4 X Care Home Connector
Salary £26,000 per annum Pro Rata + NI & Pensions, 35 & 28 hours per week, Fixed Term 12 months

Do you want a job that makes a positive difference in people's lives?

Asian Resource Centre of Croydon (ARCC) and Croydon Neighbourhood Care Association (CNCA) have joined up to recruit 4 Home Care Connectors in Croydon. We are very excited to be working in partnership with Age UK Croydon (AUKC) to deliver a new Care Home Connector service in Croydon to support residents of Care Homes.

The Care Home connector will be supporting people living in care homes to receive the same level of support as if they were living in their own home. They will support the collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners, in line with the Enhanced Health in Care Homes (EHCH) model which moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff.

The role requires the Care Home Connector

- To work with Primary Care Networks, Care Homes and system partners to ensure care home residents have access to appropriate Multi-disciplinary Team (MDT) support and receive all the benefits from the Enhanced Health in Care Home model.
- To support residents and their carers, who are having multiple simultaneous interactions with different health, care, and voluntary sector services, to link up with professionals and help navigate services.
- To enable concerted efforts between professionals involved in the care of residents to develop Personalised Care and Support Planning (PCSP) in line with the requirements of The Enhanced Health in Care Homes (EHCH) framework.

We are looking for an enthusiastic, compassionate, person-centred individual. Most importantly, we are looking for an approach to working with people that ensures that care and support planning is influenced by the wishes identified by those individuals to improve their health and wellbeing and can work as part of an integrated team to achieve this.

This programme is a 1-year pilot project and you will have the opportunity to influence the service as it develops across the borough. If you are passionate about making a difference to older people, a real team person with empathy, compassion and experience of person-centred working, then this could be the perfect opportunity for you to improve their lives.

Please see the attached job description and person specification..

To apply please send your CV along with a cover letter to recruitment@arccltd.com clearly explaining how you meet the requirements of the job description and person specification on no more than 2 sides of A4. Please note CV's without a cover letter will not be accepted.

Closing date for applications: 9am on 12th May 2022
Interview Dates: TBC

One Croydon Alliance for Health and Care

JOB DESCRIPTION

Job Title: Integrated Community Networks Plus (ICN+) Care Home Connector

Contract: Fixed Term, 12 months

Grade/Salary: £26,000 Pro Rata + NI & Pensions

Hours: 35 & 28 hours

Location: Croydon, exact location TBC

Stakeholder Relationships: One Croydon Alliance Organisations

Budget Responsibility: None

BACKGROUND

One Croydon Alliance

The One Croydon Alliance is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning to improve the lives of older people in Croydon. The partners in this Alliance are: Croydon Council, Croydon Health Services, Croydon Clinical Commissioning Group, Croydon GP Collaborative, South London and Maudsley Mental Health NHS Trust and Age UK Croydon.

In 2014, Croydon Council and the Croydon Clinical Commissioning Group recognised they faced a common challenge to improve services for older people in an environment where demand was increasing and resources were reducing. They agreed to work together to establish an Outcome Based Commissioning (OBC) framework to develop services for people over 65.

There followed an extensive engagement programme with local residents and stakeholder groups to agree local outcome priorities and local providers worked to develop a new Model of Care in consultation with local stakeholders and service users.

In April 2017, local partners formed an alliance and signed a 1-year transition plan the Croydon Alliance Agreement based upon which was followed by a further 9 years extension signed in March 2018.

Initially, the Alliance focused on older people and developed the Living Independently for Everyone (LIFE) service as well as setting up the GP Huddles and Telemedicine in Care Homes.

The Alliance has now extended its work to all adults and the direction of travel is that eventually the whole population will be in scope for Alliance working.

Alliance Vision and Ambition

'Working together to help you lead your life'

"The Alliance vision is to support the people in Croydon to be independent and live longer, healthier and fulfilling lives and be able to access high quality care, in the right place and at the right time, thereby reducing health inequality in Croydon. The aim is to achieve this vision while realising financial sustainability in the system and maintaining improved outcomes".

Integrated Community Networks Plus (ICN+)

The aim of the ICN+ programme is to establish an integrated community health and social care service comprising services from across Adult Social Care, Croydon Health Services, Mental Health and the voluntary sector within each locality. The teams will enable information sharing, joint assessment and care management. The integrated service model will ensure a one name, one budget one team approach, use of an agreed single eligibility assessment and review process, and increased entry pathways - all working to the same key outcomes.

