Breaking barriers to social care

Glasgow Disability Alliance Community Navigator research report 2023-24

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Contents

Executive summary

Through the *Future Visions for Social Care* programme funded by the Scottish Government, Glasgow Disability Alliance (GDA) has employed a full-time Community Navigator since April 2022. The *Future Visions for Social Care* model combines:

- A Social Care Expert Group (SCEG) of disabled people that seeks to influence social care and National Care Service policy;
- A Community Navigator to support disabled people in the Glasgow region to find pathways to independent living, and;
- A part-time researcher to collate and write-up the evidence that emerges from SCEG and the Community Navigator to feed into national and local policy.

The role of the Community Navigator (CN) is to support disabled people in the Glasgow region to overcome barriers to getting and/or utilising the social care they need, and to support services to remove those barriers. Through *Future Visions*, the SCEG allows disabled people, including people supported by the CN that wish to be involved, to connect with others to enhance their collective 'voice', and to influence social care policy and practice, including co-design projects with the Scottish Government.

The 2022-23 work of the CN was analysed in the March 2023 report 'Navigating social care, independent living and human rights. Four Community Navigator cases from Future Visions for Social Care' (Scobie, Brunner & McAloon, 2023). This 2024 report both reinforces and adds to that evidence, by synthesising CN quantitative data from 2022-24 with in-depth qualitative data from a sample of five 2023-24 CN cases.

From April 2022 to March 2024, the CN worked with 242 people, and made a total of 869 interventions to support them. Across those two years, individuals supported by the CN have been predominantly female, are of all age ranges, and mainly live alone. They are all disabled people with a range of impairments and conditions. Over half the people working with the CN have no social care at all, but feel they need it. A quarter receive some social care, but it does not meet their needs. These are indicators of the depth of unmet social care needs among disabled people (see Zarkou & Brunner, 2023). Major types of support provided by the CN include advocacy and supporting self-advocacy; work with services (notably social work, housing and health); and a wide range of other supports, often to help people with basic needs.

Only a minority of CN cases between April 2022 and March 2024 were to directly help people with navigating barriers to Self-Directed Support. Instead, their work has been chiefly needed beyond that, supporting disabled people who do not know their entitlement to social care; that have sometimes been discouraged after trying to find SDS on their own; or who are highly marginalised and face intersectional barriers, including basic health needs, abject poverty, inaccessible housing, and who need support navigating a range of services, often outwith formal social care.

Referrals to the CN mainly come through disabled people contacting GDA, demonstrating a key advantage of having the CN housed within a Disabled People's Organisation. The 869 interventions made by the CN also include support provided by GDA services, notably specialist welfare rights advice, coaching, and IT support, so making a virtuous circle.

The CN operates through four principles:

(i) building trust with the person they support, and with social care and other public services;

(ii) No 'time limit' for support, and no 'closed cases';

(iii) Getting social care in place usually involves wider public services;

(iv) Being based within a Disabled People's Organisation.

Together these elements constitute the distinctive 'package' that allows the CN to successfully intervene and support highly marginalised disabled people who face intersecting barriers to improve their opportunity to achieve and sustain social care and independent living.

Some disabled people, especially those that experience intersecting barriers, need a combination of temporal depth and intersectoral breadth to be able to have the chance to get and keep the social care they need. This is where the CN offers a distinct and complementary resource to those provided by advocacy services, Community Link Workers and SDS-specific projects such as those funded through the Scottish Government *Support in the Right Direction* programme.

The five in-depth cases in the report demonstrate that the CN role is also necessary because of a set of service gaps:

- health, housing and social care services are not always sufficiently integrated to support people effectively.
- social care services are not identifying and acting on unmet needs.
- some disabled people face intersecting barriers and experience marginalisation by multiple public services.
- health, housing and social care services are not sufficiently supporting disabled people to achieve independent living outcomes and wellbeing.
- health and social care services are not always upholding human rights - reinforcing the 2023 Community Navigator report (Scobie, Brunner & McAloon, 2023).

The work of the CN highlights these issues in the Glasgow region. This in turn suggests a need for a comparable CN service, housed in a disabled-person-led organisation or similar, in every local authority in Scotland. This was recommended in the 2023 Future Visions for Social Care report *A Time to be Bold* (Brunner, Burke, Scobie & Lawson, 2023).

In summary, the Community Navigator model:

a. **Reaches highly marginalised disabled people who face intersecting barriers** - and who exist in every local authority.

b. **Complements** advocacy, Support in the Right Direction, Community Link Worker, and other local supports.

c. **Reaches beyond other navigation services** - it is beyond 'signposting', is cross-impairment, is cross-service, and is open-ended. It is not limited by age or geography.

d. **Is founded on the values, credibility, and resource of the 'holding' organisation** - a disabled-people led organisation that is also intersectoral and multidisciplinary.

e. **Enables connection** to community, peer support and empowerment (through GDA groups and the SCEG).

f. **Draws 'voice' and the lived experiences of highly marginalised disabled people who face intersecting barriers** into local and national policy

g. **Is strongly researched** - through the *Future Visions for Social Care* model that includes researcher support. This maximises robust and credible findings that are useful for politicians, policy makers and practitioners.

h. **Supports statutory services and practitioners to fulfil their human rights obligations and deliver independent living for disabled people.**

This report concludes with a set of implications for local and national social care-related policymakers and practitioners:

a. Gaps in the social care system make the Community Navigator role necessary (but still not sufficient to remove all barriers to receiving good social care).

b. The CN helps public services, including those outwith social care, to improve how they remove barriers facing disabled people.

c. The CN principle of no 'case closed', only 'inactive', enables swift take-up should a person supported by the CN re-approach them. Can IJBs, Health and Social Care Partnerships, and social services across Scotland learn from this re-orientation to reduce social care waiting times?

d. The five in-depth CN cases highlight how the 'double whammy' in not funding sufficient social care for people with significant health conditions detriments the lived experience of disabled people – and shows the benefits of preventative social care.

e. The CN work demonstrates real-world examples of how disabled people need some, more, or amended social care to enable them to achieve and sustain independent living – and so fulfil unmet social care needs.

f. Every local authority needs a strategy for identifying and supporting disabled people living alone, to make sure they have the social care they need.

g. The *Future Visions for Social Care* model, notably the Social Care Expert Group, offers peer support and empowerment opportunities for people supported by the CN, and enables service leaders and providers to learn from the lived experience of those highly marginalised from social care - and to change in response.

h. The report demonstrates that there is a need for ongoing funding for community navigator positions in every local authority in Scotland, housed within a disabled-people-led organisation.

This report presents evidenced, strategic learning for the Scottish Government, local authorities, IJBs and Health and Social Care Partnerships to take forward.

1. Introduction

> *'The impact on my life of the failure of my social care has had much more impact than my medical condition and impairments. This failure contributes to disability - to poverty, inequality and exclusion'* (person supported by the CN, Nov 2023).

Through the *Future Visions for Social Care* programme funded by the Scottish Government, GDA has employed a full-time Community Navigator (CN) since April 2022. The role of the CN is to support disabled people in the Glasgow region facing barriers to getting and/or utilising the social care they need. The 2022-23 work of the CN was analysed in the March 2023 report *'Navigating social care, independent living and human rights. Four Community Navigator cases from Future Visions for Social Care'* (Scobie, Brunner & McAloon, 2023). This paper reinforces and adds to that evidence. Below, we first describe the distinctive role of the CN, specifying how it complements other social care and advocacy support services. We then present quantitative data from April 2022 to March 2024 that specifies the CN's wide range of client groups and interventions. This is followed by in-depth descriptions of the CN's work with a sample of five cases from 2023-24. Finally, conclusions synthesise the learning from the CN work, including:

- implications for national and local social care-related policy and strategy.
- the case for CN-style roles being mainstreamed throughout Scotland to reduce barriers to accessing social care and rights to independent living for disabled people - especially for those most marginalised.

2. Role of the GDA Community Navigator

a. Introduction

Self-directed Support (SDS) should be enacting independent living for everyone in Scotland who uses any of the four SDS options for social care. From 2012, the Scottish Government funded GDA to run *Future Visions for Social Care* (a) to demonstrate how barriers to social care experienced by disabled adults living in the community can be addressed; (b) to indicate how Self-directed Support can achieve independent living outcomes; (c) to enable disabled people to influence health and social care policy and practice.

Since April 2022 funding has specifically focused on activities that contribute to Scottish Government aims to progressively support independent living, including through Self-Directed Support, and to sustain collaboration and co-design in developing Scotland's National Care Service and implementing social care policy, both locally and nationally. The *Future Visions* model now combines:

- A Social Care Expert Group (SCEG) of disabled people that seeks to influence social care and National Care Service policy;
- A Community Navigator to support disabled people in the Glasgow region to find pathways to independent living, and;
- A part-time researcher to collate and write-up the evidence that emerges from SCEG and the Community Navigator to feed into national and local policy.

The purpose of SDS and the goal of independent living have established meanings in Scotland:

- 'Self-directed support, alongside many other policies, is intended to support, promote and protect the human rights and independent living of care and support users in Scotland. It aims to ensure that care and support is delivered in a way that supports choice and control over one's own life and which respects the person's right to participate in society.' (Social Care (Self-directed Support) (Scotland) Act 2013 (Scottish Government, 2014, p.4)).

