NHS
East London
NHS Foundation Trust

Tower Hamlets Community Health Services Directorate

CONSULTATION ON PROPOSAL FOR A SPECIALISED CARE NAVIGATION SERVICE FOR PEOPLE WITH MULTIPLE AND HIGHLY COMPLEX HEALTH AND SOCIAL CARE NEEDS

1. Introduction

1.1. The Trust wishes to enter into formal consultation with staff and their Trade Unions in line with its agreed policy set out in 'Management of Staff Affected by Change Policy and Procedure' (version number 11, May 2021). The Trade Unions and affected staff are invited to raise questions and comments which can be taken into account before the proposals are finalised.

1.2. The purpose of this consultation document is to outline the proposal that the service aim of the TH EPCT Care Navigation Service will change and with that the established team will be reduced from four Care Navigator (Band 4) posts to seven Lead Care Navigator (Band 5) posts. The paper is intended for **CHS TH EPCT Care Navigation Service** and will outline the operational and business case for proposing the change including all contractual and service changes affecting staff.

1.3. The process of consultation is to ensure all staff are informed of the proposal and is also intended to allow the affected employees the opportunity to respond and take an active role in this process.

2. Background

2.1 The Community Tower Hamlets Care Navigation Service was established in 2005 to support residents with multiple long term health conditions and social care issues. This is a unique service offer in that generally care navigation/personalised care services offered by the NHS only deal with on social issues. People with multiple long term health conditions often also have social issues, which results in a high level of complex needs where health and social care issues impact on each other. The TH Care Navigation Service, throughout its existence has a track record of supporting such residents with their highly complex needs to achieve stability and prevent deterioration. This in turn results in a reduction in GP attendance, use of emergency services, including Emergency Department attendance and ultimately hospital admission. The service also supports early discharge from hospital.

2.2 In the 2018 as part of TH Community Health Services Transformation Programme, the Care Navigation service was redesigned. Referral criteria were reviewed and a case management model implemented and the staffing establishment reduced to reflect the new service criteria. The new model comprised of seven Senior Care Navigators (Band 5) who were assigned residents with multiple highly complex health and social care needs with high risk and five Care Navigators (Band 4) who were assigned referral for residents with high risk but non-complex needs.

2.3 The CHS TH Care Navigation Service is highly appreciated and valued by all stakeholders within Tower Hamlets. This was demonstrated by MacMillan Cancer Support commissioning additional Care Navigator resource to encompass residents with cancer for a pilot in 2022/23. The service overall used this time limited scheme to further the way residents with

a range of multiple complex long term conditions with high are supported by the Senior Care Navigators (Band 5).

2.4 A report commissioned by Tower Hamlets Together in 2024 and published in October 2024, *'A systematic review of social prescribing and connector roles in Tower Hamlets'* compared all of the various 'personalised care' type roles within Tower Hamlets. (Social prescribers, Care Coordinators, Health and Well-being Support Workers, Community Connectors etc.). Many of these roles are Primary Care based, being provided by individual GP Practices with exception of the ELFT Community Connectors who work with people with mental health needs. This review identified a duplication in that the ELFT provided Care Navigation Service is working with residents whose needs could be addressed with more immediacy by the Social Prescribers and Navigators attached to the GP Practices. These needs are of low complexity, i.e. ordering a pendent alarm or key safe.

2.5 Personalised Care roles have lately also been established at the Royal Hospital, Barts Health NHS Trust, for instance in Cardiology Services. The Discharge Navigators in the Transfer of Care Hub roles include a sign posting element to support people at the time of discharge without the need for onward referrals.

2.6 The need for lower level practical assistance with using various support services provided by the Care Navigators (Band 4) is reduced by the offer of the TH Connect website with links to various support services across Tower Hamlets. For example, it can direct residents to benefits advice, how to apply for Blue Badges, Taxi cards etc..

2.7 Referrals into the Care Navigation service are predominately from Primary Care (approx. 70%) but also other sources including self-referrals. A proportion of the referrals from Primary Care are of a 'sign posting' nature and (30%) should be directed to the other personalised care roles or other staff within Primary care, for example, requesting pendant alarms, key safes, requests for benefit reviews, accessing the community. This work at the moment is being assigned to the Care Navigators (Band 4).

