ScotPHN Health & Housing

Title of project/initiative	
Contact for project • Name, email, telephone • Website of project, if available	Gillian McCamley (Programme Manager) gillian.communityconnectors@gcvs.org.uk 0141 271 2304 Colin Vincent (Programme Coordination) 0141 271 2313 colin.communityconnectors@gcvs.org.uk
Which organisations are involved? • Planning/monitoring/delivery • Partners • Sponsors • Funders – how funded?	The service is delivered by Glasgow Council for the Voluntary Sector (GCVS) in partnership with the Glasgow & West of Scotland Forum of Housing Associations (GWSF) with area staff delivering the service from Queens Cross Housing Association in the North West of the city, Shettleston Housing Association in the North East and Southside Housing Association in the south. The project is supported by a reference group consisting of members of the Housing Forum and local TSI. The project is funded within the Accommodation Based Strategy workstream of the Integrated Care Fund, provided to pursue to the Government's agenda on Reshaping Care for Older People.
Brief description of project • Rationale • Aims and objectives • Key activities • Target population • Geographical area • Start (± finish) dates	GCVS carried out consultations with 500 older people and carers as part of the RCOP agenda and the clear response was that older people wanted clearer access to information about what supports, services and activities were available to them. Community Connectors was conceived with this in mind. As part of the Integrated Care Fund's Accommodation Based Strategy, we aim to enable older people to live more vibrant, independent lives within their communities for longer. This is achieved by tailored, one to one support to engage with services. The partnership element means that GCVS can bring its expertise of the local third sector landscape in terms of service provision and community assets while GWSF provides community anchor organisations, helping our service reach those most in need. **<u>Our Approach</u>** **The service reflects that older people need many different types of support to live healthy, fulfilling and independent lives: both in a preventative sense and following periods of ill health. We recognise that some people will only require information or signposting, whereas others will need more in-depth support.** **Good conversations will be at the heart of our approach with our practitioners working to outcome planning processes and adopting an asset based approach to their work. We prioritise getting to know the person first to know what's important to them and what's already working for them. We use this basis to build a fuller picture of where someone's at, what strengths they can**

	build on and what their best hopes are. With the complete picture we can prioritise bringing in services which are relevant and most likely to produce positive outcomes. For those struggling with medical conditions, we employ self-management training to maximise wellbeing and reduce barriers to engagement with services leading to longer term independence. The service supports anyone over 60 within our geographical areas or anyone caring for someone over 60. We currently provide services to those living in the following areas: North West: G20 & G22 and parts of G3 & G4 North East: G32 South: G41, G42, G43, G51 and G52 The project is funded for 2 years through 2015/16 and 2016/17 with a probability of 3 year funding and beyond.
Resources • Staffing • Time • Financial	The service is delivered by 10 members of staff: **<u>Central Team</u>** **Programme Manager** – Strategic lead on the programme remit includes service development, stakeholder engagement and line management. **Programme Coordinator** – Day to day operations of the programme including monitoring & evaluation. **Volunteer Coordinator** – Works across all three sectors to support and coordinate older people who are interested in sharing their time, skills and expertise with others. This role clearly supports the recognition of 'older people as assets' strand of Reshaping Care for Older People. The current and potential contribution of older people was also highlighted in the 2013 consultation with older people, reinforcing the spectrum of wellbeing and activity levels amongst older people. **Data Collector / Analyst** – Responsible for mapping community assets and maintaining the integrity of the third sector Infobase (managed by GCVS) in respect of services for older people allowing for intuitive onward referrals. **<u>Area Teams x 3</u>** Community Connectors Practitioner – Works one to one with older people within the community, getting to know them and what's important to them. Trained in good conversations and asset based approaches, the practitioner establish what's working for a person and what strengths they can build on and then works with the person to engage with relevant services to support their best hopes for independent living and engagement with the community. **Client Liaison & Administration Officer** – The first point of contact for incoming enquiries. They keep the lines of communication running smoothly between older people and local services as well as providing admin support to maximise the practitioners capacity to see older people on a one to one basis. All staff work 35 hours per week with the exception of the Data Analyst who works 21 hours.

	Funding is in the region of £260,000 p/a
Evaluation and outcomes • Reach • Impact	In progress (see attached report)
Reflections on project • What was successful? • What was challenging? • What would be done differently in future?	In progress (see attached report)
Next steps • What is the future of this initiative?	There is a strong perception that the Community Connectors model fills a significant gap in joining up services for older people and, as such, we are currently involved in evaluation and research with a view to citywide rollout.
Wider application • Is this project scalable? • Is it transferable to other areas/contexts?	As part of the current research and evaluation, we are exploring a plan for scaling the project up to meet the needs of the whole city including exploration of what such a staffing structure would look like and how these assets would be deployed in the most effective way. We believe in the strength of the model and fully believe that it could work in other areas. In theory, the model should be able to transfer to other contexts however, we recognise the challenges this brings. If we were, for example, to apply the model to vulnerable adults under 60, we enter an area with much less service provision.
Any further information • Reports or publications • Other reflections	See attached report
Person completing pro-forma	Colin Vincent (Programme Coordinator)
Date of completion	04/10/16

Pro-forma for gathering information on case studies