- 'Independent living means people of all ages having the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. It does not mean living by yourself, or fending for yourself. It means having rights to practical assistance and support to participate in society and live a full life.' (Independent Review of Adult Social Care, Scottish Government, 2021, p.9)[1]

Most cases that reach the CN are people with multiple barriers to independent living. They are disabled people that are really struggling to achieve 'voice' in services, or to get even a basic level of support. The CN is regularly contacted by disabled people that are living in abject poverty, in misery, and in isolation, in housing that is entirely unsuitable for their needs, sometimes with little food, and commonly with no meaningful support from statutory services. These people supported by the CN are a world away from being able to apply for, get or keep the social care and Self-directed Support for which they have a desperate need. CN cases are often disabled people with multiple health and support needs, for whom services are a 'lifeline': lack of social care can have life-and-limb consequences or breach a person's human rights (see Scobie, Brunner & McAloon, 2023). Between April 2022 and March 2024, 57% of CN clients had no social care in place at all, with 25% receiving some social care, which did not meet their needs (see Section 4). But the CN also supports disabled people that do receive social care and SDS, but need more of it to *'participate in society and live a full life'* (Scottish Government, 2021, p.9) and so to live according to the aims of SDS and the goal of independent living in Scotland.

b. How the Community Navigator works

> *"I don't usually find it easy to speak to people, there are some to do with social work and housing who speak to you like an impostor. I can speak to [CN] because I trust GDA, they have always helped me and I know I can trust you."* (person supported by the CN, Feb 2024).

(i) Building trust – with the person they support, and with services

The key that enables the CN to support highly marginalised disabled people who face intersecting barriers, and who may have a broken, tenuous, or non-existent relationship with services, is trust-building. The CN can support people to get what they need from services in the first instance because they are able to get an accurate picture from the person of their situation. This is only possible because disabled people know the CN is 'on their side' and because the CN works to build trust, allowing the person to express the sometimes emotional, difficult, and even contradictory details of their story. This trust-building then allows the CN to help people from where they are really at, 'warts and all'. The CN can understand what the person has tried, and can evaluate their capability of taking things further with advice ('self-advocacy'), or whether the person needs more direct support to get the help they need. This means that the CN knows about the individual's history with services, and (with consent), can talk to statutory services with awareness of that history. In turn, this allows the CN to build strong relationships with services, and, vitally, to not waste services' time.

The CN acts as more than a 'signpost', becoming a 'go-between' and acting as a conduit for opening-up service responsiveness. For the people they support, the CN 'role models' how to engage with services. For services, they reduce barriers to engaging with highly marginalised disabled people who face intersecting barriers.

[1] This vision of Independent Living was previously also set out and agreed in a Shared Vision signed by Scottish Government, NHS, COSLA and the Steering Group of Independent Living In Scotland in 2009. Glasgow City Health & Social Care IJB signed up to a similar vision of Independent Living in 2016: 31 October 2016 | Glasgow City Health and Social Care Partnership (hscp.scot) IJB Minutes of 21st Sept 2016.

(ii) No 'time limit' for support, and no 'closed cases'

The CN has no specified limit to the number of engagements they have with a person they support, or how long they should be supporting them. This is needs-led and professionally judged by the CN. They can support disabled people whatever their impairments, whatever the barriers, however long it takes. Short-term interventions are given where people have more uncomplicated needs and can self-advocate. However, this is the exception to the rule. Cases can continue for months and even years if peoples' social care needs continue to be unmet or only partially met.

Importantly, CN cases are rarely 'closed' but are classed as 'inactive', enabling the CN to quickly take up peoples' cases quickly again as it is so common for peoples' circumstances to alter and impairment-based needs to change, or for social care packages to be reviewed, services to reorganise, or for individual professionals move on. This can all lead to fresh barriers and renewed community navigation needs, which the CN can then quickly pick up if a person re-approaches.

(iii) Getting social care in place usually involves wider public services

The role of the GDA Community Navigator is to support disabled people in the Glasgow region with getting the social care they need and with navigating barriers to independent living. However, as the five in-depth cases below demonstrate, social care is not an 'island'. To support disabled people to be able to get and keep social care the CN often needs to work with other public services, such as primary and secondary health services, housing, providers and benefits agencies. The CN also contacts professionals directly involved in social care such as social work, occupational therapy and physiotherapy. The CN uses their professional judgement to liaise with whichever service or agency can best 'unblock' the barrier that is in the way of the person receiving the social care they need.

(iv) The importance of being based within a Disabled People's Organisation

A specific feature of *Future Visions for Social Care* is that the CN is situated within GDA, a Disabled People's Organisation (DPO), that contains welfare rights advice, digital support, wellbeing services, and personal learning and development as well as collective activities based on a community learning and development model, tailored for disabled people.

As a DPO, GDA operates from the social model of disability, the cornerstone of disability equality which defines disability as a social construction, caused by society's barriers and not by medical conditions or impairments. In other words, the inequality disabled people experience results from barriers faced from living in a society with systems and structures that are not designed to include disabled people or to enable their participation and contributions. The CN through their work seeks to empower people that have commonly had experience of disempowerment through their lives as disabled people and as users of services. Being based within GDA means that the CN approach to support is built on empathy, knowledge and understanding, because GDA and its activities are run by disabled people, are accessible and are built around needs of the individual being supported.

GDA uses a community development approach. *Future Visions for Social Care* is located in this context and therefore employs methods which build capacity and increase peoples' sense of empowerment. For the CN this means working alongside their client, role modelling negotiation strategies, and ensuring consent when the CN needs to advocate on their behalf. The CN's empowerment methods and approaches also apply to the professionals with whom the CN negotiates, as they seek to support them to use the power they have to resolve issues.

Through *Future Visions*, community development, peer support and collective empowerment are activated through the Social Care Expert Group. SCEG allows disabled people, including people supported by the CN that wish to be involved, to build knowledge, skills and confidence in an accessible context, to connect with

others to enhance their collective 'voice', and to influence social care policy and practice together, including co-design projects with the Scottish Government. The CN work, importantly, can give disabled people the strength and opportunity to be involved in co-design of policy through SCEG. However, sometimes disabled people involved in SCEG and co-design have to drop out because of social care gaps, and the CN can help them bring their lived experience 'back in' to SCEG and co-design by supporting them to get their social care back in place.

GDA, its programmes and teams provide referral points into the CN for disabled people experiencing barriers to social care. For example, GDA receives calls or other contacts from disabled members of the public in social care or related need – about 60% of CN clients come this direct route (see Section 4). GDA's teams also provide expert support for CN clients that need this. For example, the CN can access or refer people they support to GDA's Welfare Rights, wellbeing support or digital inclusion teams, or link the individual into GDA's learning, leisure, and policy-influencing activities that help to tackle isolation, build community, and empower disabled people. Being part of an interdisciplinary and high-profile DPO therefore means that disabled people can not only find the CN in the first instance; it also means that the CN has support from GDA colleagues to reduce and remove intersectoral barriers to social care, and to support their cases towards wellbeing and independent living.

Together these four elements constitute the distinctive 'package' that allows the CN to successfully intervene and support disabled people experiencing complex barriers to improve their opportunity to achieve and sustain social care, independent living, and wellbeing.

3. How the Community Navigator complements other support structures for disabled people needing social care

Similarly to other local authorities in Scotland, there are several routes through which disabled people in the Glasgow region can seek support if they are experiencing barriers to getting and keeping the social care they need. Support in the Right Direction (SIRD)-funded projects, Community Link Workers (CLW), and advocacy services are all vital elements as part of the web of support for diverse disabled people seeking social care.

Some disabled people may need only an SIRD project to support them to obtain and maintain the Self-Directed Support (SDS) that they need. Vital as the SIRD-funded projects are, as described above, for so many disabled people getting and keeping good social care can involve far more complexities than being informed about, applying for, or receiving an SDS package. Similarly, some disabled people may simply need a limited number of appointments with a Community Link Worker to 'signpost' them to the support that they need beyond the GP surgery. Imperative as Community Link Workers are, as noted above, supporting disabled people with complex impairments, living with poverty and in inaccessible housing and experiencing multiple barriers across public services, requires intensive and 'hands on' medium to long-term support to activate the social care they need, which is more than CLWs are typically able to provide. And essential as advocacy services are for enabling individual 'voice', the CN supports disabled people in very active ways to navigate services, and to seek collective voice through SCEG. The CN also works with any disabled person – they do not specialise in (for example) learning difficulties or mental distress, as advocacy services are typically funded to do, nor are they restricted by geography.

