**One Croydon Alliance for Health and Care**

**JOB DESCRIPTION**

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

**Contract:** Fixed Term, 12 months

**Grade/Salary:**  NHS Band 5 or Equivalent

**Hours:** 37.5

**Location:** Croydon, exact location TBC

**Stakeholder**

**Relationships:** One Croydon Alliance Organisations

**Budget Responsibility:** None

***All frontline health and care workers are required to be fully vaccinated against Covid 19 by 1st April 2022.  The first dose of the vaccine must be given by 3rd February 2022 in order to meet this deadline.***

***Applicants for front line roles will be required to provide evidence of vaccination as part of any pre-employment checks.***

**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 Personal Independence Coordinators (PICs) under 50s
* Mental Health PICs
* Named person for smaller community services e.g., Diabetes

**Preventative Approach**

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 social isolated, we will support them to stay independent and healthy.

Alongside rolling out the new team, access to support will also be available via Community Hubs, formerly known as “Talking Points” in the community. Health, social care and voluntary sector staff will attend the Community Hubs to provide the required support.

The Community-led support approach will be adopted by all staff at the Community Hubs. Staff will talk to people about what is important to them and explain what assets are available within local community to support them. The Community Hubs will also provide advice about healthy living, housing and benefits. There will also be access to a social prescriber and ongoing PICs support.

Croydon’s assets as a place include a vibrant and diverse voluntary and community sector (VCS). We want to support the voluntary and community sector in each locality so that people can make connections and take part in social and physical activities in their local area. Local voluntary partnerships are developing in different ways across our six localities.

Integrated Community Networks Plus (ICN+) is a major programme of transformation and integration that will improve outcomes for Croydon people through a proactive and preventative approach within each of the six Localities of the Borough. It is focused on all adults and is aligned with services for children and families.

The rollout of the ICN+ integrated community teams has started to see positive outcomes for Croydon residents. To enable the model to be sustainable and to proactively support residents to stay well, the ICN+ Care Home Coordinator role is being introduced.

**KEY FUNCTIONS**

Functions of the role include:

* To work with the wider System to implement the key principles and elements of the Enhanced Health in Care Homes (EHCH) Framework in the Croydon Care Homes hosted by one of the ICN+ Localities.
* To establish relationships between PCNs and ICN+ MDTs to deliver an integrated approach to the delivery of the EHCH framework.
* To work with the individual, their carer or care home, to develop a support plan including an action plan and supporting the coordination of tasks to be completed.
* To provide a central, continuous point of contact for the individual, assigned person their relatives/carers and the range of professionals involved in the care plan; and to escalate actions that have not been undertaken by professionals involved in the care plan.
* To participate in regular multi-agency team meetings. This will require the ICN+ Care Home Coordinator to provide advice and information on community support options into the meetings and take referrals as and when required.
* To work with the individual, their carer or care home, to develop strategies to enable them to manage their long-term health condition better.
* To work with individuals to support them to prioritise and address the practical, social and emotional issues in their lives which affect their wellbeing.
* To link up with the hospital services (ED) to identify high intensity users who may benefit from care coordination to support them become less reliant on statutory services.
* To support residents who are open to the ICN+ caseload, to a maximum of 20 cases per Coordinator at any one time.

**KEY RESULT AREAS**

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

* Improved resident experience of services, which will be more person-centred and holistic and accessible close to home.
* Care Homes have equitable access to services within the ICN+ locality, as all other Croydon residents
* Improved Patient Safety as ICN+ team members will be able to view the joint care plan developed by the ICN+ Care Home Coordinator.
* Improved outcomes for 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.
* Shared care plan approach will support cultural change and make the ICN+ service more proactive than reactive.
* The benefits of proactive and preventative care leading over time to reduced health inequalities, longer healthy life expectancy, improved wellbeing.
* Reduced bureaucracy as everything will be recorded in one place on the Care Plan.
* This approach will be more person-centred, allowing residents to feel more in control of their care and support.
* Will support statutory obligations to assessing and support planning.

**KEY WORKING RELATIONSHIPS**

The post will report to the ICN+ Team Leader. Other key working relationships include:

* Primary Care Networks and their Care Home leads
* One Croydon PMO colleagues
* ICN+ Team Members across both statutory and voluntary and community sector organisations

**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 Coordinator

**Grade:** NHS Band 5 or Equivalent

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|  | **Criteria** | **Essential** | **Desired** |
| **Education/ Qualifications** | Demonstrable commitment to professional and personal development. | ✓ |  |
| Trained in motivational coaching and/or interviewing. |  | ✓ |
| **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 and to use person centred approach to meet these needs. | ✓ |  |
| Ability to deliver services in a person-centred way (enabling/empowering approach) promoting independence in clients. | ✓ |  |
| 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. | ✓ |  |
| Understanding of how to monitor and improve service quality for the benefit of customers, and 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 of One Croydon Alliance/ICN+ | ✓ |  |
| 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 | ✓ |  |