Haringey Reach and Connect

Service Specification

Public Voice working in partnership with mind in Haringey for better mental health Vibrance involving people, inspiring lives

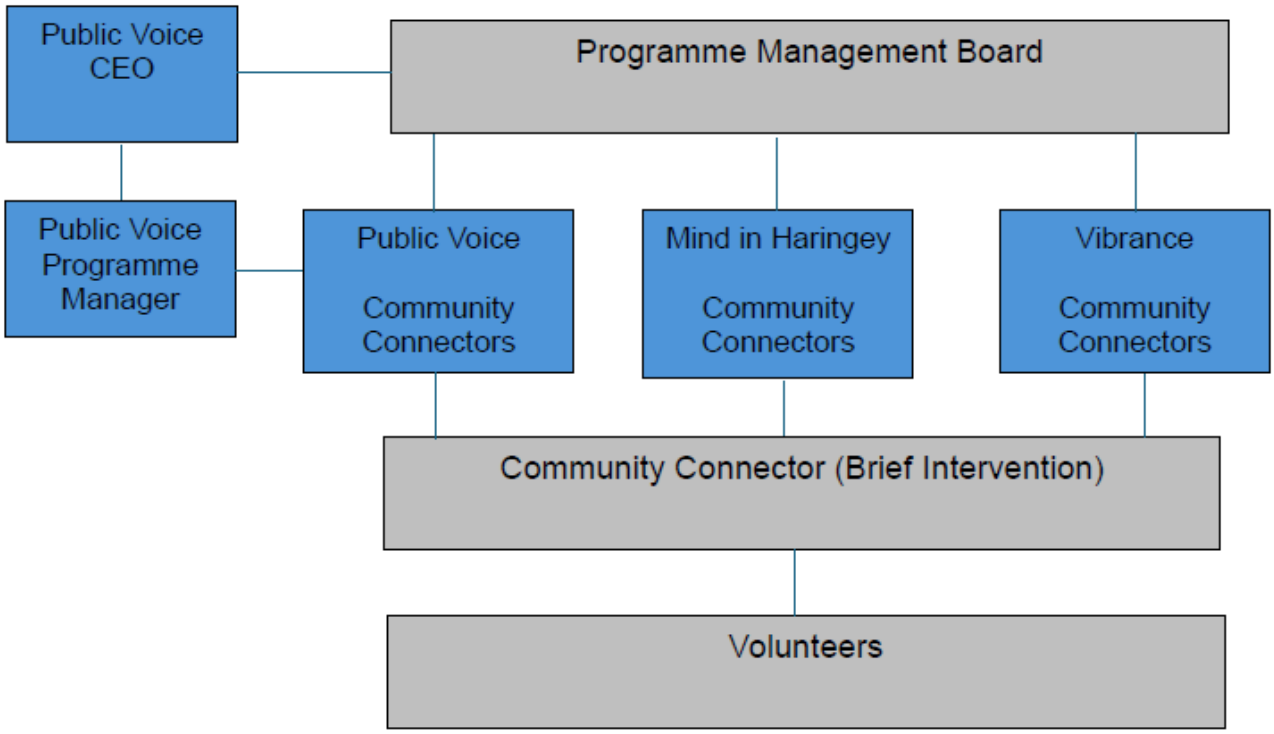
Reach and Connect

Community Navigator Service for Older People

Service Specification

1. Introduction

The service is delivered by a consortium of local third sector organisations led by Public Voice, www.publicvoice.london .The other consortium members are MIND in Haringey, and Vibrance.



2. Description of the Service

This service will be a borough-wide Community Navigator Service for older people aged 50+ under one unified contract and will be delivered from a range of community settings in eight localities within the London Borough of Haringey.

Community Connectors will work across the borough, from a range of settings, including libraries, community centres, sheltered housing schemes, GP practices and at local events, in localities which cover the whole borough. Connectors will become local experts, gathering and sharing information about local opportunities and non-service based activities and support for older people, bringing people together and supporting them to remain confident and independent in their everyday lives.

Connectors will be available to all Haringey residents 50+ in person, by e-mail and telephone and will offer support to identify what a good life looks like and then enable individuals to build the skills, networks and confidence to achieve their goals.