2.8 This chart shows the origins of the referrals into the service since April 2024

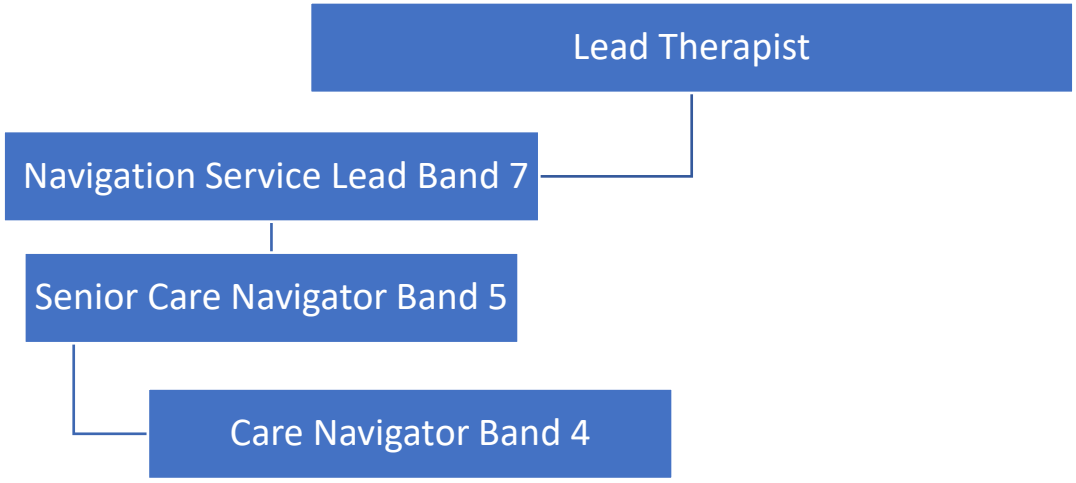
Care Navigation Service	Apr	May	Jun	Jul	Aug	Sep	Oct	
Source of community referral: Care Home							1	1
Source of community referral: Carer/Relative	1	1	1		1	1	1	6
Source of community referral: CHS	5	4	5	2	2	3	7	28
Source of community referral: GP	69	70	69	67	68	67	52	462
Source of community referral: Hospice	2	1		1		1	2	7
Source of community referral: Inpatient/Outpatient	6	9	8	4	4	5	5	41
Source of community referral: Independent Sector	1				1			2
Source of community referral: Adult social care	4	2	3	2	3	2	3	19
Source of community referral: Mental Health Service		1	1				2	4
Source of community referral: Not known	1	4	13	5	6	2	3	30
Source of community referral: Self-Referral				1				1
Total	**89**	**91**	**99**	**82**	**85**	**81**	**74**	**601**

'Not Known' source refers to referrals received from Neurology, Respiratory, Social Prescribers, RESET, which generally are for people with highly complex needs.

2.9 Of the 74 referrals received in Oct 2024 approx. 40% were non-complex cases, i.e. requests for blue badges, taxi cards, applications for support with housework and/or shopping and housing issues relating to housing applications and repairs.

3 Current Structure

3.1 Current Care Navigation Team structure as below



ROLE	Established No WTE	Headcount
Team Manager AfC Band 7	0.8 WTE	1
Lead Care Navigators AfC Band 5	7 WTE	7
Care Navigators AfC Band 4	4.8 WTE	5

3.1 In order to improve the management of demand, which differs according to TH Locality, the allocation of staff to Locality has been changed to a borough wide service in November

2024. It is expected that this will reduce waiting lists in the North Localities and offer sustained cover for sickness and annual leave.

4 Proposal

4.1 It is proposed that the TH Care Navigation Service solely provides a specialist, highly personalised service for individuals presenting with multiple and complex health and social care needs through the Senior Care Navigators (Band 5). This would complement the strategy set out in Tower Hamlets Together in 2024, 'A systematic review of social prescribing and connector roles in Tower Hamlets', which aims to standardise the personalised care roles that support residents with needs that are of low complexity and provided via Primary Care and Public Health.