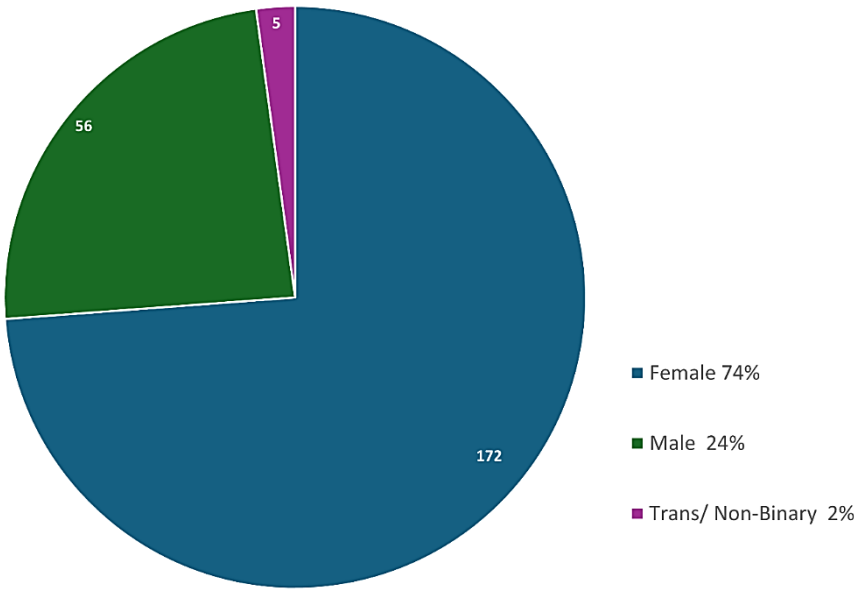
Some disabled people, especially those that are highly marginalised and face intersecting barriers, need a combination of temporal depth and intersectoral breadth to be able to have the chance to get and keep the social care they need. This is where the CN offers a distinctive and complementary service to advocacy, Community Link Workers or SDS-specific projects. The four types of service complement each other.

4. Analysis of Community Navigator interventions: April 2022-March 2024

This section contains quantitative data from the CN work between 1st April 2022 and 31st March 2024. It summarises the demographics of people supported by the CN; their social care status; and the range of themes on which the CN has worked.

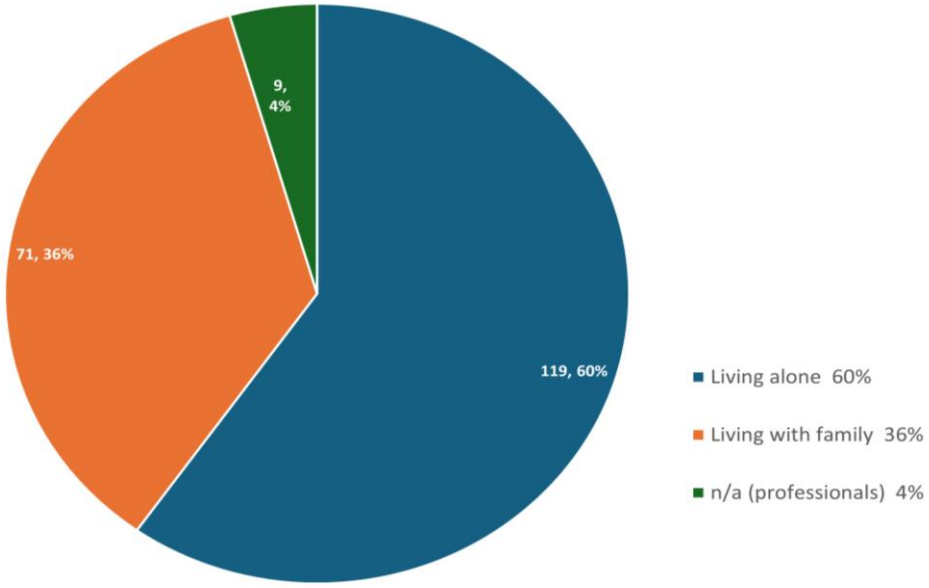
The CN made a total of 869 interventions over the two years, and worked with 242 individuals. Demographic data is collected with consent; therefore, some may be missing due to non-disclosure. GDA does not collect demographic data from professionals supported by the project.

a. Sex of those supported by the CN



74% of those supported by the CN identify as female. While females tend to live longer than males, CN cases are through the life course (see below).

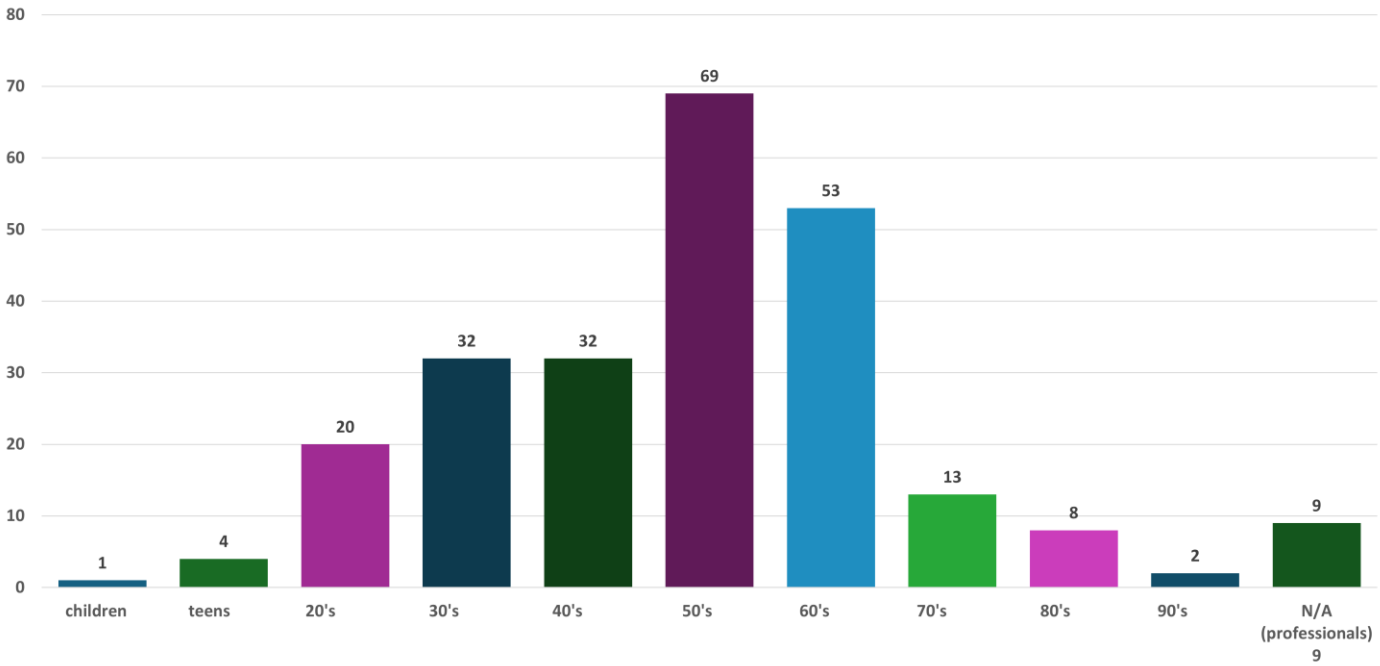
b. Living circumstances of those supported by the CN



60 % of those supported by the CN live alone. If a disabled person lives alone and needs help to navigate social care, who do they turn to, to get support?

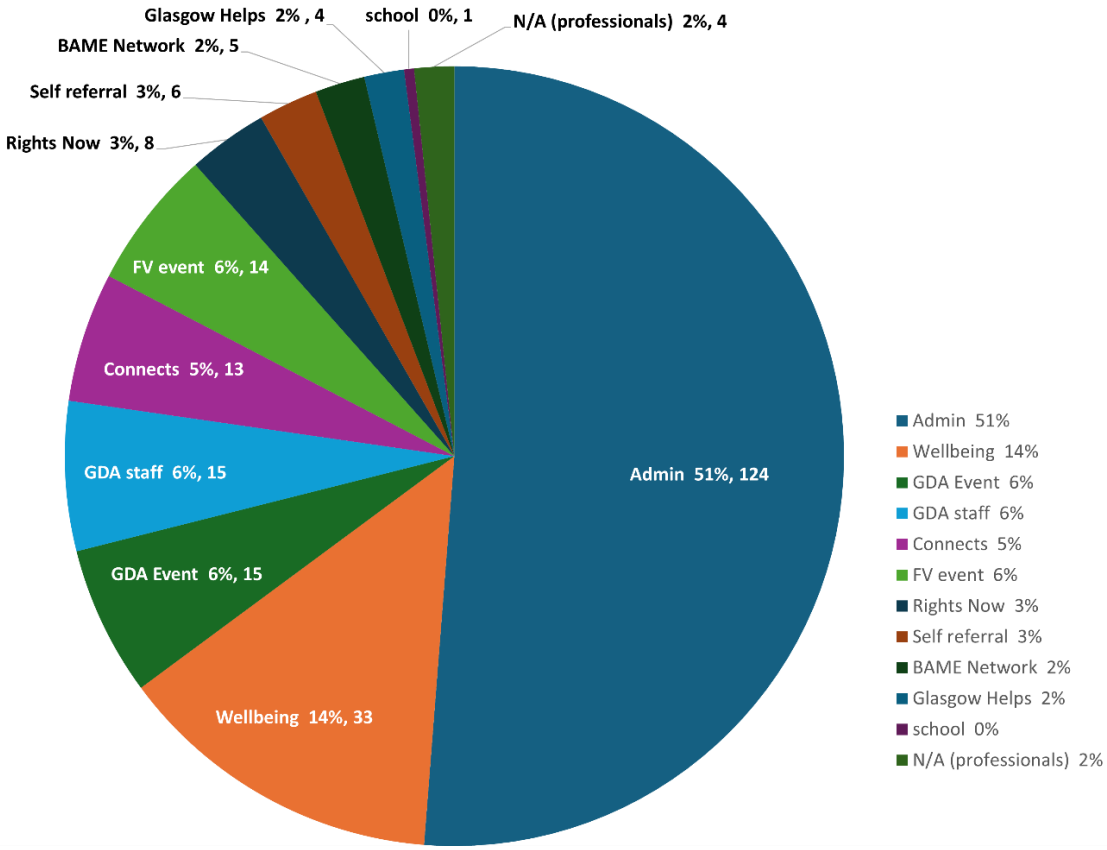
It is important to note that the 36% of those living with family members are very often living with other disabled people, including disabled children, parents or spouses. In many of these cases the CN is supporting the whole family.

