



Community
Care Navigator
and
Trusted
Assessor

Who are they?

- Someone who helps people to find their way through the many health, care and voluntary services available
- Someone who helps them get the right help to meet their needs
- Someone who can also help people develop a plan that works for them
- Someone who can link them with community resources to support them in taking action to enhance their health and wellbeing

How does it work?

- People aged 50+ are referred to the CN by friends, family, care managers, health visitors, doctors, voluntary sector, housing, etc
- People can self refer
- Depending on their needs a home visit is arranged
- Information given or further action taken

Impact

- The convenience of having someone visiting them in their own home
- Somewhere safe to discuss various options
- Choice and control increased through greater awareness of local resources and range of ways forward

Impact

- S needed to have a hip operation but refused to until her 7 dogs were cared for. Caroline found someone to look after the dogs, arranged aids and equipment to be installed before S came home so S could be discharged without any delay. Since her return home no care has been needed.
- *“you took me from suicidal to perhaps I can cope. Made such a difference to my quality of life and my reason to live.”*

What if?

S has a bad fall, rushed to hospital by ambulance, hip replaced + broken arm, concussion:

- Ambulance call out £247
- Additional 4 nights in hospital £1,000
- Residential stay for 2 weeks £1,100
- Health visitor once a week for 4 weeks £256
- Total cost £2,603
- CN Service £730 per week

What next?

- Hospital Care Navigators working at the William Harvey Hospital with the Integrated Discharge Team
- KCC workshops looking at the future development of the CN Service
- Possible extension to all adults
- Extend the CN service to all GP practices