Services under ICN+ localities are as follows:

- Community nursing
- Adult social care over 65s
- Adult social care under 65s
- Therapy services
- Age UK Croydon Personal Independence Coordinators (PIC) over 50s
- Mental Health PICs
- Named person for smaller community services e.g., Diabetes

The ICN+ model aims to support people to stay well rather than treat them when they become sick. It focuses on preventing people developing long term conditions, such as diabetes or depression. If people have a condition, we will work with them to stop it from becoming worse. We recognise that physical health and mental health go hand in hand. Therefore, if we focus on preventing people from becoming lonely and socially isolated, we will support them to stay independent and healthy.

The Enhanced Health in Care Homes Framework

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners. The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach.

C**are Element 2 of the Framework (MDT support including coordinated health and social care) identifies as best practice the introduction of care coordinators who can link-up and build on services already provided in the community. Care coordinators provide support to residents and their carers who are having multiple simultaneous interactions with different health, care, and voluntary sector services. They will provide the vital connection and coordination between care homes, their residents and the local MDT delivered as part of the EHCH model.**

Care Homes in Croydon

Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. Approximately half are Older People's homes and the rest are MD/LD homes.

Given the scale of the challenge for Croydon in supporting this large number of care homes, access to services for Care Home residents has historically been variable as some services were not commissioned to cater for care home residents; whilst specialist services commissioned for care homes, especially LD and Mental Health, have always been extremely stretched.

To address this inequity of access more investment is being put into ICN+ so that residents in every care home can have the same level of access to locality services as any other

Croydon resident. The Care Home connectors will be crucial to enable this enhanced level of access.

SUMMARY OF THE ROLE

- To work with Primary Care Networks, Care Homes and system partners to ensure care home residents have access to appropriate MDT support and receive all the benefits from the Enhanced Health in Care Home model.
- To support residents and their carers, who are having multiple simultaneous interactions with different health, care, and voluntary sector services, to link up with professionals and help navigate services.
- To enable concerted efforts between professionals involved in the care of residents to develop a PCSP in line with the requirements of the EHCH framework.

KEY FUNCTIONS

To work with the wider System to implement the key principles and elements of the Enhanced Health in Care Homes (EHCH) Framework in Croydon Care Homes hosted by one of the ICN+ Localities:

- To establish relationships between PCNs and MDTs (Multiagency huddles, ICN+ MDTs or Complex Care MDTs) to deliver an integrated approach to the delivery of care to the residents in line with the EHCH framework requirement.
- To work with Care Homes, PCNs, GPs and other professionals to identify and take resident requiring MDT discussions to the relevant ICN+ MDT
- To support members of the Care Home / ICN+ MDT in the development of Personalised Care and Support Plans for residents as identified by Care Homes, GPs or other professional involved in the care of a resident. This will be achieved through coordination of actions, agreement at the MDT of who will write the plan, and check on progress
- To feed back to GPs or other professionals (including care homes staff) involved in the care of a resident any agreed actions or care plan agreed by the MDTs
- To provide a central, continuous point of contact for the residents, relatives/carers and the range of professionals involved in the care plan for the residents.
- To ensure care is coordinated, agreed actions followed up by relevant professionals and communication between involved services is seamless.
- To participate in regular multi-agency team meetings, providing advice and information on community support options at these meetings.
- To develop an understanding of available community services and signpost care homes, families and professionals to these where required.
- Promote the role of the ICN+ Care Home Connector through engagement with Care Homes and other professionals.
- Support with the uptake of screening programmes (including cancer), immunisation programmes, health checks and other relevant services within Care Home residents, acting as a champion for these schemes to Care Home residents.
- Act as the single point of contact for gathering and collating information on out of borough residents when they first enter the Croydon system.

KEY RESULT AREAS

The key outcomes for the ICN+ Care Home Connector role are:

- Improved Care Home resident experience of services, which will be more coordinated, more holistic and person-centred thanks to access to a multi-agency/multi disciplinary team and the development of more personalised care and support plan.
- Care Homes have equitable access to services within the ICN+ locality, as all other Croydon residents
- Residents will have better access to community support, information and advice to help prevent crisis leading to empowered communities that feel more connected, less isolated and less dependent on statutory services.
- ICN+ service will be more proactive than reactive. More proactive and preventative care will lead over time to reduced health inequalities, longer healthy life expectancy, improved wellbeing.