c. Age range of those supported by the CN



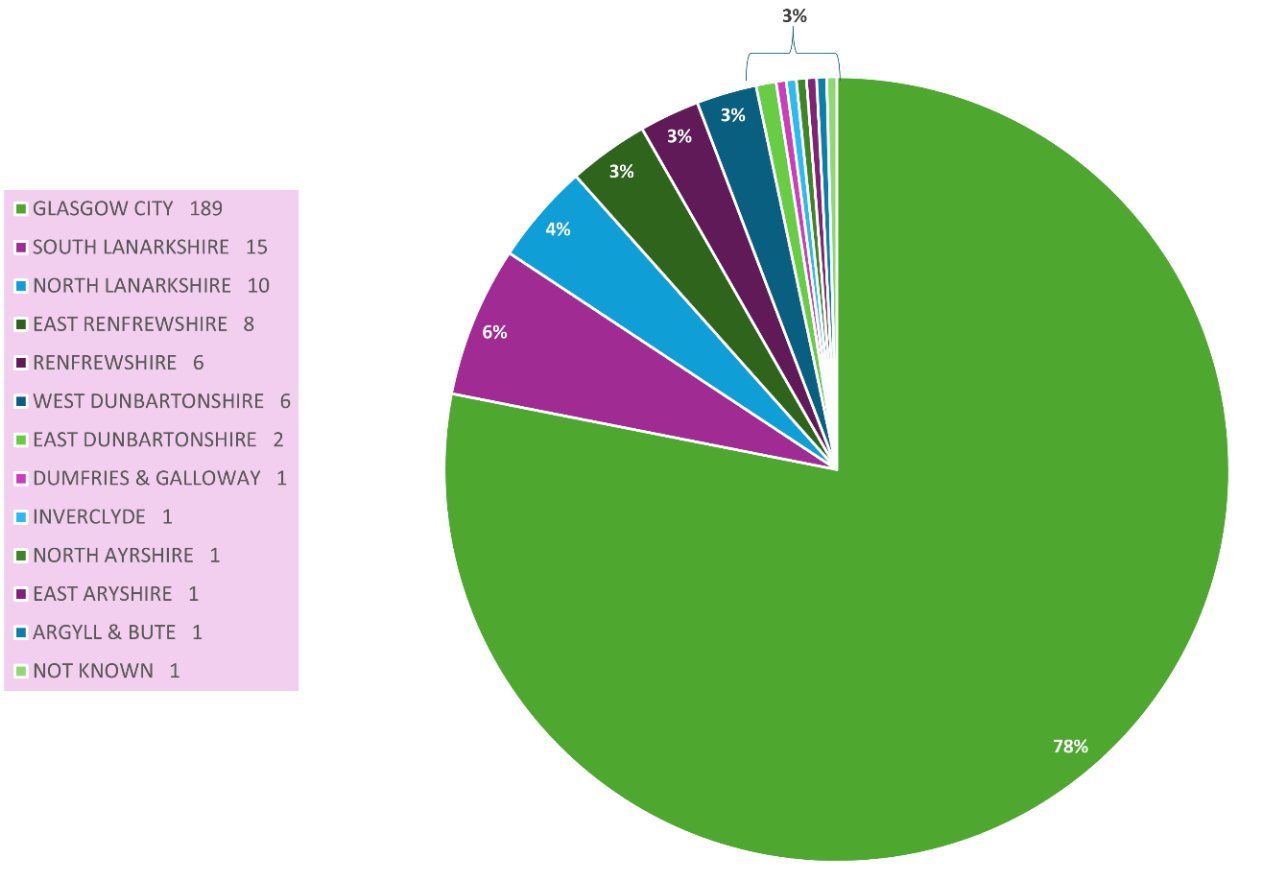
The bulk of people supported by the CN are aged in their 50s or 60s. However, there are significant numbers in their 20s, 30s and 40s. Social care is needed and used by people through the life course.

d. Referral routes for those supported by the CN



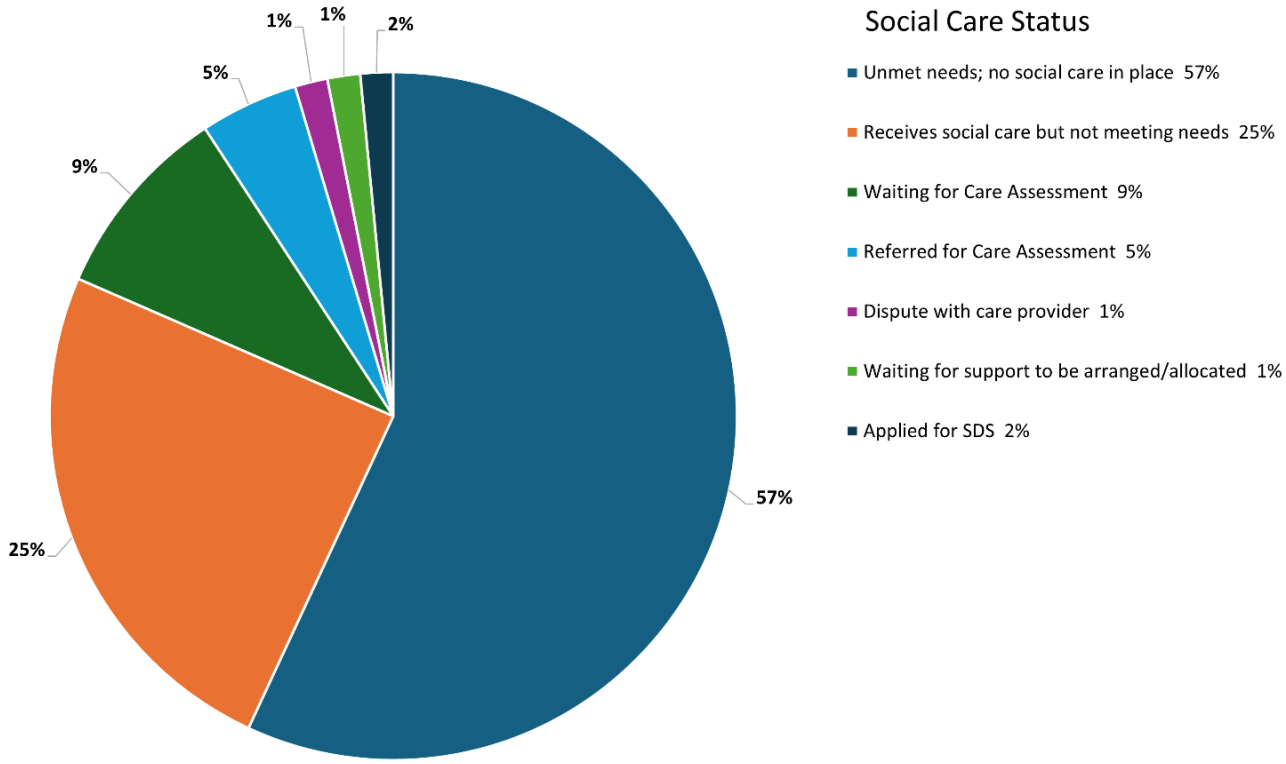
About 60% of referrals to the CN are via individual disabled people contacting the GDA administration team, or through self-referral in other ways. The rest mainly come via other GDA teams, networks and events where a potential social care navigation need for a person is identified. A small number of other professionals refer people to the CN for advice and support, usually Community Link Workers.

