Haringey Reach and Connect

Community Connector Application Pack

Public Voice working in partnership with mind in Haringey for better mental health

Vibrance involving people, inspiring lives

Dear Applicant,

Thank you for expressing an interest in joining us to work as a Community Connector in what is a very ambitious, exciting, and innovative programme supporting people over 50 living in Haringey.

This programme has been running for nearly three years and offers us an opportunity to develop creative solutions to combat social isolation and loneliness. We are now entering a new contract phase in our fourth year, which provides an opportunity for the team to put their mark on the strategy and development of the program and to ultimately make a real difference to the lives of older people.

We have one fixed-term vacancy in the team since a current member of the team will be covering the Programme Manager role whilst they are on maternity leave until the end of March 2023. The team of Community Connectors is made up of six individuals who are based out in the community.

The Role Description and Person Specification in this pack describe the job and the personal profile which will be required to perform the role to the standard we expect. Please address these criteria when making your application but if there are some knowledge criteria that you think you may not fully meet, we may be able to address these as part of the induction training.

We are looking for individuals who are passionate about improving the lives of older people, and the who have well developed interpersonal skills and are willing to go “that extra mile” to meet our challenging targets.

We welcome applications from people of all ages and demographic characteristics.

Your application should include a CV which addresses the person specification in no more than two sides of A4, Arial font 11 and a **personal statement** of no more than two sides of A4, Arial font 11 which explains why you would be an effective Community Connector.

Applications, with a copy of the monitoring form should be submitted via email to info@publicvoice.london by **9am on Tuesday 07 June 2022**. Interviews will be held the week commencing **13 June 2022.** Postal applications can be sent to: Public Voice, Tottenham Town Hall, Town Hall Approach Road, London, N15 4RX

If you require the recruitment pack in an alternative format please call 020 3196 1900.

We look forward to receiving your application.

Community Connector
Salary: £30,900 per Annum + 3% pension contribution
Location: London Borough of Haringey

An exciting career step to lead on community building for older people, including LGBTQI+ residents: Would you like to be part of an innovative multi-agency programme supporting Haringey residents who are 50+, at risk of social isolation or who have suffered a recent life event that threatens their wellbeing?

You will be responsible for one of eight localities offering generic and specialist information, signposting, guidance and short-term support to older people living in Haringey to maintain their independence and remain in their own home.

You will ensure that those from the LGBTQI+ community, those with mental health issues, Learning Disabilities and others at risk of social isolation are encouraged to engage with our services. If you are passionate about engaging with older people in a diverse community and can work on your own initiative to help us develop a new service, we would like to hear from you.

Application and selection

To apply, you are asked to provide:

- A copy of your CV.
- A personal statement of no more than two sides of A4 detailing why you are applying and how you meet the person specification criteria – all applications will be reviewed against the person specification criteria, so it is important to address these in your personal statement.
- A completed monitoring form.

You are also asked to supply contact details for two referees, one of whom should be a current or recent employer or someone who has known you in a professional capacity.

Applications should be submitted via email to info@publicvoice.london

The deadline for all applications is **Tuesday 07 June 2022, 9am.**

Community Connector Role Profile / Job Description

Report to: Programme Manager

Contract: Fixed Term until 31 March 2023.

Salary: £30,900

Location: London borough of Haringey

Job Summary

The Community Connectors play a key role in delivering the outcomes of the Reach and Connect service for older people in Haringey by:

- Making a person's life better by understanding his/her priorities and aspirations
- helping them to access a range of information
- getting the right help from available services
- developing relationships and community networks
- getting an individual's voice heard about things that are important to them
- helping to find paid work and /or volunteering opportunities
- ensuring all contacts, interventions and outcomes recorded on a central CRM

The Connectors will be located across different sectors of the Borough employed by one of the three consortium partners – Public Voice, MIND, and Vibrance: with day-to-day management by the Programme Manager. This role will be employed by Mind in Haringey.

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Main duties

1. To promote the Reach and Connect service and the Haringey Circle Programme to the local community, voluntary and community sector groups and key stakeholders and partners.
2. To signpost older people to appropriate services, including those in the community and voluntary sector which may be able to meet their current and future needs.
3. To make sources of information about services available to individuals so that they are able to help themselves.
4. To ensure that those who need a short term intensive intervention receive one to one support and advocacy when appropriate.
5. To connect people with the wide range of community activities available in Haringey and elsewhere to provide opportunities for new friendships and reduce social isolation.
6. Where appropriate to connect people to each other through shared common interests and the need for mutual support.
7. To promote and support the Haringey Circle Programme to increase membership, recruit volunteer champions and expand the range of activities on offer.
8. To provide support and briefings to Link Workers based in the Primary Care Networks.
9. To manage a small pool of volunteers as required.
10. To promote positive relationships with key partners and stakeholders including local ward councilors.
11. To work in partnership with existing “community navigators” – PCN Link Workers, Local Area Coordinators, Care Coordinators, Dementia Navigators and others.
12. To ensure that all contacts, referrals and related activities are recorded on the CRM in a timely manner and before each quarterly reporting deadline
13. To identify issues relating to systemic service failures and report these to the Programme Manager.
14. To provide performance information, data analysis and written reports as required.
15. To contribute to achieving the targets and milestones necessary to meet the Contract specification and outcomes.
16. To set up and service a representative steering group of local community members to provide a sounding board for the project, generate ideas and provide some local accountability.

