Appendix 1

Extract from the Specification

City Community Connections Service

2.1 **Partnerships and Subcontracting**

In respect of Addendum 1 / Lot 1 the City of London will consider tenders for **partnerships and subcontracting arrangements or other such arrangements**. The appointed provider will either employ and train his own staff and volunteers or partner with other organisations or sub-contract elements of the service but at all times he shall maintain the responsibility to ensure suitably experienced and capable staff and / or volunteers are used for the delivery of the Coordination, Communication, Connection and Community Support Activities specified above.

This Service is focused on coordination, communication, connection and community support activities, which are delivered in the community to residents of the City of London Corporation.

2.2 **Coordination** – the service will provide a coordinating function for all other functions it offers to the City of London Corporation. This will include:

- Managing the transition between services for individuals so that anyone who currently accesses a service in the community, which may change as a result of this tender, is supported through any change in provider or service they receive.
- assessing, recording, monitoring and reporting on outcomes and for people using services in the community, including those from other providers including City Finance, City Call Handling and Response and City Community Care Equipment Services
- collecting, recording and reporting usage and performance data from other services in the community, including those from Providers of Community Support function activities
- collecting, recording and reporting signposting and referrals into and out of the City Community Connections service with signposting to include, but not be limited to, the services named within Section 3 of the Core Specification
- arranging and participating in service development and review meetings including hosting the Community and Children's Outcomes Delivery (Co-Production) Board (CCODB).

2.3 **Communication** – the service will provide a communication function for all other services in the City community. This will include but not be limited:

- Developing and maintaining a website to provide a central communication point where information about community-based activities can be easily accessed and shared. (See Core Specification Section 3 for some examples of activities and services to include).
- The website should contain a specific section with support and information available to Carers, including young carers.
- The website should make explicit links/reference to the FYI website for families and young people's information service and City of London Corporation Corporation's website pages.
- Providing a telephone number (with voicemail function) that can be promoted as a central 'one stop shop' for information and enquiries about support and activities that are available to people in the City of London
- Developing and maintaining at least one physical presence within the City of London Corporation as a 'hub' for information to be displayed and shared
- Developing and distributing a range of communication materials to promote the City of London Corporation Community Connections service
- Promoting the service to a wide range of statutory and community organisations, practitioners or leaders who are likely to make referrals into the service or who can provide support and activities to people. This could be achieved through a variety of methods (e.g. attending team meetings, hosting information sessions)
- Ensuring full use is made of existing publications such as City Resident and other communication channels such as the Barbican Broadcasts to raise awareness of community activities
- Making more use of new technology such as Meetup and interests.me to enable people to find out about activities and make new connections.

2.4 **Connection** – the service will provide a connection function to each individual City of London Corporation resident (or their carer) that makes a contact with or is referred to the Service. This will include:

- Offering information about local community activities that may meet a person's needs.
- Ensuring all people who require an individual befriender or volunteer to support them are matched with one, and / or that the person has a named contact person either in the City Community Connections Service or in an appropriate other service (such as Community Connectors or a Network Navigator from the Wellbeing Network).

- Offering the individual, the option of a full community support assessment through the service or alternatively a referral to their social prescribing coordinator based in a GP practice.
- The community support assessment will include, but is not limited to:

    - Explanation of the City Community Connection service and exploration of person's understanding of reason for referral / their reason for contacting the service
    - Discussion of the main areas of need
    - Completion of well-being star or another appropriate outcomes framework
    - Discussion and signposting to relevant services and activities, including City Community Finance, City Call and Response and City Community Equipment if appropriate
    - Discussion around initial person's reaction and potential barriers to attending
    - Identification of other issues if any
    - Need for individual volunteer support / befriending
    - Written agreed action / wellbeing plan

- A community support follow-up contact should be arranged and made within four weeks of the initial assessment. Reasons for failure to attend or complete actions should be recorded.
- A further wellbeing star or alternative outcomes framework should be completed at the end of the person's contact with the service, or every three months that they remain in contact with the service.
- If the person's needs appear to be increasing and /or wellbeing declining, then support should be offered to person to contact their GP and /or Adult Social Care as appropriate.

2.5 **Community Support Activities** – the service will either directly provide, sub contract or contact a wide range of support activities and interventions that can be offered to the person in the community. This will include:

- Signposting / referring people to the wide range of services which are available in the community (see Core Specification Section 3 for some examples)
- Promoting the social and emotional wellbeing courses that are available free of charge to people through the City of London Corporation and Hackney Wellbeing Network and developing the relationship so that more courses can be offered at venues in the City of London Corporation.
- Promoting and establishing links with primary care and community health services such as community dentists, opticians, pharmacies, podiatrists that can support people to stay well in the community.
- On a short-term basis (e.g. for a maximum of 6 weeks), using a volunteer befriender to support an individual to access new services in

the community, or to support their wellbeing for example by providing support to a person to set up an internet shopping service.

- Care Navigation – supporting people from hospital settings with short term information and support to help them settle back into the community.
- Running group-based interventions or activities in community settings. These should be targeted to support certain groups (e.g. Carers, people with dementia) if there is evidence of a gap in current services and evidence of improved outcomes will be provided.
- Developing new groups or initiatives linked into and delivered from the neighbourhood model, particularly linking in with the Neaman GP Practice and with GP practices in Tower Hamlets.
- Establishing a range of specific support activities and initiatives that are supporting Carers, including young carers. For example, a City Community Carers Card offering discounts could be developed.
- Establishing ways (such as access to a handyperson or skilled volunteer support) that people can be supported to stay safely in their homes through minor repairs, fire safety improvements or removal of fall or trip hazards.
- Establishing other initiatives or links to other community services such as food/meals provision, pet carers, hospital transport provision, hoarding and decluttering services which will help people stay or return safely to their home.
- Any new developments or initiatives that are developed over the course of the contract which require additional funding (for example to cover venue hire, staffing or volunteer training) will be considered through the CCODB.

In Year One it is anticipated that as a minimum there will continue to be a Care-navigation type service which will support outcomes and associated indicators around discharge from hospitals. This service should work jointly with Adult Social Care to facilitate the process and transition from hospital to home and ensure a person can quickly regain independence.