Neighbourhoods

Find Support Services, a website for City and Hackney residents to find local services.

Community Navigation Guide City & Hackney

Community Navigation (CN) is a term we use in City & Hackney to describe a wide range of local services and roles that support residents around their wellbeing by listening to what's important to them and focusing on the person's strengths. It involves connecting the resident to non-medical services, advice and activities, as well as health or local council services as needed.

In City & Hackney we have a fantastic Community Navigation system of around 30 roles and services supporting residents with a wide range of needs, a full list of CN services can be found here. The table below highlights 6 CN services, what they offer and how to introduce (refer) a resident.

Social Prescriber	Connect people to community groups, activities and statutory services for **practical, social** and **emotional support** to address **wider and social determinants** of health**.**	Details here/via GP
Health & Wellbeing Coach	Support people with **lifestyle changes** and the **self-management of health conditions** e.g. diabetes, weight loss, chronic pain.	Details here
Wellbeing Practitioner	Work longer term alongside people facing **multiple, complex, long standing challenges** from a framework of trauma informed care.	Via GP
WellFamily Plus	Support people (16+) to manage **mild to moderate mental health issues** providing **emotional** and **practical support**. Supports single people & families.	Details here
Engage Hackney	Support with **maintaining a home or tenancy, budgeting & benefit claims**, developing independent living skills and gaining access to other services.	Details here
ELFT Community Connector	Support people with **serious mental Illness** and **personality disorders**, to **access activities & services locally**. Accessed as part of a referral to the Neighbourhood Mental Health Teams, if appropriate they will be allocated to a Connector.	Details here
Care Coordinators (Proactive Care)	**Proactively contact** people living with **moderate frailty** and **multiple long-term conditions** to provide **strengths-based personalised health & wellbeing support** to age well.	Proactive contact only

Please click here for the neighbourhood multi-disciplinary team roles spreadsheet which includes a list of the people in CN roles in the 8 neighbourhoods of City & Hackney.

Please ensure you include a detailed reason when making an introduction to a CN service.

Advice & Signposting Options - If resident has pressing debt, benefit or housing issues and needs specialist advice, always signpost to advice options first. You might also refer to Community Navigation if the resident needs additional support to contact and access advice providers

List of voluntary sector advice providers (range of advice types and communities supported).

London Borough of Hackney housing options Telephone 020 8356 2929 (office hours) or 020 8356 2300 (after 6pm)

Case Studies

Social Prescribing - Mr B, 65 yr-old

Mr B presented with depression, bereavement, isolation (formerly shielding patient)

Mr B was referred to social prescribing by his GP because of his low mood and social isolation. Mr B explained that since his wife and brother died the previous 12 months, he had lost the motivation to leave the house and socialise with others. He lived alone and had no support network around him.

Social Prescriber offered 3 more sessions and provided safe space for Mr B to explore his ambivalence and lack of motivation to be "more social". Mr B ultimately agreed to try befriending service because he reflected that he used to enjoy being a social person. He was matched with someone through the Compassionate Neighbour programme. He enjoys speaking to his befriender on a weekly basis, and is looking forward to meeting them in person to do things in the community.

Mr B agreed to a referral to St Joseph hospice for bereavement counselling and engaged well.

Mr B described how the service helped him "start to feel that someone knows you exist." He was starting to feel better and his mood improved. He commented: "My mind is starting to be alive now, I'm not as lonely. I have people around me who care"

Health & Wellbeing Coach - H- 60 years old

H was referred to a Health & Wellbeing Coach by his GP for support to manage pre-diabetes.

HWBC supported H to talk through his concerns, set goals and take small actions towards 'getting fitter, eating well and losing weight', H does not exercise. He enjoys walking but feels he rarely has the time, describing himself as 'workaholic'. He eats meals when he 'has time' and snacks between meals on crisps and biscuits.

HWBC supported H to find information and appropriate activities such as men only swimming sessions and establishing a regular pattern of meals with attention to portion size, increasing foods with low glycaemic index, preparing healthy snacks.

H was motivated to make changes but felt discouraged by the slow pace of losing weight. HWBC supported H to manage expectations and make sustainable changes in lifestyle that would impact on weight.

H noticed that he felt better keeping to a regular meal pattern and reducing portion size. He progressively moved from 0 hours of activity to 2 hours walking a week and swimming once a week. HWBC also explored mindful walking and mindful eating, supporting H to develop more skills for reducing stress and eating well. At session 5 of 8 H reported feeling much better in himself, 'body and mind' and sessions began to focus more on how to sustain the changes moving forward.

Engage Hackney - TT - 41-55 years old

TT had a physical disability and was suffering with depression, mental health issues and was having difficulties with debts. She received sick pay through employment and had a Personal Independence Payment (PIP), but she ended up losing her job due to prolonged illness, and also she revealed she had a relationship breakdown. TT has memory problems and often forgets her appointments. Her 17 year old son is her main carer and would like to take the strain of him so that he can concentration on his education. She also had huge rent arrears. Due to pain she gets upset easily and shouts at others. She needed help with appointments, reminders for medication, help shopping, finding work, and filling in forms.

Engage Hackney worked with TT for 11 months, we supported her with practical information and emotional support. We helped her applying for a disabled person's freedom pass and blue disabled badge. We supported her maximise income by reporting a change in her circumstanced and her Personal Independence Payment (PIP) was changed to an enhanced rate. They made a back payment and she was able to clear some of her rent arrears and other debts. We helped her apply for housing and council tax benefits, and was awarded both. We helped her fill out forms which she struggled with because of arthritis in her hands. We supported her applying for grants and we cleared some of the EDF energy debt, we were able to get food items, vouchers, and arrange food deliveries, a washing machine and bed

We also signposted her to Shaw Trust to receive support finding jobs.

TT was so pleased with the support service that she sent an email to the manager to show how pleased she was. She said she wants to work in a support service to be able to replicate the kind of support she received. With this she was encouraged to apply for jobs and now has secured a job.