Person Specification

Education	
1. Education to degree level or equivalent level:	Desirable
Knowledge	
2. Knowledge of the challenges facing many older people in living a fulfilling and satisfying life	Essential
3. Understands the meaning and components of “wellbeing” in relation to older people	Essential
4. Understand the how the governance and delivery of the health and social care system and other statutory services work in a London borough	Essential
5. Understanding that there are cultural issues in relation to older people and the implications for delivering the service	Essential
6. Legal framework relating to Adult Safeguarding and Mental Capacity	Essential
7. Data Protection legislation and confidentiality	Essential
8. Knowledge of the community and voluntary sector organisations in Haringey	Desirable
9. Knowledge of the information sources which can be used to signpost older people to local and national services	Desirable
10. Fluency in a relevant second language	Desirable
Skills	
11. Well-developed interpersonal skills and the ability to empathise with older people including good listening skills	Essential
12. Good verbal and written communication skills	Essential
13. Good IT skills and the ability to work with a CRM system and basic Desk Top Publishing (DTP)	Essential
14. The ability to work with and manage volunteers and other team members	Essential
15. Good organisational and time management skills	Essential
16. Ability to work with a range of key partners and be recognised as a competent and credible community leader	Essential
Experience	
17. Working in a multi-cultural, diverse urban environment:	Essential
18. Programme / Project management in a community setting	Desirable
19. Working with older people in a community setting	Desirable
20. A minimum of two years in a community development or similar role	Desirable

21. Project monitoring and evaluation in a performance management environment	Desirable

Personal qualities

22. Passionate about improving the wellbeing of older people.
23. Warmth and understanding.
24. Entrepreneurial / self-starter and good team player.
25. Creative problem solver.

Other

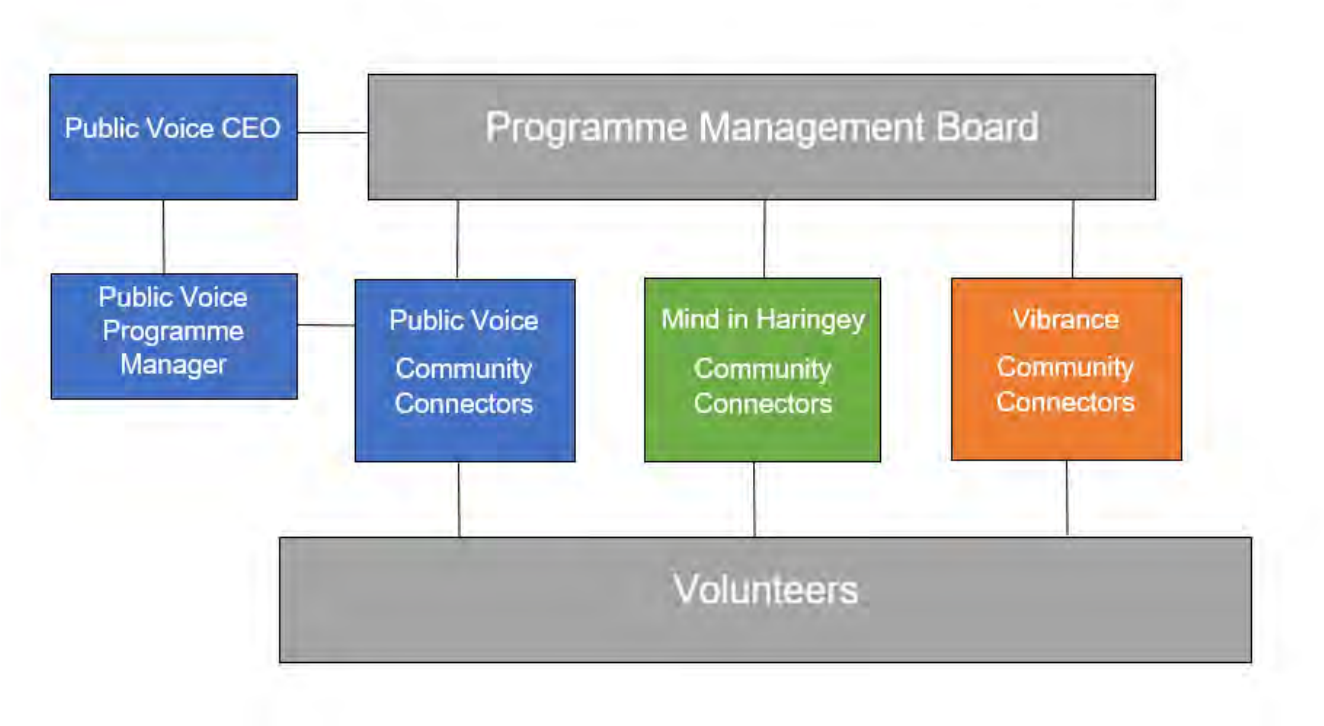
26. Able to work flexibly on evenings and weekends as necessary – this will be arranged and agreed in advance with the Programme Manager

Community Navigator Service for Older People

Service Specification

1. Introduction

This new and innovative service will be 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.



In addition to the above, we will also have a Haringey Circle service, based on the successful Rochdale Circle model (and informed by the experience of the London Circles) – Circle is a membership organisation that facilitates older people to organise and attend social events that they are interested in and provides opportunities for social connections and mutual support.

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 eight 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.