e. Local authority area of those supported by the CN



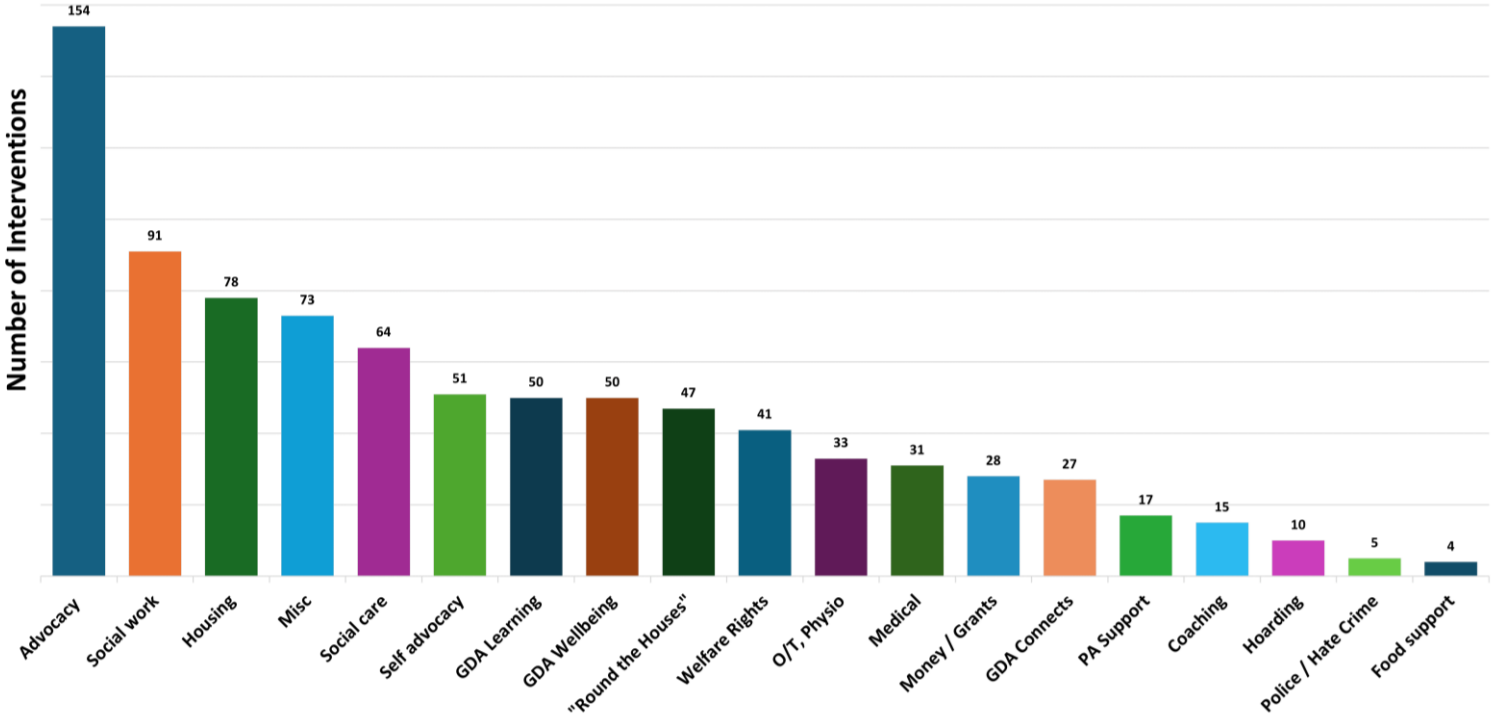
While those supported by the CN usually live in Glasgow, in 2022-24 the CN has been contacted by and worked with people from eleven other local authority areas. This demonstrates that there is also a need for community navigation support workers in other local authority areas.

f. Social care status of those supported by the CN



57% of people using the CN have no social care in place at all, but feel they need it. 25% receive some social care, but it does not meet their needs. 9% are waiting for a care assessment. This demonstrates the depth of unmet social care needs of people supported by the CN.

g. Types of CN intervention



The total number of interventions made by the CN over the two years is 869. This demonstrates that most of the people supported by the CN need more than one type of intervention – often they need several. This is demonstrated in the five in-depth case descriptions in **Section 5.** Table 1 details the support given by the CN under each of the 19 headings. The sheer range of types of intervention by the CN is striking, and can be divided into four broader categories:

- Providing advocacy or supporting self-advocacy.
- Work with services (e.g. social work, housing or health).
- GDA internal referral (e.g. for specialist welfare rights advice, coaching or IT support).
- Other – including supporting people with issues that are being ignored, or where they have been sent 'round the houses' without resolution by services, supporting people with money issues or food needs, very specific issues such as hoarding, and miscellaneous issues (exemplified in Table 1).

Table 1

Support Theme	Number of Interventions	Details of support needed
Advocacy	154	CN is acting as advocate for the person.
Social work	91	Dealing with a social work issue – complaint; referrals for assessment; also non-social care social work issues; Adult Protection, etc.
Housing	78	Dealing with housing issue – repairs, complaints, unsuitable housing, moving, application for house move, etc.
Misc.	73	Examples: supporting a person to get a postal vote; sorting out insurance issues and claims; dealing with a flea infestation; helping an elderly woman to not be harassed by social work about her son's living situation; supporting someone with very complicated dietary needs to access food support; supporting a disabled person who works Mon-Fri to access social activities; supporting a person to access a driving assessment for disabled people to learn to drive; supporting someone to get pets back home from SSPCA after housing thought they had left home; supporting a person to access emergency information jewellery; supporting someone to get a refund from a slimming club when the club were unable to weigh a wheelchair user; supporting a person to dispose of an old bed to enable a new one to be delivered.
Social care	64	Dealing with existing social care package issues.
Self advocacy	51	Providing support, confidence building and guidance to people to enable them to speak up for themselves.
GDA Learning	50	Supporting people to access GDA Learning.
GDA Wellbeing	50	Referring people to GDA Wellbeing colleagues; providing wellbeing support directly to the person.
Being Ignored	47	When the person has been 'round the houses' trying to access support and not getting anywhere.
Welfare Rights	41	People requiring welfare rights support; usually referred to GDA Rights Now if in Glasgow.
O/T, Physio	33	Person needing OT / physio support / referral / complaint / equipment – can be health or social work.
Medical	31	Usually this is supporting people to access GP appointments; also chasing appts / referrals to medical services.
Money / Grants	28	Supporting with financial needs, e.g. support to apply for individual grants; dealing with utilities.
GDA Connects	27	People needing digital inclusion support – referred to GDA Connects.
GDA PA Support	17	Providing PA support via GDA for individuals in need.
GDA Coaching	15	Referral for individual coaching support via GDA.
Hoarding	10	Supporting people to deal with impacts of hoarding and find solutions in terms of their hoarding.
Police / Hate Crime	5	People needing support to deal with neighbour disputes; hate crime; self-harming behaviour; etc.
Food support	4	People needing foodbank referrals and support.

Conclusion on Community Navigator quantitative data.

The data show that the 242 people supported by the CN across the past two years are predominantly female, are of all ages, and mainly live alone. The referrals come in through GDA administration and GDA services – demonstrating the benefit of having the CN housed within a DPO. The 869 interventions made by the CN also include copious support provided by GDA teams, making a virtuous circle.

The data also show the reality that only a small amount of the work that the CN does is about directly supporting people with navigating SDS. The work is predominantly the 'step before' that, supporting people that have sometimes been discouraged after trying to find SDS on their own; or who do not know their entitlement to social care; or who are in a predicament, which can sometimes be very serious, including basic health needs, poverty, or detrimental housing, and who need support with navigating a range of services to get them into a position to apply for and access social care services. The CN job is to understand the person's needs, and to help them navigate their way closer to having those needs met. All too often these are the most basic needs of life, such as food, an accessible home, or money.

5. Five in-depth Community Navigator cases

a. Introduction

The five cases below are co-written by Fiona McAloon (GDA Community Navigator) and Dr Richard Brunner, University of Glasgow. The descriptions are based on the CN's contemporaneous records, with minor editing for clarity. They include the time taken by the CN to do the actual work of supporting each of the cases, ranging from three hours to over nine hours. Each case description is followed by a short summary of the impact that the CN's work had, and the policy and practice learning demonstrated.

The cases that the CN supports rarely fit into neat 'boxes' or categories. People supported by the CN usually have a combination of services they interact with, impairments they live with, and barriers that they face to getting social care. The sample below are purposively selected to demonstrate the breadth of cases that the CN supports. They are not selected based on 'the best' or 'successes', but instead to offer a deep dive into the complexity of the work that is often required by the CN to secure the social care required by individuals. As seen below, CN support typically involves numerous interventions (calls, meetings, applications for support or assessment, conversations and negotiations with the person they support, and multiple contacts with multiple services). While each individual action will typically take minutes rather than hours, cases often continue across months, even years. Therefore, the cases below are not 'closed'; some of them are 'inactive', and some continue to be 'active'.

b. Five Community Navigator cases

Case 1: Lucy - trapped in a nursing home

Lucy is a disabled woman in her 60's, who uses a wheelchair. In August 2022, the breakdown of her marriage led to Lucy approaching social work and housing for help with accommodation. Because there was no temporary accommodation suitable for her needs, Lucy was offered a place in a nursing home. She accepted this and put her personal belongings into storage until a suitable tenancy could be found.

In April 2023, Lucy contacted the GDA Community Navigator (CN) to say she had a tenancy offer and would get the keys the next day. She did not know how she would manage to get her belongings out of storage and unpacked. Such support was not offered by her social worker or housing officer.

Using the resources of GDA, the CN arranged Personal Assistant (PA) support to meet Lucy at her new home, unpack and place the belongings coming out of storage. Lucy reported feeling incredibly happy to have her home and expressed gratitude to GDA for supporting her. She expected to physically move in during the next few days when her care package would commence. [CN support input = 40 mins].

