## **Navigator JD**

## **About the work**

SMART (St Mary Abbots Rehabilitation and Training) has been commissioned by West London Clinical Commissioning Group (NHS) to deliver a mental health Navigator Service.

## **About the Navigation Service**

The Navigation Service offers short term support to people with long term mental health needs who are registered with a GP Practice in Kensington and Chelsea and the Queens Park or Paddington. The service offers practical support with a wide range of issues, including benefits, housing and debt and enables people to access specialist advice and information. It supports people to access services and to take step to improve their wellbeing.

The Navigators are part of the Community Living Well Service that brings together a range of clinical and wellbeing services, to offer coordinated support to promote social, physical and mental wellbeing. The Community Living Well service is provided by the NHS and voluntary sector organisations, working in partnership. The service aims to ***“to improve the mental and physical wellbeing of those with long term mental health needs, and provide better social support so that people are able to maintain good health and wellbeing, maintain independence and achieve their self-determined goals”.***

## **Job Purpose**

* To deliver an excellent service by co-working with people who have mental health needs, in primary care, in a supportive, practical, warm, empowering and holistic way towards better health and happiness.
* To work, as part of an integrated team including GPs, therapists and Primary Care Liaison Nurses (PCLNs) in identifying and supporting people to reduce the risk of relapse.
* To provide practical support with a range of issues including social isolation, benefits, housing, debt and accessing health and social care services.
* To work on a short-term basis with people with a wide range of needs and have the ability to prioritise and case-manage those individuals.
* To ensure that people can access services and activities available in the community – both free and where charges apply - based on the Navigator’s detailed knowledge of the relevant access arrangements, eligibility criteria and service content.
* To use co-production, motivational interviewing and behaviour activation techniques as well as regular reviews and follow-ups to ensure people are kept engaged and motivated.
* Where people have complex needs and are at risk of falling through the gaps between services, Navigators will facilitate holistic, person-centred planning and co-ordination of input from different professionals.
* To assist people to access an assessment for Adult Social Care where appropriate and to provide information in connection with personal budgets.
* To enable the impact of the service to be assessed and to inform the improvement of other local services by keeping electronic records of all referrals and interventions, and producing regular reports on activity and outcomes, both for the project steering group and commissioners.

## **Duties and Responsibilities**

1. To take referrals from GPs and other members of the multi-disciplinary team; reviewing and progressing these as appropriate.
2. To work collaboratively with people and their support network to direct them to appropriate services. In addition to sources of direct support and help, this includes wider services and activities that may help to promote people’s health, wellbeing and independence. Services may be open access or require payment, either through a personal budget or own funds.
3. The Navigator will work collaboratively with the other members of the Community Living Well Service; supporting each other to manage the work and meeting regularly as a team for supervision, monitoring and reporting on progress.
4. Navigators will provide short-term case management and will liaise with a range of multi-disciplinary professionals who are involved in a person’s care, ensuring a smooth and coordinated approach, especially where multiple agencies are involved.
5. The Navigator will work alongside a small team of volunteers to extend their reach and capacity. They will mentor and train them and need to be aware of the procedures and practices involved in working with volunteers.
6. To supply basic information on what benefits the person may be eligible for and support them to access these.
7. To manage safeguarding concerns and data protection confidentiality appropriately.
8. To provide the person, and their carer where appropriate, with a co-produced Wellbeing Plan led by the person, detailing how their needs can be met, who will support them and how.
9. The Navigator will be expected to develop their knowledge of local services, using existing databases and developing links with service providers, keeping up-to-date with service changes and developments. Effective relationships and close working practices will need to be developed with those services.
10. The Navigator will also play a role in informing GPs about the holistic range of services available in the community and how they can access them directly.
11. The Navigator will help people to access community care assessments as well as carers’ assessments, where potentially eligible, and will then follow up with the person to ensure the process is going smoothly, liaising with Council staff as necessary.
12. Navigators should be able to identify when early intervention for a mental health issue is needed and seek advice and support on how this can be managed. They should also be able to identify when there is a need for urgent action or for a step-up in care and alert the relevant professional(s).
13. The Navigator will be expected to keep accurate and up-to-date records of their contact with clients; including the use of patient management systems such as SystmOne (relevant training will be provided).
14. The post-holder should accurately update and amend tasks on the Community Living Well information management systems, ensuring actions are noted, raised and completed.
15. Navigators will gather, record and collate information, including case studies, in a prescribed format in order to demonstrate the impact of the service. This will include producing quarterly reports for service commissioners, collecting service feedback and using the Wellbeing Star.
16. The Navigator should be able to demonstrate an understanding of the impact of the service on wider health, social and voluntary sector services.
17. The Navigator will be expected to contribute towards the development of the project, attending meetings and giving presentations as requested by their line manager.
18. Navigators are in a key position to identify opportunities and gaps in services. They will feed back information on this as well as service quality and accessibility to commissioners.
19. The Navigator will provide management with performance data when required. This may include contributing to business reports so that key performance indicators can be accurately measured and objectives achieved.
20. The post-holder will adhere to all policies and procedures including those around health and safety and finance.
21. The Navigator will attend staff meetings with their employer (SMART) when required.

**Person Specification**

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| **Education and Qualifications:** | **Essential/Desirable** |
| Health, social care or information advice.  | D |
| 3 or more GCSEs including Maths, Science and English | D |
| A-levels | D |

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| **Competencies and Experience:** | **Essential/Desirable** |
| At least 1 years’ experience of working in health, social care or information and advice in direct contact with service users with mental health needs and in a paid capacity. | E |
| In-depth understanding of the current experiences and challenges faced by the diverse range of people who have mental health needs and their carers | E |
| Experience of person-centred planning and coproduction. | E |
| Computer literate and able to work with Microsoft packages including Word and Excel. Ability to use databases and patient management systems.  | E |
| Excellent research skills and an ongoing commitment to gain knowledge and awareness of services, support, rights and entitlements.  | E |
| Excellent verbal and written communication skills. | E |
| Thorough and up-to-date knowledge and understanding of policy and practice in Adult Social Care and Health, including the principles of personalisation and information sharing | E |
| Experience in keeping accurate and up-to-date records in relation to client work and an ability to ensure actions are noted, raised and completed. | E |
| Experience in collating and providing performance related data for reports.  | E |
| Knowledge of safeguarding issues and processes | E |
| Fluent in one or more languages other than English  | D |
| Awareness of data protection legislation and an understanding of how and when information can be shared and how to maintain confidentiality. | E |
| Able to demonstrate active listening skills. | E |
| Experience of working with volunteers. | D |
| A positive and empowering approach to working with people using motivational interviewing, solution focussed and strengths based approaches.  | E |

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| **Behaviours and Ways of Working:**  | **Essential/Desirable** |
| Pro-active approach to work and able to multi-task and problem solve. | E |
| Ability to prioritise own workload to manage a case load effectively and economically. | E |
| Willingness to work flexibly across several locations. Willingness and stamina to move around various locations in the Borough | E |
| Tactful, empathetic, diplomatic and able to develop relationships with people from a wide range of backgrounds. | E |
| Flexible and creative approach to meet service need, using a person-centred, strengths-based approach | E |
| Self-motivated and enthusiasm for the role. | E |