As well as universal support to all 50+ residents, Connectors will offer brief interventions of approximately two weeks to support people to manage and move through the initial impact of significant life events. The aim of this short-term intensive support is to support people to manage acute issues that commonly lead to homelessness, hospitalisation (or re-admission) or escalation in social care need such as:

- Returning home from hospital
- Experiencing a bereavement
- Moving home
- Following a break-in or experience of crime
- Following a fall or injury

The service will provide low to medium level support, be flexible and responsive to the multiple needs of service users and will actively seek to provide the service to older people at risk of social isolation e.g., LGBT+, disabled, BAME and socio-economically disadvantaged groups.

The service will recognise and celebrate the diverse skills and experiences older people have to offer. This will include supporting older people to develop peer support activities, hold community events and deliver training and workshops that address the priorities of people in their locality and enable the sharing of skills.

The service will be available outside of office hours where it is identified this would be beneficial and support the aims of the service.

3. Aims and Objectives

The aim of the service model is to provide proactive housing-related support that enables older people to live connected, active and independent lives. The service will provide;

- UNIVERSAL OFFER: individual and group support providing information, signposting and capacity building on a wide range of issues and opportunities. Usually delivered through drop-in sessions, events, and support groups and by appointment.
- TARGETED OFFER: intensive brief interventions that enable older people to manage complex issues such as returning from hospital, moving home, bereavement and experiencing crime. Usually delivered in and around the home for a maximum period of two-weeks.
- a holistic person-centred approach that sees housing support as a platform to address a range of experiences, needs and circumstances.

- support that enables people to identify and respond to emerging health and social care needs by accessing non-service interventions such as befriending, mentoring and volunteering.
- fair and equal access to the service for all vulnerable older people.
- safeguarding of vulnerable adults and protection from abuse, neglect and hate crime
- enabling older people to remain independent, improve their health and wellbeing and feel more included in their communities.
- supporting older people to be able to live within a diverse community, with people who are from different backgrounds with a wide range of cultural and religious beliefs and experiences.
- support to maximise income; this will include ensuring the service user is receiving the correct welfare benefits.
- support to reduce any debts and manage finances, including rent arrears.
- supporting each service user in accordance with their ability to live independently. This will require liaison and partnership with social care, health and housing partners to ensure people are receiving housing and support that is appropriate and safe.
- working in partnership with statutory and voluntary sector agencies in health, housing and social care as appropriate. This could include but not be limited to the following agencies: Adults Social Care, Assistive Technology Teams, Dementia Care Providers, Day Centres, Local Area Coordinators, GPs and Hospitals, Haringey Learning Disability Partnership, Floating Support Providers, Drug and Alcohol Treatment/Substance Misuse Services, Community Safety Teams, Domestic Violence and Hate Crime Teams, Mental Health Rehabilitation and Recovery Teams.
- developing and jointly reviewing support plans with other agencies that have contact with the service user.
- promoting health and wellbeing and work with residents to address any acute health issues.
- working with service users to reduce/eliminate anti-social behaviour.
- supporting key government policies including those covering the prevention of homelessness, reducing offending and fear of crime, the respect agenda, the prevention and wellbeing agenda, with the aim of creating sustainable communities.
- recruiting, training and developing staff with appropriate skills, qualifications and competencies who are committed to the delivery of a high quality service user centred service.
- implementing a robust outcomes and performance monitoring framework so that the quality of service can be demonstrated, on a scheduled basis and as required.
- working with the Strategic Commissioning Team to develop the service and measure outcomes.

4. Referrals & Access

The service is available to all older people aged 50 years and over who request support as a result of, but not limited to, the following experiences:

- Risk of or actual homelessness and/or in need of support that better meets their identified housing requirements
- Support needs linked to frailty, social isolation, mental health, substance misuse, offending or disability.

The service will not operate a referral process for the universal offer, but will accept introductions via e-mail, telephone or in person.

For the brief intervention service, a short referral form will be required to understand the particular support requirements and circumstances of those requiring support. However, should an older person approach for brief intervention support, without referral by a professional, the service will complete the referral form with them as a brief assessment.

If a referral for brief intervention support is refused by the service provider, reasons for refusal must be clearly documented and shared with referral agents and older people themselves. The right to challenge a decision should be available to all applicants.