In early August 2023, Lucy contacted the CN to say she was still in the nursing home. It seems that her social worker had retired suddenly without signing the package off. Her care package remained on a waiting list. Lucy reported having spoken to Social Work who kept saying they will call back but never actually did. Lucy said that she would give Social Work a couple of weeks more to organize things before involving the CN. [20 mins]

In late August, the CN contacted L's social worker asking for L's case to be escalated. The CN pointed out the misuse of resources involving a person having to live in a nursing home because there is no social care to support them to move into their own home. L's social worker said she would approach the team leader to see what can be done. [50 mins]

A week later the CN contacted Social Work again. The social worker said that Home Care were not returning calls. The CN contacted Home Care directly who said they had no record of Lucy as an active case, and to call Social Care Direct, the body who take referrals. Social Care Direct said they could not help as Lucy already had a social worker. The CN then contacted social work complaints giving the details of how Lucy had waited since April for a care package. The complaints handler said that the matter will be investigated, and someone would get back to the caller. [65mins]

A week later, the CN called Lucy to ask if there was any movement. Lucy reported that her social worker was more attentive but nothing else had happened. [40 mins]

Two days later, due to the complaint raised by the CN, Lucy was visited by her social worker and an O/T. She was told she would be able to move into her own home in the week beginning the 26th September. [20 mins]

On 26th September, Lucy moved into her property, after five months of waiting in a nursing home.

Helping Lucy to navigate this process took approximately four hours of work from the Community Navigator between April and September 2023.

Impact of the Community Navigator

This case demonstrates:

- the persistence required by the CN, including overcoming misinformation and using a variety of strategies, including informal attempts to collaborate and making a formal complaint, to get movement.
- how onerous and painstaking the work is to resolve this type of problem, and the difference CN support made.
- how the resources of GDA complement gaps left by statutory services, in this case providing PA support with unpacking.
- that with the correct support, a disabled person can achieve their goal of independent living i.e. accessing the support this person needed to live the life they wanted, in their own home and with choices equal to others.

Policy and practice learning

This case demonstrates:

- how an expensive care home place can be taken up for months, even though a person had an independent living option ready for them.
- how the person's right to live in their own home was overridden for months, not only breaching their human rights but also costing the state more money.
- the importance of transparent and accessible complaints procedures, as a last resort for changing 'stuck' situations.
- how case management by social work services can be hampered by fragmented communications and lack of joined up working between departments.

Case 2: Wanda – navigating SDS review meetings

Wanda, a woman in her 30's on Self Directed Support who lives at home in a rural area with her parents, contacted GDA in July 2023 to discuss her upcoming review with social work. Wanda felt that the review may cut her care package and felt that her social worker was pushing her to leave home. She wanted to know what to ask at the review. She had an advocate who would be with her for the meeting. The GDA Community Navigator (CN) advised her on questions to ask at the review if she felt compromised in any way.

At the review meeting the social worker asked if she could speak to Wanda on her own, rather than in the presence of the advocate. Wanda refused this saying the person was there for support. Wanda called the CN after the meeting to say her social worker had expressed that the care Wanda was currently receiving was inconsistent, and suggested that Wanda would be better with an agency because of the situation on some weekends. Wanda agreed the care could be more settled at weekends, but she liked the care team she employs through her SDS. At weekends, Wanda's mum filled in as a member of the care team. The social worker felt this was not appropriate and did not want her mum to be a paid carer. Wanda felt this was unfair if her Mum was happy carrying out care tasks for her. The social worker also wanted Wanda to think about moving away from her parents' home into her own, and that a local town would ease transition of care.

After this review, the social worker contacted Wanda again, saying "there are things that warrant further investigation", and that she would have to re-do the entire review and assessment of care. Wanda was understandably alarmed about this. The social worker also said she wanted to meet with Wanda and a care company to see what they could offer. Wanda felt upset about this as she was not sure she wanted any agency involvement.

When she spoke to the CN about the ambiguity of statements like "warrant further investigation" the CN advised Wanda to ask for clarification of this in an email. Wanda requested the CN to be present at the re-scheduled review. The CN agreed to do this to support Wanda.

At this meeting Wanda was asked about moving home away from her parents. She was asked about "how long she could be left alone" and encouraged to be alone for longer periods of time. Wanda did not feel ready to leave her parents; she had no exterior support structure or friends. The social worker was disgruntled at the presence of the CN and said if Wanda felt uncomfortable "she (the social worker) did not have to be there". The CN intervened to say that Wanda never implied that her social worker was unwelcome, merely that she wished for some additional support.

Although the social worker felt that more consistent support could be secured in a more urban location, they accepted that Wanda was not ready to move away from her home village to a town where she did not know anyone. The social worker said she would leave the package "as is" for now and arrange a further review in a few months.

Social work contacted Wanda in January 2024 to suggest scheduling a new appointment. The CN will attend to support Wanda. The case is ongoing.

Helping Wanda to navigate this process took approximately 9.3 hours of work from the Community Navigator between July 2023 and January 2024.

Impact of the Community Navigator

This case demonstrates:

- a typical case of a person seeking support as they sense that their care package will be changed at review to something that does not suit their wishes or needs.
- how the CN work complements advocacy work.

Policy and practice learning

This case demonstrates:

- the care needed by professionals to avoid inflammatory language ('warrant investigation' in this case).
- the potential for misuse of power due to what might be genuine concerns but remain unsubstantiated.
- the tension between potential paternalism of services versus respecting individual autonomy and choices.
- the culture and practice shift still needed for service providers to fully embrace peoples' choice to use advocacy or Community Navigation support.

Case 3: Laura & Sasha – navigating wellbeing and connection, post-Covid-19

Laura, a woman in her 70s, initially contacted GDA in August 2023, to ask if we knew of anyone who could make use of her electric wheelchair, because she no longer went out and felt she had no use for it. The GDA Community Navigator (CN) visited, to better understand the situation. Laura had been an active member of the disabled community and a member of a disabled peoples' drama group.

Laura had struggled with various impairments for many years and needed to shield during Covid. Laura experienced acute anxiety during Covid, and became less keen to leave her home, which left her increasingly isolated. In 2023, she contracted a blood clot in her lung and ongoing circulatory issues that mean that she cannot sit with her legs down and needs to sit with her legs always outstretched. She cannot weight-bear and is dependent on care staff hoisting her from bed to chair. Care staff from an agency attend four times per day for 20 minutes per visit. They support Laura with continence, meal provisions, necessary hygiene/laundry, and shopping.

Without social care to accompany Laura, or the money for the use of accessible taxis (which are more expensive), going out had become too difficult. The CN said that if Laura wanted to go out GDA could arrange ways of doing this, but Laura said that she was content to remain at home now. Laura used to use her iPad to connect to activities and to shop online, but had lost the password and lost the momentum to take charge of things. The only person that visited her regularly (care staff aside) was her friend Sasha.

Sasha makes the journey across the city to visit Laura weekly; this is despite her own declining health. Sasha gets two buses and walks up a steep hill to Laura's home, which she finds increasingly difficult due to her health and worries about winter weather. Laura and Sasha used to meet in the city and go for lunches; they used to go on holidays together. Life has significantly changed for them both. It was becoming increasingly hard for the friends to keep seeing each other – visits that supported the wellbeing of both.

Discussing with Laura how her situation might be improved, the CN suggested that the GDA digital team visit and re-connect her iPad. Laura could then participate in GDA activities online and video-call her friend, and her sons who did not live locally. The CN suggested a tablet support device to rest on her knee, so she could use the tablet hands-free. In October 2023 the GDA Digital Team visited Laura, unlocked and refreshed the iPad, sourced the proper support device for her to use in her reclining chair, entered the apps and sites that Laura used regularly, and supported her to sign up for GDA online events. Laura was delighted with this. The Digital Team made a follow-up visit in November to check all was still ok.

The CN discussed with Laura how else life could be made easier for her. Laura felt that the weekly journey for her friend Sasha was too arduous. The CN contacted Sasha, who confirmed the barriers to transport, in particular getting on and off buses and walking up the hill to Laura's home. The CN arranged for GDA to fund a weekly taxi for Sasha to get there each week. At the time of writing, this has been happening for three months, but GDA cannot support this in perpetuity.

In subsequent conversations, Laura has said how grateful she is that her friend can visit her without difficulty. Sasha has also said that she is grateful for the ease of travel. The difficulties she was experiencing were making it impossible to continue the visits the two friends enjoyed so much. The CN has had to explain that this support is time/resource limited. Laura and Sasha acknowledge this and express gratitude for the temporary removal of the barriers that make life difficult for them, which has made life happier, removed anxiety and physical difficulty, connected Laura to the outside world again, and ensured the friendship of years has been preserved.

By removing simple barriers, the friends can enjoy time together in companionship. By GDA assisting the visits, Sasha's physical health has been protected, and it is likely that both parties' mental health has been improved by having the visits to look forward to.

This case took 3 hours of work from the Community Navigator, plus 2hrs approx. from the GDA Digital Team.

