

**Home from Hospital Co-ordinator**

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| **Salary:** | **Band 4 £22,696** |
| **Location:** | Harrogate |
| **Reporting to:** | Home from Hospital Manager |
| **Hours:** | 20 hours per week - Monday to Friday, with OOH phone cover  |
| **Role Guide** | Home from Hospital Co-ordinators will develop strong relationships with local hospital teams and the 5 discharge hubs to identify appropriate referrals. They will take referrals to the service and carry out dynamic risk assessments to prioritise support and provide clients with short-term practical and emotional support at home to reduce the risk of re-admission to hospital and assist in their return to independence.  |
| **Relating to your role** |  |
|  | **Referrals and Assessment:** * Take referrals via single point of access phone line, dedicated email or web forms.
* Carry out initial dynamic risk assessment to prioritise and grade support needed.
* Allocate referrals in priority order to team members in relevant locality.
* Liaise with the locality Discharge Hub (one of 5 discharge hubs across North Yorkshire) to identify and receive appropriate referrals as per the Discharge to Assess model.
* Carry out pre-discharge planning work as appropriate

**Service Promotion:** |
|  | * Builds positive relationships with hospital teams to promote the service, attending relevant meetings and ward rounds as required to generate referrals.
* Promotes the service to relevant health and community services – e.g. NYCC discharge hubs, Re-ablement, Living Well, community response teams, GP practices etc.

**Provide client support:*** Following allocation of referral, establishes contact to assess client needs, assisting them to set individual goals and developing a support plan with the client.
* Provides practical help and support at home, which is not already available, to meet the individual’s identified needs.
* Actively refer and/or signpost clients on to appropriate service providers to meet their immediate and ongoing needs.
* Recruit, manage and retain volunteers to support clients.
* Liaises with health and social care professional and family as appropriate.
* Identify carers and cross refer these to carer support services as appropriate.
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|  | **General** |
|  | * Efficiently manages a caseload of clients, ensuring effective liaison with other agencies.
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|  | * Ensures all processes and procedures are adhered to in the safe delivery of the service, keeping up to date confidential accurate records (electronic and/or paper).
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|  | * Assists the Programme Manager with monitoring and evaluation of the service and its clients, ensuring progress and success of the scheme can be continually demonstrated.
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|  | * Supports and supervises volunteers as appropriate and participates/assists in facilitating volunteer training where required.
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| **Working with others** |  |
|  | * Demonstrates effective team working skills, interacting well with other departments and participates in team meetings and training.
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|  | * Displays self confidence and initiative.
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|  | * Makes a positive contribution to Carers’ Resource, is willing to function as a member of a small team and proactively assist in the development of the organisation.
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|  | * Demonstrates active listening and observational skills, accepting and learning from feedback.
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| **Understanding the organisation** |  |
|  | * Assists with the analysis of trends and recommendations for service improvement.
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|  | * Acts as ambassador for Carers’ Resource, protecting and promoting its good name and reputation at all times, and contributing to its development.
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|  | * Works within policies and practices of Carers’ Resource, follows health and safety procedures and maintains confidentiality.
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|  | * If required, participates as a representative of Carers’ Resource, in multi-agency meetings, voluntary fora and other events, feeding back appropriately to line manager and the team.
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| **Developing personally**  |  |
|  | * Takes responsibility, in consultation with line manager, for personal development and progression, participating in performance reviews and undertakes any training deemed necessary.
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|  | * Keeps up-to-date about services, benefits and organisations available to clients.
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|  | * Good timekeeper and good attendance.
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| **Person Specification** | **Essential** | **Desirable** |
| **Experience** |
| Experience of assessing the needs of vulnerable people and providing reassuring person-centred support in-line with their goals. | ✓ |  |
| Experience of supporting clients in their own homes | ✓ |  |
| Experience of working in the health and social care sector | ✓ |  |
| **Skills & abilities** |
| Able to manage complex workload | ✓ |  |
| Skilled communicator who can competently and calmly liaise with Health & Social Care professions and client’s family members  | ✓ |  |
| An independent and resourceful employee, comfortable in operating as a lone-worker within a community setting  | ✓ |  |
| Comfortable in visiting potential clients on hospital wards | ✓ |  |
| Organisational abilities, an ordered systematic approach to work and an eye for detail | ✓ |  |
| Ability and commitment to working as part of an extended team | ✓ |  |
| Need to be self motivated, to organise time effectively, to manage workload, to prioritise tasks and to work to agreed targets | ✓ |  |
| **Knowledge** |
| Evidence of a good general education | ✓ |  |
| IT literate – a competent user of Word and email | ✓ |  |
| An understanding of the hospital discharge process  |  | ✓ |
| An understanding of the issues that can affect those who have had a stay in hospital  |  | ✓ |
| An awareness of the teams/agencies that can be involved in post-discharge support |  | ✓ |
| Some knowledge or experience of how to manage a project and develop its potential |  | ✓ |
| **Other requirements** |
| An understanding of the need for confidentiality, sensitivity and a non judgemental attitude | ✓ |  |
| Daily use of own transport, clean, current driving licence and business class insurance | ✓ |  |
| Double vaccinated for Covid 19 ( or evidence of medical exemption) | ✓ |  |