Although the service is intended for people aged 50 years and over, it is recognised that other groups of vulnerable people might benefit from the particular support available, due to age-related circumstances or health issues, for example learning disabled adults with early on-set dementia.

5. Exclusions

It is expected that the provider will work from a ‘can-do’ approach in the first instance. No service user should be unreasonably excluded from accessing the service. The Provider is expected to ensure that where an applicant is rejected, advice and information about other relevant available services is offered.

Any decision to admit or reject applicants will be based upon the capability of the service to meet the person’s individual needs and an assessment of risk.

People who require high levels of support, care or supervision to live independently may not find the service beneficial or suitable for their particular needs.

Brief interventions will offer housing-related support, not social care or medical treatment and the Community Navigator Service is not a replacement for these provisions.

6. Policies and Procedures

The service provider(s) will demonstrate through their policies, procedures and practices the commitment and ability to meet the following principles:

- Deliver a personalised service that meets the individual needs of each service user, recognising service users’ rights to have maximum control over their lives.

- Treat service users as individuals and promote their dignity, independence and social inclusion.
- The service acknowledges and respects service users' gender, sexual orientation, age, disability, race, faith and culture as set out in the Equality Act 2010.
- Support service users to realise their personal potential and aspirations.

7. Move On

Most people who access the service will do so in one-off meetings, events and activities and therefore move-on is not applicable.

For the brief intervention service, service exits will be planned, agreed with the service user and any appropriate statutory agency delivering care and support in advance.

8. Service Outcomes

To provide support that will work positively with older people, cognisant of the particular personal, social, health and housing issues they face.

To provide support that ensures older people live in safe, suitable and comfortable physical environments, and meet the responsibilities of their tenancy agreements.

To raise the self-esteem of older people by assisting them to achieve health and wellbeing goals and to identify the care and support they need to live independently.

To promote greater independence for all service users through practical assistance, emotional support and skills training.

To promote engagement, supporting access to and participation in learning activities, mentoring, befriending and intergenerational activities.

To recognise older people as assets, encouraging them to share their diverse skills and experiences with others in their community through mentoring, story-telling and oral history, open days, pop-up crèche sessions, skill-sharing etc.

To link older people with appropriate voluntary and statutory agencies including primary healthcare, assistive technologies, substance misuse, mental health, debt advice, legal advice, health and meaningful occupation etc.

To provide support that enables older people to live safely, proactively addressing any risks, either to themselves or to others, that result from health, housing or social care needs or risk of abuse and exploitation from or towards others.

Co-production acknowledges that people with 'lived experience' are often best placed to advise on what support and services will make a positive difference to their lives. The

service will promote co-production by working with older people so that they are active participants in the design, development, delivery and evaluation of services.

To promote co-production values and behaviours:

- Ownership, understanding and support for co-production by all
- A commitment to sharing power and decisions with service users
- A culture in which people are valued and respected
- A culture of openness and honesty
- Clear communication

To implement a co-production model that is open and transparent;

- Use open & fair approaches to recruit a range of people who use the services, taking positive steps to include under-represented groups.
- Identify areas of work where co-production can have a genuine impact, and involve service users in the very earliest stages of project design.
- Train and develop staff and service users, so that everyone understands what co-production is and how to make it happen.
- Put systems in place that reward and recognise the contributions people make.
- Building co-production into work programmes so that it becomes standard.
- Regularly review and report on progress.

9. Service Capacity

The service capacity will be flexible and dynamic in response to demand, for a minimum of 1800 hours per month, which may be delivered by a combination of one-to-one and group support.

It is expected that each person receiving brief intervention support will receive 5 hours support per week for two weeks. Therefore each Navigator will only be able to support a maximum of 3 brief intervention service users at any one time.

10. Service Outcomes

Support will be delivered within a robust outcomes framework, based on the *Five Ways to Wellbeing* model, adapted to include housing and independence for older people. The aim of the service is to help older people identify, plan for and achieve ‘what a good life looks like for them’.


