for each respondent which was self-generated by the service users so that surveys could be linked.

Datasets from Qualtrics and Microsoft Excel as well as from the baseline, follow-up and 3-month follow-up survey were merged so that one row represented one service user. Not all 3-month follow-up responses could be matched according to the unique code, therefore, not all were included in the analysis. If further information was available, such as demographics, this was included in the dataset. In addition to the recoding of items, and deletion of irrelevant variables, duplicates were also deleted

as part of the data preparation process. For the baseline survey, we used the earliest responses (if there were, for instance, the same number of questions completed in duplicate) and for the follow-up survey, the latest responses were used. We further checked for informed consent, with only those responses with a valid consent form included in the analysis. This meant that about 40 survey responses could not be included in the analysis.

In addition to general data preparation the two validated scales were prepared for analysis. For SWEMWBS this meant transforming the raw scores into metric scores. For the EQ-5D, this meant transforming the five-level version (EQ-5D-5L) into the three-level version (EQ-5D-3L) where this was used, so that the categories were consistent across all responses. We also calculated the index value where all five dimensions included a response. England only included the first four dimensions; therefore, no index value could be calculated and subsequently, no data from England were included in the economic evaluation.

Analysis: We calculated descriptive statistics for the baseline assessment and compared them with national statistics where available. Significance tests were used to compare scores between baseline and follow-up, as well as baseline, follow-up and 3-month follow-up. Assumptions for significance tests were explored and where these were not met nonparametric alternatives were used, as the sample size was small. We used a significance level of 5 percent and tested two-sided if not stated otherwise.

Limitations: There were several limitations to the data analysis. First of all, the date of completion related to the navigator service differed (i.e., how close to the start and end of the navigator service the survey was completed) and as the start and end date of the navigator service are not included for all survey responses, we cannot report on this. There were different completion modes and scales were not completed consistently. Generally, the response rate was rather low to the survey, but also differed by site, for example, no follow-up response was received from Northern Ireland. The uptake of the 3-month follow-up survey was especially low. As no demographic data (apart from one site) was matched with the survey data, we were unable to check how representative the survey sample is of the overall sample. However, demographic data stopped being recorded overall, so there was no possibility to check for representativeness. This also meant we were not able to undertake any subgroup analysis.

Healthcare staff surveys

Data completion and preparation: The anonymous link to the baseline survey was distributed via email to key staff in the four sites with the request to forward it to anyone who had contact with the navigator or referred patients on the CHMN service. The link to the follow-up survey was sent to everyone who completed the baseline survey and agreed to the second survey.

The baseline survey included questions about a) information about the survey respondent, b) awareness of the service and satisfaction with it, c) baseline responses regarding health and system outcomes and job satisfaction, and d) feedback on the navigator service. The follow-up survey consisted of questions about a) satisfaction with the service, b) follow-up responses regarding the same outcomes, c) views on outcomes for beneficiaries, and d) the overall impact of the

service. Most questions were closed (Likert-scale or matrix questions) and there were some open-ended questions.

We matched the baseline and follow-up survey data according to the email address provided. Eleven healthcare staff completed the baseline survey, and of those five also completed the follow-up survey.

Analysis: We calculated descriptive statistics for the majority of the questions. As the sample size was very small, we were not able to use statistical tests to compare responses to the questions that were included in both surveys.

Limitations: The main limitation is the small number of responses, which is far below the estimated 30 responses. Also, only staff from two sites completed the follow-up survey.

Project/monitoring data

Monitoring data were shared with us in the form of monthly summary statistics which we received on a six-monthly basis. The data included information about the number of referrals, caseload, discharges, appointments (offered, attended, and DNA's), incidents, and the number of service users working towards an outcome (e.g., employment). There were some inconsistencies between sites, including what information was recorded and what categories were used. For example, Northern Ireland, Scotland and Wales also included some basic demographic information (gender and age). In Scotland, the caseload count was calculated by the increase in referrals and the number of monthly discharges. The monitoring was analysed descriptively. There were some inconsistencies regarding the number of appointments offered, attended and not attended. Where the number of appointments offered was not equal to the sum of number of appointments attended and number of DNA, the sum of the latter two was used instead to represent numbers of appointment offered.

Additional diversity was only shared with us for the interim report, this covered the period May 2020 (for England and Wales) and June 2021 (for Northern Ireland and Scotland) up to December 2021, and was provided as aggregated figures for the full period (i.e., not monthly as the monitoring data). This data was summarised again for this report.

Information about age (below 20 or above 20) and gender (female or male) for new referrals reported as part of the monthly aggregated monitoring data was analysed. However, there were inconsistencies between those figures and the gender and age information reported as part of the summary diversity data, especially for age. Therefore, information about age is not reported for this final report.