4.2 The revised TH CHS Care Navigation Service will provide a highly personalised service through intense and targeted intervention that cannot be provided elsewhere in the borough.

4.3 Within the current service model approximately 80 referrals are received each month. In the new model this would be reduced by approx. 40%, representing the referrals for people with non-complex needs and allocated to the Care Navigators (Band 4).

4.4 With changing the TH CHS Care Navigation Service to provide a service for people with highly complex needs that are classed as high risk only, the Care Navigators (Band 4) will no longer be required.

4.5 The Senior Care Navigators (Band 5) will continue to work closely with Adult Social Care and other community and voluntary services through joint working and will support those residents where their skills and knowledge will have the greatest.

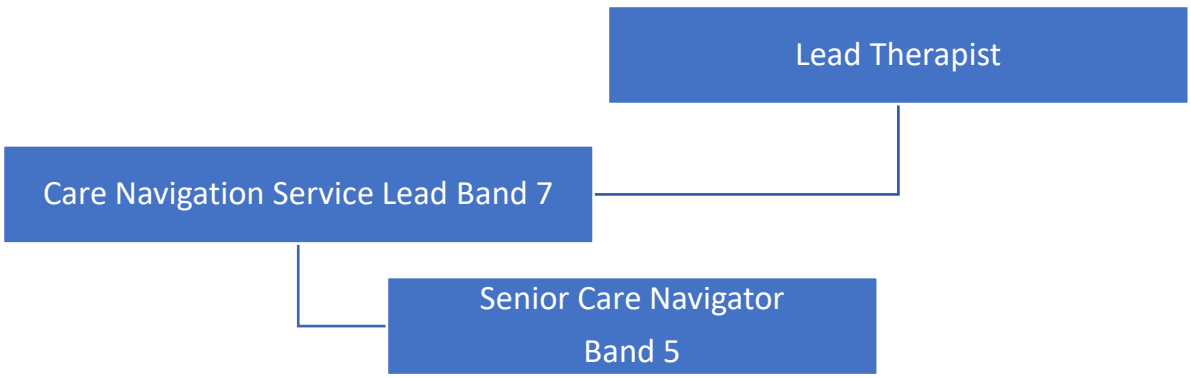
4.6 The case for change is informed by the opportunity to streamline service provision in Tower Hamlets in relation to personalised services provided in Primary Care and contribute to the Trusts financial viability target.

5 Proposed structure

5.1 The table below show the current and proposed staffing establishment for the change management along with the current vacancy position and number of staff at risk within the team.

Role	AfC Band	WTE	WTE Post deleted	WTE Vacant	No Staff affected	No Posts Available in future team	No Staff at risk
Team Manager	7	1	0	0	0	1	0
Senior Care Navigator	**5**	**7**	**0**	**0**	**0**	**7**	**0**
Care Navigator	**4**	**4.8**	**4.8**	**1**	**4**	**0**	**4**
Totals		**12.8**	**4.8**	**1**	**4**	**8**	**4**

5.2 The following team structure is being proposed going forward, Care Navigators (Band 5) will still continue to report directly to the team manager.



6 Impact on staff

6.1 The proposal is to reduce the current Care Navigators' role will result in four post holders at risk of redundancy.

6.2 All staff affected will be offered an individual consultation meeting to discuss, how the proposal impact them personally and provide any feedback in relation to this proposal.

6.3 Similar role vacancies will be held vacant for the duration of this consultation across CHS Tower Hamlets which could act as potential suitable alternative employment for those at risk.

6.4 All efforts will be made to avoid redundancies and find suitable alternative employment through Trust's Redeployment process, additional training will be provided if needed

7 Financial, staffing and workload implications

7.1 The cost savings expected as a result of these changes are £166,900. If there are any changes as a result of the feedback from the consultations or other unforeseen circumstances the revised figures will form part of the consultation feedback process.

