



Care Navigation in Essex

Brian Goodwin
Community Services Manager
Rural Community Council of Essex

Community Agents Essex

The aims are:

1. To improve the health and wellbeing of older people and their informal carers.
2. To support and maintain independent living.
3. Reduce demand on health and social care services.

1/7/2014 to 28/2/2019

- Community Agents Essex has visited and supported 19,056 older people.
- As a result of our support less than 10% were referred back to Social Care.
- It is person centred and only 3.6% make no progress towards achieving their goals. 79.7% fully achieve their goals.
- Follow up calls indicate that 85.7% clients that would have been likely to receive a care package are still living at home with no further (statutory services) help after 12 months.



**Home
From
Hospital**

HOME FROM HOSPITAL

*To empower and enable older people
to leave hospital, return home and
live as independently as possible*



Home from Hospital aims:

- To help older people return home and live independently for as long as possible.
- To help older people access self-help and use their own support networks to live physically and emotionally well
- To provide access to further support within the community via voluntary organisations, wider health support (self-referrals, sensory, equipment etc) and access to Social Care where appropriate.

Referral Pathways

Hostpital Pathway

Refferal from:

Wards
FAU
EAU
Discharge
Coordinators
Social Workers
Rapid Discharge
Nurses

D2A Pathway

Refferal from:

Elm Tree
Silver Springs
The Oaks
The Haven
Baumont Mannor
OT's (ECC)
PT's (Ace)
SW's (ECC)

H2A Pathway

Refferal from:

Hub in hospital
(process is still in
progress)
Care providers (Swan)
Therapists PT/OT's
(Ace) (referral
pathway identified)
Not quite in practice,
work in progress

IP/external Pathway

Refferal from:

SW (ECC)
connected to:
Harwich,
Clacton
& Coastal Beds

(Very few and far
between)

Who we can help

- Patients who are over 65yrs
- vulnerable individuals or couples Who were previously living independent
- who may require additional support, with mobility – additional equipment at home etc
- with social and/or lifestyle issues and need other services – home help, shopping, transport, etc.
- Patients who have family carers who may require additional support
- Patients with on-going health issues – medical, emotional etc.

What happens next

1st Visit

- We see patients at bedside on the day they are referred
- We then have a conversation with them discussing their needs

2nd Visit

- We then visit at home within 24/48 hours of patient being discharged from Hospital
- No later than 72 hours

Outcome

- We discuss their needs further
- find suitable solutions tailored just for them

Home from Hospital achievements to date:

- From 1/1/2018 – we have assisted over 1000 patient cases.
- On average 98.8% of patients remain at home after 19 days which exceeds the target of 95% at 3 days
- Have built a fantastic relationship with Social Services, where our input is valued on a daily basis.
- Working even closer with our colleagues in Health services.
- Helping Future Gov to develop their digital app with the view to improve patient information/knowledge of services
- Continuing the development of working partnerships with external charities and organisations, such as CVS', Age Concern, Essex Sight etc.

Family Support Workers

- Learning Disability support covering Essex
- Individuals or their families
- Partnership with:
 - Essex Mencap
 - Braintree Mencap
 - Chelmsford Mencap
 - Southend Mencap
 - Colchester Gateway



Care Navigation Partnerships

- Working with Essex Lifestyle Service in each CCG area to support all adults:
 - West Essex with Age UK Essex (Smartlife)
 - Basildon & Brentwood
 - Castle Point and Rochford with CAVS
 - Mid Essex with CVS's
 - NE Essex with C360 and CVST
- Support Sanctuary Housing tenants



Essex
Lifestyle
Service



live well link well

THE SOCIAL PRESCRIBING COLLABORATION IN MID ESSEX

Questions?