Connect
Stay Independent
Get Active
What does a good life look like to you?
Take Notice
Keep Learning
Give to Others

Connect ***Older people feel connected to others and feel confident to access peer, family and community support.*** • Improve their mental wellbeing by building relationships with family, friends, the wider community and social connections. • Make new friends and engage in peer support opportunities • Feel more involved in the wider community e.g. participating in local events, residents groups and activities. • Spend time with people of different ages, backgrounds and experiences.	**Get Active** ***Older people participate in health and wellbeing activities and feel their physical, mental and emotional health are improved.*** • Learn about and engage in physical activities that they enjoy • Engage in the daily physical tasks of running a home • Access health services to improve, maintain and regain physical health • Get involved in local health promotion activities e.g. exercise classes, blood pressure testing, health MOTs and STI testing.
Keep Learning ***Older people feel they have gained new skills and capabilities that boost confidence and enable them to self-help.*** • Learn new skills by participating in activities, classes and events • Identify and access leisure/cultural/faith/informal learning activities. • Be 'digitally active', engaging with online advice, information and communities • Identify and access work-like activities and adult education e.g. volunteering	**Give to Others** ***Older people feel their skills, experiences and ideas are valued and appreciated by the service and the community.*** • Help and support other people e.g. grandparenting, peer mentoring & befriending • Participate in activities that foster good relations between people from different backgrounds • Take part in improving the services they receive, how they are run and how they can improved
Take Notice ***Older people know about their local community and appreciate their neighbourhood and environment.*** • Pay attention to their health and wellbeing and understand how to take action against low mood, loneliness, loss and isolation • Talk to others about the local community • Be a good neighbour & alert the Council to local issues • Have a positive effect on the natural environment	**Stay Independent** ***Older people feel their home is a safe, welcoming and appropriate place to live.*** • Make choices about where and how they want to live • Stay in their homes for longer, by accessing appropriate services, aids and adaptations at the right time • Feel satisfied with maintenance and repair work • Feel confident with household tasks and where to access help • Move to a new home in a planned way, not as a result of crisis

11. Fair Access, Diversity & Inclusion

The service must be accessible to all sections of the community and actively promote the service to those groups who are under-represented. It must be clear to services users what the service offers and what support they can expect to receive.

The provider will produce information for current and prospective service users, with up to date information on the service they can expect to receive and how they can meaningfully participate in the development of the service. This must include information on the following:-

- General health and safety, including emergency procedures
- Out of hours procedures
- How to make a complaint
- How to provide suggestions and compliments
- Whistle blowing procedures
- Safeguarding and how to report abuse
- Equalities policy
- Local amenities and how they can be accessed
- Established links to other services

Information must be in plain English and be available in appropriate formats and translated if required.

The provider should make full use of local data and research to identify and reach out to potential service users and ensure that service delivery reflects the wide-ranging communities in Haringey.

The provider must ensure that lessons are learnt from service user feedback and this is used for the development and continuous improvement of the service.

The provider will be able to demonstrate that changes have been made to improve the quality of the service in response to service user/stakeholder feedback.

12. Assessment and Support Planning

Formal assessment and support planning will not apply to the universal element of the Community Navigator Service. However, it is expected that Navigators will collect relevant information about the people they are introduced to, what they are seeking help with and the outcome of any conversation/meeting/support session they had.

For the brief intervention service, the support needs and risks of the individual will be briefly assessed and a plan developed and agreed with the service user. The support plan must be based on the identified areas of support required and designed to produce

improved outcomes. The length and detail should be proportionate for a brief-intervention service.

The support plan will clearly state what actions are required to meet identified needs within the two-week brief intervention period. The plan will be reviewed at the end of the brief intervention to identify what was achieved and what follow-on support needs to be arranged.

The provider will ensure that service users lead the risk assessment and support planning process. Service users will be able to confirm that they have been involved in the support planning process.

The support plan needs to be agreed and signed by the provider and service user.

The provider will give the service user a copy of their support plan.

The provider will adopt a multi-disciplinary approach, liaising with council departments and other voluntary, statutory and community agencies to seek alternative support provision once the brief intervention has ended.

To underpin the support planning process the provider will develop appropriate approaches to supporting service users with challenging life events, such as bereavement, victimisation, returning home from hospital and moving home.

Taking into account the varying support needs of service users the development of these approaches will be informed by meaningful service user involvement, co-production and co-design of services.