Impact of the Community Navigator

This case demonstrates:

- how the CN, with the GDA Digital Team, helped to actualise independent living.
- how the 'wrap around' services of GDA knitted together the elements to allow Laura to maintain connection with their family and friend.
- the 'wellbeing' focus of these interventions. Laura had minimal contact with any other people apart from their care workers who were there for a brief time and were necessarily task-led. Being able to keep the friends connected avoids potential demand for further social work intervention (e.g. formal assessment and allocation of social hours or befriending).
- how interventions can be responsive to increasing impairments and changing lifestyles.
- how future wellbeing in Scotland will increasingly involve digital inclusion. GDA is foreseeing this by employing IT inclusion experts that can support the CN.

Policy and practice learning

This case demonstrates:

- generational dimensions: ageing people and the array of new technologies demand new types of intervention to remove barriers: not only safe transport, but also digital inclusion. This is 21st Century social care.
- unmet needs: receiving four daily supports may suggest that Laura's social care needs are being met. But this is far from true. Laura has unmet needs around their need and right to participate, and even to contribute. 'Unmet needs' need to be accurately and routinely captured.
- person-centred support to tackle social isolation: formal interventions to address isolation and loneliness are more likely to reach those that can get to services and supports (e.g. lunch clubs, social clubs). More must be done for socially isolated disabled people with higher level support needs: person-centred support for people who are older and/or disabled and require support to sustain friendships at home.
- 'wellbeing' policies and strategies must include actions to target those with higher level support needs, who have an equal right and need to live well.
- services need to assess situations holistically: in this case, the holistic approach of the CN got beyond the presenting issue of the wheelchair and resulted in enabling another disabled person (with no social care) to support the individual who asked for assistance.

Case 4: Miles – navigating the health implications of unmet social care needs

Miles is a man in his 70s with physical and visual impairments. He contacted GDA in November 2023, to ask for support regarding his care slots and his community alarm. The GDA Community Navigator (CN) identified four issues.

a. Miles said that he had used the community alarm to ask for help. This was because his evening care staff forgot to attach his night catheter bag (note: a backup of urine can be extremely dangerous). He asked the community alarm team for help to attach the bag to allow the flow from the leg bag. They refused attendance. This meant that Miles attempted to do this himself, despite experiencing manual dexterity issues and being unable to get out of bed. The result was spilt urine, not because this had to happen, but because help was refused.

b. Miles also stated that he asked for a different community alarm provider even if he had to pay for it, as the service was unhelpful for him. He was told that the local authority has the monopoly for the area and there was no other provider. He was unhappy about this and wished to challenge the service on what they do.

c. Miles also described some care staff not being able to hoist him due to lack of training. This meant that he was often left in bed, and now had muscular atrophy due to lack of movement. He reported that because he was rarely in his wheelchair, he is unable to attend hospital appointments. He also reported he would like to be moving more and to have physio if possible.

d. Finally, Miles had asked for support from the sensory impairment team as he was experiencing an increase in his visual impairment. He was told months ago that someone would call him but no one had.

The CN applied through the social services online system for support and attention for Miles. Two weeks later there had been no response. The CN called social work and asked for the duty worker and was told someone would call back. The CN continued to pursue the four issues with the following outcomes:

a. and b. The issues with the community alarm were addressed. It was agreed that it was reasonable to use the alarm for catheter bag issues.

c. A tracking hoist has been installed and all staff are trained to use it. However, physiotherapy was refused, so Miles is having to pay privately for this.

d. Miles received an assessment from the sensory impairment team. Unfortunately, due to an accident with Miles's power chair whilst this was taking place it was halted, with the O/T saying Miles had to have support in order to have the assessment. The CN is currently challenging this decision on the grounds that it was the first time Miles had used this power chair, and as such, it was this unfamiliarity that led to the accident.

Helping Miles to navigate this process took approximately 7.6 hours of work from the Community Navigator between November 2023 and January 2024

Impact of the Community Navigator

This case demonstrates:

- how the CN supports a person with multiple impairments, and facing barriers that straddle health and social care.
- how an advocacy role by the CN was needed to enable Miles to get responses on these multiple issues from multiple services.

Policy and practice learning

This case demonstrates:

- the potential for life-threatening health impacts if the highly skilled work of professional care staff is imperfectly conducted (in this case, a catheter).
- that if there is one community alarm provider, this limits choice for people that use social care. This will apply to other social care services too.
- there are potentially significant, negative health impacts on disabled people with chronic health conditions (in this case, muscular atrophy) if care teams do not hold requisite skills needed by individuals (in this case, hoist operation).
- that people can currently be placed in the position of having to pay privately for physiotherapy which is a basic health and care need for them.

Case 5: Donald – navigating hospital discharge

April 2023

Donald, a man in his 60s, lives alone in a local authority bordering Glasgow. He is a stroke survivor, and was in hospital approx. 1 year ago with a fractured shoulder after a fall at home. His health and balance is deteriorating since the stroke. He was kept in hospital for longer than necessary because no care was available to support him on discharge. Donald self-discharged as he was stressed and unhappy being in hospital so long. Hospital indicated Occupational Therapy (OT) would visit him at home to see what aids and adjustments were necessary for his safety and comfort.

Nine months later, Donald called GDA and asked if anyone could help, reporting that the promised assessment never happened. He had tried calling social work/OT enquiring about the promised assessment, with no response.

The GDA Community Navigator (CN) called Donald who said that he was unsteady before the fracture, and that his balance was becoming an increasing problem. He was finding it difficult to navigate safely around his home; he had fallen out of bed and fallen in the hallway, and was generally unable to maintain balance and strength. He was having trouble in the shower. Donald felt he needed a handrail in his hallway, grab rails in the shower, a safety barrier beside his bed to prevent him falling out, and a trolley table to move food and drink from the kitchen. He feared another significant fall and major fracture. It needed an in-depth conversation for the CN to fully understand his situation and needs. Donald said that he was grateful for the support and gave permission to the CN to contact social work on his behalf. [CN support input = 40 minutes]

The CN then contacted social work, initially through an application portal to request the assessment of support needs.

Donald called the CN to inform that a call handler telephoned 3 days later and told him he should "buy handrails from Amazon" as they don't supply these any more. After discussion with Donald, the CN called social work to challenge this. During this conversation, the representative said that Donald's PIP was awarded to purchase aids to make his life easier, and that O/T services would not help with this. The CN pointed out that PIP is awarded to cover extra expenses incurred by disability, not essential equipment, and asked how a call handler was qualified to advise on what aids were appropriate for Donald, what height they should be installed at, and who was going to do the installing since the person is disabled? The call handler then advised that perhaps the neighbouring council might help, as Donald lived on the boundary. The CN then asked why this information wasn't given to Donald initially, instead of telling him to shop at Amazon. [40 mins]

The CN contacted the neighbouring local authority to request support for Donald. The call handler told the CN that Donald had received an assessment visit on discharge from hospital. The CN replied that someone had phoned Donald, but not visited, from the first council area after our request for support online, and that when they phoned him he felt they were "giving him the brush off"– that's why he contacted GDA - and assured them that no O/T had attended Donald. This person also said that when people receive certain benefits, they are expected to use them for aids. The CN again disputed this interpretation of PIP and also said that without a proper, and appropriate, occupational therapy assessment, a person would not know what the most suitable aids actually were - how are folk expected to have the skill of an O/T professional? The call handler said she would call Donald to see how they could help him. [30 minutes]

May 2023

The CN called Donald to enquire on progress. It transpired the person did call Donald and again he was advised to purchase his own handrails, claiming that social work did not supply these. Donald was still refused access to an Occupational Therapy assessment. The CN spoke to Donald again and asked if he would be ok with her contacting his GP to see if they could help with a referral. Donald said yes please as he felt no-one listens to him when he calls. The CN made the call, and the GP was happy to refer him. [40 mins]

August 2023

The CN called Donald for a report on any progress. Donald said that OT phoned him some weeks ago, but no one had visited. He said he purchased a bed handrail from Amazon because he was too scared to wait any longer, and that his friend had built and installed it. He said he was still unsteady and afraid when walking around the home and in the shower. With Donald's agreement, the CN contacted social work again to ask what was happening and why Donald had not received attention as a high fall risk. They replied that Donald was on a waiting list for an O/T visit, with no timescale due to the length of the list. The CN pointed out that Donald is a vulnerable person with a high risk of falling and that she would make a record of this response for Donald's use in the event of another fall and fracture situation. [20 mins]

October 2023

Donald called the CN. There had still been no visit from O/T. Donald said that he was promised grab rails for his shower weeks ago, handrails for the hallway were still refused, and a trolley table was refused on the grounds that they gave him one 13 years ago (the wheels were not working now). The CN called social work, asking that they investigate why he had received no response from them, and reiterating that Donald required a proper needs assessment. The call handler said she would call installation services to enquire.

Four days later, Donald called to say that he had received his grab rails for the shower installed by disability equipment suppliers, but that no other service was authorised. Donald said he remained unsteady and off-balance. [30 minutes]

Late October 2023

The CN has been unable to get occupational therapy attention for Donald. Donald feels anxious about his safety, he feels vulnerable and reports the instances of falling are becoming more frequent. The CN is persisting with attempts to get Donald the service he needs for his safety and independence to be maximised.