7.2 Caseloads for the Senior Care Navigators are expected to remain the same. However, there may be some reduction as Senior Care Navigators (Band 5) are currently working with some non-complex cases due to staffing related issues i.e. leave, sickness of the Care Navigators (Band 4).

7.3 The Senior Care Navigators would no longer need to discharge staff management, thus further reducing their workload.

Senior Care Navigator caseload current model average	Senior Care Navigator caseload new model average
Approx. 20	Approx. 15

8 Service User Impact Assessment

8.1 The service and assistance provided by the Care Navigators (Band 4) to residents can be obtained from personal care roles embedded in Primary Care without delay. Such referrals are triaged by the Care Navigation Service as 'routine' and are added to a four to six week waiting list. This means that residents may wait unduly long for simple assistance with for instance ordering a pendent alarm or key safe or benefit reviews.

8.2 Personalised Care roles are also being developed in Secondary Care at Royal London Hospital, where an element of the of Discharge Navigator role introduced 18 months ago provide sign posting to patients before discharge. Before that, a referral to the Care Navigation Service was required, which meant that Navigator input would not be offered for some time post discharge. Personalised Care roles (social prescribers) provide sign posting at the Barts Health Heart Centre and cardiac rehabilitation, providing timely signposting to local community services.

8.2 Residents with highly complex needs will still receive the highly specialised service they require from the Senior Care Navigators (Band 5). There are pathways between the various Personalised Care roles in Tower Hamlets to refer residents with a lower complexity of need.

8.3 There Referral criteria for the TH Care Navigation Service have been reviewed. Demand and capacity for residents with high complexity and high risk of need has been assessed and the resource of Senior Care Navigators is sufficient to absorb a rise in referrals for residents with such needs.

8.4 Residents who require personalised care services as they cannot access the internet and/or are housebound can be supported through the personalised care service provided by GP Practices.

9 Timetable & Proposed Implementation

9.1 The Proposals for organisational change to (Service) will be managed in line with the Trusts ''Management of Staff Affected by Change Policy and Procedure'' (Appendix 1).

9.2 There will be a formal consultation period of 30 days commencing on 6th January 2025.

9.3 The Trust is committed to achieving meaningful consultation and therefore welcomes feedback and comments on the proposed organisation change proposals. Any comments should be made in writing either via e mail directed to Petra.nittel@nhs.net

9.4 On completion of the 30 day consultation timeframe all comments received will be considered and a final decision will be made and communicated to affected staff.

9.5 The timetable summarises the full implementation plan and is attached as Appendix 2.

10. Equality Analysis

10.1 Under equality legislation, public authorities have legal duties to pay 'due regard' to the need to eliminate discrimination and promote equality with regard to race, disability and gender, including gender reassignment, religion age as well as to promote good race relations.

10.2 The law requires that this duty to pay 'due regard' be demonstrated in the decision making process. Assessing the potential equality impact of proposed changes to policies, procedures and practices is one of the key ways in which public authorities can show 'due regard'. The Template is attached as Appendix 3.

Appendix 1
'Management of Staff Affected by Change Policy and Procedure'' attached with the document and letter to staff affected.

Appendix 2
Implementation Timetable

Date	Action
4th December 2024	Consultation document shared with Staff Side and TU reps
06th January 2025	Start of consultation. Consultation document given to affected staff
w/c 6th January 2025	Group meeting to discuss proposals.
w/c 13th January 2025	Consultation meetings with individuals, as required
w/c 6th January 2025	Responses to consultation from Staffside, individual TUs or staff submitted to management (it is a matter for those responding to decide who should be copied into their response)
5th February 2025	End of consultation period
w/c 10th February 2025	Management consider all responses and discuss their response with Staff Side and try to reach agreement when views are conflicting. At this stage any need for further consultation or an extension can be considered
w/c 17th February 2025	Written notification of decision following consultation, including timetable for implementation of changes
w/c 24th February 2025	Meeting to confirm impact on affected people
w/c 8th September 2025	Impact assessment of major change to be undertaken 6 months after implementation

Appendix 3 Equality Analysis Attached as a separate paper