KEY WORKING RELATIONSHIPS

The ICN+ Care Home Connector will work with a range of other key services including:

- GPs and Primary Care services
- Primary Care Networks Care Home DES
- Integrated Community Networks Plus (ICN+)
- Multi Agency huddles
- Care Homes
- CHS A&E
- CHS discharge team
- One Croydon Alliance partners
- Ageing Well Programme

GENERAL

Green Commitment
Ensuring both individual and teamwork meets the Council's Green Commitment Policy goals in reducing energy consumption and waste, increasing renewable energy use and recycling, contributing to a reduction in traffic congestion and using sustainable materials

Data Protection
Being aware of the council's responsibilities under the Data Protection Act 1998 for the security, accuracy and relevance of personal data held, ensuring that all administrative and financial processes also comply.

Confidentiality
Treating all information acquired through employment, both formally and informally, in confidence. There are strict rules and protocols defining employee access to and use of the council's databases. Any breach of these rules and protocols will be subject to disciplinary investigation. There are internal procedures in place for employees to raise matters of concern regarding such issues as bad practice or mismanagement

Equalities and Diversity
The council has a strong commitment to achieving equality of opportunity in its services to the community and in the employment of people. It expects all employees to understand, comply with and promote its policies in their own work, undertake any appropriate training to help them to challenge prejudice or discrimination

Health and Safety
Being responsible for own Health & Safety, as well as that of colleagues, service users and the public. Employees should co-operate with management, follow established systems of work, use protective equipment and report defects and hazards to management. Managers should carry out, monitor and review risk assessments, providing robust induction and training packages for new and transferring staff, to ensure they receive relevant H&S training, including refresher training, report all accidents in a timely manner on council accident forms, ensure H&S is a standing item in team meetings, liaise with trade union safety representatives about local safety matters and induct and monitor any visiting contractors etc., as appropriate

Contribute as an effective and collaborative team member
This will involve:

- Participating in training to demonstrate competence.
- Undertaking training as required for the role.
- Participating in the development, implementation and monitoring of service plans.
- Championing the professional integrity of the service

This job description can be updated annually as part of the personal development plan.

Person Specification: ICN+ Care Home Connector

	Criteria	Essential	Desired
Education/ Qualifications	Demonstrable commitment to professional and personal development.	✔	
	Trained in motivational coaching and/or interviewing. (training can be provided)		✔
Skills/Abilities	Interpersonal skills that enable you to work with people at all levels, motivate others, build strong working relationships and influence/change people's attitudes when necessary.	✔	
	Commitment to partnership working, including ability to work cooperatively with GPs, colleagues and other stakeholders.	✔	
	Excellent coordination and organisational skills, including ability to prioritise and plan own workload, manage multiple tasks and work to tight deadlines.	✔	
	Strong communication skills (listening, verbal and written) that enable you to inform and advise others clearly, and communicate with a variety of audiences including clients, health and care professionals, commissioners and other organisations' staff.	✔	
	Ability to understand and manage diverse and complex client needs	✔	
	Demonstrable understanding and experience of the person-centred approach to supporting people enabling and empowering them and promoting independence		
	Ability to understand and manage professional boundaries.	✔	
Experience	Demonstrable experience of working with people with health and social care needs, or community-based work with socially	✔	

	excluded groups, or those experiencing health inequalities.		
	Demonstrable experience of coaching or working with clients with health care needs to meet specified outcomes		✔
	Demonstrable experience of working successfully in partnership across functional/organisational boundaries.		✔
Knowledge	Knowledge of local area, and local community and voluntary sector services.	✔	
	A broad understanding of health and social care services.	✔	
	An understanding of the change process within an individual, and how to elicit and maintain changes in behaviours.		✔
	The ability to demonstrate and foster a culture of sharing best practice with colleagues and learning from others.	✔	
Personality & Personal Attributes	Self-managing and administrating, resourceful and solution focused.	✔	
	High level of personal integrity and ability to demonstrate commitment to the aims and values ENTER ORG Name here	✔	
	High degree of empathy, understanding and diplomacy.	✔	
	Ability to demonstrate commitment to the principle and practice of equal opportunities, and a commitment to enabling people to achieve their potential	✔	