30 Jan 2024

Nothing has changed. The local authority argue that there needs to be a risk to 'tissue integrity' in order to get homecare.

At the time of writing, the Community Navigator has spent more than 4 hours over seven months working with Donald trying to achieve the outcome to which he is entitled.

Impact of the Community Navigator

This case demonstrates:

- the painstaking, assertive, diplomatic and open-ended CN work that is commonly needed to support a person with multiple vulnerabilities to get the support they need.
- how the CN's advocacy has led to social work changing the information that they originally gave to Donald on needing to buy grab rails from his PIP. Social services changed their argument that they no longer install grab rails as they are a hazard. Without the CN, Donald would have been given inaccurate information and had to live with that.
- that, despite CN support, Donald remains in a vulnerable position 18 months after hospital discharge. The assessment on discharge from hospital in approx. April 2022 has still not happened.

Policy and practice learning

This case demonstrates:

- that there can be lack of clarity over who has responsibility for assessment on discharge from hospital.
- a need for quality assurance over the consistency and accuracy of information from social care at local authority level (e.g. grab rails policy, PIP rules)
- issues in relation to unmet needs and prevention (for example, is 'tissue integrity' risk a reasonable 'bar' for receiving homecare?)
- how are cases like this resolved – who owns the problem?
- the provision of information, support and potentially low-level cost equipment is preventative and can keep people safer for longer. The balance between prevention and earlier intervention and crisis response is being eroded. This may end up costing public services more in the medium to longer term due to potential falls, emergency admissions, and so on.

Conclusion on Community Navigator five in-depth cases.

The five cases demonstrate the temporal depth and intersectoral breadth that is the 'day job' of the CN, as they do the painstaking work of supporting disabled people to have the chance to get and keep the social care they need. The cases demonstrate the 'life-and-limb' issues that can arise in the intersection between health and social care services; the marginalisation from social care experienced by some disabled people; and the potential for achieving independent living using a combination of enabling real-world connection, and digital inclusion, in this case through GDA's person-centred approach.

There are a series of policy learnings at both national and local authority levels from this work as specified beneath each case.

As the five cases show, the CN role is necessary because:

- health, housing and social care services are not always sufficiently integrated to support people effectively.
- social care services are not identifying and acting on unmet needs.
- some disabled people face intersecting barriers and experience marginalisation by multiple public services.
- health, housing and social care services are not sufficiently supporting disabled people to achieve independent living outcomes and wellbeing.
- health and social care services are not always upholding human rights - reinforcing the March 2023 Community Navigator report (Scobie, Brunner & McAloon, 2023).

The work of the CN highlights these issues in the Glasgow region. This in turn suggests a need for a comparable CN service, housed in a disabled-person-led organisation or similar, in every local authority in Scotland.

6. Summary of themes and learning for policy and practice

This report builds on the March 2023 Community Navigator report (Scobie, Brunner & McAloon, 2023). It further demonstrates the breadth and depth of the CN work, supporting people to navigate barriers to social care and wider public service support both within the home and in the wider community.

The CN work highlights the value of social care in i. averting admission to hospital and ii. enabling swift discharge from in-patient services. The CN kicks into action when this does not happen. However, as the quantitative data shows, the CN supports disabled people that are highly marginalised from social care and other services with a very wide range of interventions. However, the CN is subject to short-term funding, and cannot possibly serve everyone that the system might 'miss'. As a previous GDA *Future Visions* report advocated (*A Time to be Bold*, Brunner, Burke, Scobie & Lawson, 2023), in order to fulfil the ambition of collaborative reform of social care and to achieve the wider National Care Service goal of achieving consistency and equality in social care in every area of Scotland, a disabled-people led organisation needs to be sustained in every local authority area, to lead a Future Visions-style programme - and incorporating a Community Navigation role.

The Community Navigator is a prototype for how social care and related public services can be supported to deliver their statutory responsibilities to all disabled people, in particular highly marginalised disabled people who face intersecting barriers.

The Community Navigator model:

a. **Reaches highly marginalised disabled people who face intersecting barriers** - and who exist in every local authority.

b. **Complements** advocacy, Support in the Right Direction, Community Link Worker, and other local supports.

c. **Reaches beyond other navigation services** - it is beyond 'signposting', is cross-impairment, is cross-service, and is open-ended. It is not limited by age or geography.

d. **Is founded on the values, credibility, and resource of the 'holding' organisation** - a disabled-people led organisation that is also intersectoral and multidisciplinary.

e. **Enables connection** to community, peer support and empowerment (through GDA groups and the SCEG).

f. **Draws 'voice' and the lived experiences of highly marginalised disabled people who face intersecting barriers** into local and national policy

g. **Is strongly researched** - through the *Future Visions for Social Care* model that includes researcher support. This maximises robust and credible findings that are useful for politicians, policy makers and practitioners.

h. **Supports statutory services and practitioners to fulfil their human rights obligations and deliver independent living for disabled people.**

7. Implications for local and national social care-related policymakers and practitioners

a. Gaps in the social care system make the Community Navigator role necessary (but still not sufficient to remove all barriers to receiving good social care). People are complicated; services can be too. This makes navigation support roles vital for two reasons: to support disabled people, especially those most marginalised, to get and keep the social care they need; and to enable services to fully serve all their citizens, especially those most marginalised. All local authorities will have disabled residents that need significant support and outreach to be able to get and keep the social care they need.

b. The CN helps public services, including those outwith social care, to improve how they remove barriers to disabled people, because their work necessarily reaches beyond formal social care services. The October 2023 GDA research report 'What Works in Community-Based Adult Social Care in Scotland?', concluded that good social care can only be delivered if other public services take actions to remove barriers for disabled people as well (Brunner 2023, pp.36-37):

> 'Self-directed support cannot enable independent living by being only about individual assessments. Many disabling barriers are outwith the remit of social care. Barriers to independent living include equal access to employment, leisure, education, holidays, social spaces, public transport, participation and much more. Wider public services and Scotland's wider social and economic policies need to take a far more proactive, strategic and intersectoral approach to removing physical, social, attitudinal and other barriers to disabled peoples' opportunities to have *'the same freedom, choice, dignity and control as other citizens at home, at work, and in the community.'* (Scottish Government, 2021, p.9).'

c. The CN principle of no 'case closed', only 'inactive', enables swift take-up should a person they support re-approach. Can IJBs, Health and Social Care Partnerships, and social services across Scotland learn from this re-orientation to reduce social care waiting times?

d. The in-depth CN cases highlight the well-established 'double whammy' in not funding sufficient social care for people with significant health conditions: more in-patient admissions, slower discharges, more onerous work on rehabilitation, more administration, and more risk. The flip-side is that there is a 'win-win' for funding preventative social care: fewer in-patient admissions, faster discharges, less rehabilitation, less administration, lower risk. **The in-depth CN cases highlight how the 'double whammy' in not funding sufficient social care for people with significant health conditions detriments the lived experience of disabled people – and shows the benefits of preventative social care**: maintaining health and wellbeing, independent living, and quality of life for disabled people.

e. The CN work demonstrates real-world examples of how disabled people need some, more, or amended social care to enable them to achieve and sustain independent living – and so fulfil unmet social care needs. Supporting wellbeing and independent living are goals of Self-Directed Support policy and guidance in Scotland. A GDA report as part of the *Future Visions for Social Care* programme (Zarkou & Brunner, 2023, p.5) 'How should we think about "unmet need" in social care?' proposed an updated definition of unmet social care needs in Scotland that fits with the contemporary purpose of SDS and the goal of independent living:

> 'Unmet needs in adult social care' in Scotland should therefore be defined as: (a) the number of adults in Scotland that need any, more, or amended, social care to enable them to achieve and sustain independent living, and (b) the range of those unsatisfied care and support needs.

f. A disproportionate number of disabled people that live alone approach the CN for support. Who looks out for and supports the increasing numbers of people living alone that are not receiving the social care support they need - people who do not have family for support? People living alone are an increasing demographic for social care (House of Lords Adult Social Care Committee, 2022). **Every local authority needs a strategy for identifying and supporting disabled people living alone, to make sure they have the social care they need.**

g. Through the *Future Visions for Social Care* model, the CN and people supported by CN can feed directly into both local and national social care-related policy, via the Social Care Expert Group and other GDA processes. **The *Future Visions for Social Care* model offers empowerment and peer support opportunities for people supported by the CN, and enables service leaders and providers to learn from the lived experience of disabled people that are highly marginalised from social care - and to change in response.** This leads to greater likelihood of generating inclusive solutions for future social care policy and practice.

8. Conclusion

The report demonstrates how the GDA Community Navigator works to support social care and related services to support disabled people in the Glasgow region. It shows the value of the CN working with the Social Care Expert Group to enable marginalised disabled people to have more collective empowerment and peer support, and to feed into policy locally and nationally. It demonstrates that there is a need for ongoing funding for these types of position in every local authority in Scotland, housed within a disabled-people-led organisation. The report presents evidenced learning for the Scottish Government, local authorities, IJBs and Health and Social Care Partnerships to take up.

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