Hart Voluntary Action Ltd

JOB DESCRIPTION

TITLE:	Co-ordinator
PROJECT:	Making Connections Home from Hospital Service
ACCOUNTABLE TO:	Chief Executive
STAFF REPORTING:	None
WORKING WITH:	Operations Manager, Home from Hospital staff team, Making Connections staff team
PLACE(S) OF WORK:	Hart Voluntary Action, Civic Offices, Harlington Way, Fleet, GU51 4AE Frimley Park Hospital, Portsmouth Road, Frimley, Camberley, GU16 7UJ

CONTEXT

Hart Voluntary Action (HVA) has been awarded a contract by North East Hampshire and Farnham Clinical Commissioning Group (CCG) to deliver a 9-month pilot Home from Hospital service. This service will be for adult clients living in North East Hampshire only (the GP locality areas of Aldershot, Farnborough, Fleet, and Yateley), who require low-level support in the home after being discharged from Frimley Park Hospital, or Fleet and Farnham Community Hospitals. The service will run from late January to late October 2019.

The service will support clients to settle back at home after a stay in hospital. Clients will have the support of the Making Connections Home from Hospital Service for a period of up to 6 weeks to include practical tasks to ensure the client is comfortable at home and has access to ongoing support to activities in the community to keep them socially and physically active, or appropriate support to keep them living independently at home. The role does not entail providing any type of personal care.

Working as part of a team of Home from Hospital Co-ordinators, the service will provide 7 days a week cover with the focus on primarily on supporting the discharge of patients from Frimley Park Hospital. A regular presence at Frimley Park Hospital to be available to meet with hospital staff, Hampshire Adult Social Care staff and clients/clients' relatives will be a key shared responsibility of this role. Meetings with hospital/social care staff and clients at Fleet and Farnham Hospitals will be arranged as required.

It is anticipated that the service will be handling 20 new client referrals per month, so the average caseload per Co-ordinator will be 15 clients at any one time. As this is a pilot project, there may be adjustments to timing, but it is initially planned that the service will be operational between 08.00 and 19.00 each day.

The range of services that could be on offer to Home from Hospital clients are the following:

- Basic home risk assessment, preparing home – switching on lights, heating and ensuring that basic food items are available.
- Hydration and nutrition support – preparing basic snacks, ensuring food and fluids are available.
- Supporting clients to access telecare/telehealth services to maintain independence and security in the home.

- Help with shopping, collecting prescriptions, paying bills, accompanying on trips to medical appointments or to access community-led activities.
- Providing information about and facilitating access to voluntary and community based services that enable them to feel socially active and improves opportunities for independent living.
- Onward client referral to the main Making Connections "social prescription service" if required to assist clients with accessing support for befriending/companionship in the home or additional support to access community-based services.

TASKS

The key tasks of this post are to:

- Work as a team to deliver the Making Connections Home from Hospital service for clients living in North East Hampshire, providing a 7 days a week cover, working on a shift pattern.
- Liaise with all agencies, family members, and clients to ensure timely support for clients before and after discharge from hospital.
- Provide a person-centred approach to supporting individual clients.
- Provide a combination of face-to-face visits at home or in the community and telephone contacts over a period of up to 6 weeks from the point of first contact with the client.
- Ensure accurate recording of interventions and support provided through the project's case management system.

Within these generic tasks are the following specific tasks:

- Attend weekly multi-disciplinary team meetings at Frimley Park Hospital where client discharge cases are discussed.
- Attend meetings to discuss client discharge from Farnham and Fleet Community Hospitals as required.
- Respond to enquiries about referrals in a timely manner.
- Ensure all relevant referral sources have access to information about the service and how to make a referral to the service.
- Use the Making Connections project online case management system (Charity Log) to record client information at the point of referral and throughout the duration of the support provided.
- Attend staff team meetings to manage client case-load to ensure as far as possible that the client remains with the same Co-ordinator throughout the time that support is provided.
- Make contact with clients whilst they are still in hospital to ensure all relevant information has been collated, and set up action plan for actions to be taken before and after discharge from hospital.
- Agree with the client the tasks to be completed in the home before or after discharge from hospital to support independence and reduce the risk of hospital readmission.
- Maintain an appointments schedule to manage all contacts with clients.
- Liaise with Making Connections project team for information about local services and activities in the community to provide to Home from Hospital clients and/or for help with sourcing volunteer help in the home.
- Maintain communications with all agencies and family members linked to the client for the duration of the intervention.
- Maintain client records through the project's online case recording system.
- Provide reports/client case studies for internal and external use as required.
- Collate client feedback as required.
- Attend training courses as required.

PERSON SPECIFICATION

Experience/Knowledge	**Essential**	**Desirable**
Previous experience in a similar role.		√
Knowledge of the issues that affect older people, especially dementia		√
Experience of working within the health or social care sector		√
Experience of undertaking assessments		√
Understanding of person-centred planning		√
Experience of working with volunteers		√
Education/Training		
Evidence of continuing professional development within the health and social care environment that will support this role		√
Skills and Abilities		
Effective communication skills and the ability to communicate with people at all levels	√	
The ability to work independently and within a team	√	
The ability to be a facilitator rather than a fixer	√	
Excellent organisational skills	√	
The ability to produce accurate reports	√	
To work on own initiative	√	
A willingness to be flexible	√	
The ability to motivate others	√	
Proficient in MS Office and some experience of using databases	√	
Use of own car and the ability to travel within the project catchment area	√	

January 2019