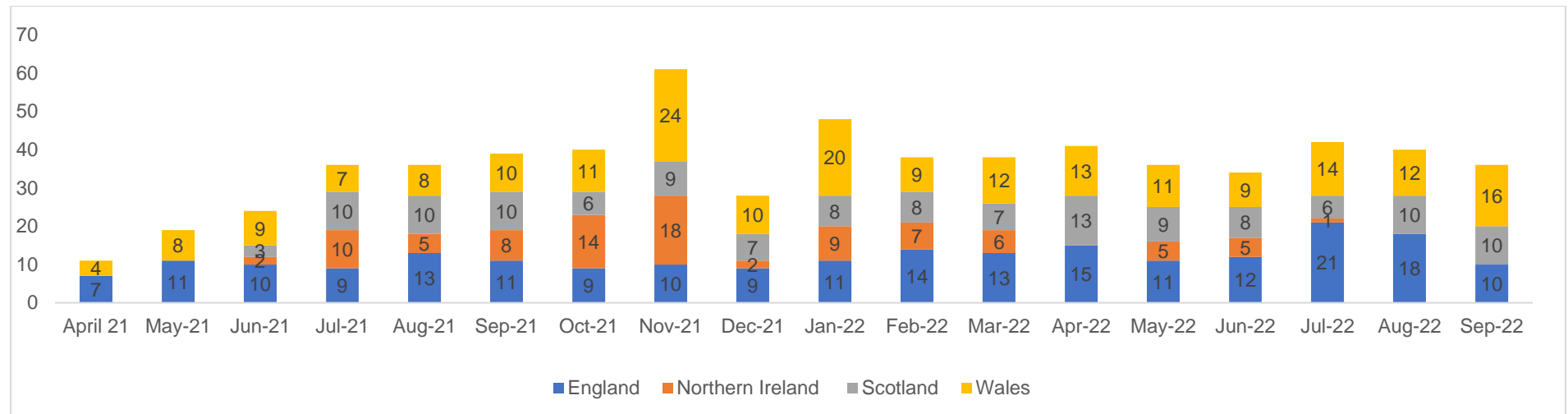
Limitations: The main limitation is that this is summary data, therefore, no case-level analysis was possible. Data was also limited and for example did not include information about the length of engagement with the navigator or more detailed demographics (e.g., ethnic information). There were also inconsistencies between the four sites in relation to data recording, which made the analysis and interpretation of the findings more challenging.

7.3.2 Qualitative methods and analysis

For this report we approached the data using thematic analysis, searching for themes and patterns across the different interviews. We used the evaluation questions (seen in [section 1.2.1](#)) as a framework for structuring the analysis, to ensure that the report addressed the most pertinent areas.

7.4 Appendix 4: Additional figures and tables

Figure A1 Number of referrals by site between April 2021 and September 2022



Note. N=647; Source: Monitoring data provided by each site.

Table A1 Caseload by site and month between April 2021 and September 2022

2021																		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
England	36	35	41	38	39	40	45	40	38	38	40	45	39	33	37	45	44	41
Northern Ireland		0	2	11	13	13	24	40	39	16	20	24		31	35	16		
Scotland		3	6	14	22	29	25	29	30	28	22	21	28	29	27	25	26	24
Wales	52	50	50	38	36	32	36	51	51	41	31	38	32	32	34	34	39	39
Total	88	88	99	101	110	114	130	160	158	123	139	179	99	125	133	120	109	104

Note. N=647; Source: Monitoring data provided by each site.

Table A2 Appointments offered, attended and not attended by site and month between April 2021 and September 2022

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
England	Appointments offered	117	132	129	157	119	129	109	100	110
	Appointments attended	99	117	116	137	90	117	93	79	92
	Did not attend appointment	18	15	13	20	29	12	16	21	18
Northern Ireland	Appointments offered	0	0	2	22	18	10	16	26	19
	Appointments attended	0	0	1	12	11	7	13	20	18
	Did not attend appointment	0	0	1	10	7	3	3	6	1
Scotland	Appointments offered	0	4	4	36	50	59	61	51	41
	Appointments attended	0	3	4	26	37	54	52	45	38

	Did not attend appointment	0	1	0	10	13	5	9	6	3
Wales	Appointments offered	224	200	182	148	98	128	118	199	170
	Appointments attended	195	180	163	135	88	106	101	168	127
	Did not attend appointment	29	20	19	13	10	22	17	31	43
All areas	Appointments offered	341	336	317	363	285	326	304	376	340
	Appointments attended	294	300	284	310	226	284	259	312	275
	Did not attend appointment	47	36	33	53	59	42	45	64	65
		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
England	Appointments offered	117	85	81	94	68	63	116	97	92
	Appointments attended	101	71	65	71	59	51	94	75	80
	Did not attend appointment	16	14	16	23	9	12	22	22	12
Northern Ireland	Appointments offered	20	35	19		20	17	7		
	Appointments attended	16	33	16		17	11	7		
	Did not attend appointment	4	2	3		3	6	0		
Scotland	Appointments offered	36	70	62	49	80	56	59	69	60
	Appointments attended	30	50	58	46	73	46	55	64	49
	Did not attend appointment	6	20	4	3	7	10	4	5	11
Wales	Appointments offered	200	153	89	184	168	166	173	96	96
	Appointments attended	179	120	84	163	149	144	134	89	82
	Did not attend appointment	21	33	5	21	19	22	39	7	14
All areas	Appointments offered	373	343	251	327	336	302	355	262	248
	Appointments attended	326	274	223	280	298	252	290	228	211
	Did not attend appointment	47	69	28	47	38	50	65	34	37

Note. Source: Monitoring data provided by each site.

7.5 Appendix 5: References

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