Care Co-ordinator
Job Description

Responsible To: Clinical Director, Vale of Evesham PCN

Hours: 16 per week

Salary: Band 3

Location: Vale of Evesham PCN

Overall Purpose of Job:

We are seeking Care Co-ordinators who will play a key co-ordinating role in Vale of Evesham PCN. Care co-ordinators provide extra time, capacity and expertise to make sure that appropriate support is made available to residents of care homes and ensure that their needs are addressed. They will help residents and their families to understand, manage and utilise personal care and support plans and contribute to increasing the number of patients with personal health budgets in place. Care Co-ordinators will work closely with Primary Care Network (PCN) and GP Practices to ensure patients receive coordinated care, which is responsive to their needs and designed in co-operation with patients, carers, and all supporting services.

Tackling health inequalities is a major focus for the PCN and this role will ensure that this key priority is embedded within all work carried out by the Care Coordinator team, who will be providing much needed advice and guidance to a diverse population of patients.

This role aims to give patients and their carers more control over their own health and care, achieve greater collaboration between GPs and their teams and community services, strengthen joint working with local partners, and improve health outcomes and tackle health inequalities.

The Care Coordinator will work as an integral part of the multi-disciplinary team supporting patients with multiple and complex needs and their carers to take an active and informed role within their own health care and wellbeing. They will provide apoint of contact for the patient and their family/carers. They will work closely with care home staff and other services to ensure the provision of seamless and integrated support.

Main Responsibilities are to:

With the use of Clinical Systems and engagement with PCNs and Practices, actively identify a caseload of patients who are in need of a care package at a designated surgery

Work directly with patients, their carers and advocates in line with best practice, to develop a holistic personalised care and support plan that brings together all the patients identified care and support needs and reflects what matters most to them.

Support people to understand their level of knowledge, skills and confidence when engaging with the support planning process and managing their health and wellbeing, including the use of the Patient Activation Measure

Help people to manage their needs through answering queries, making and managing appointments and ensuring that people have good quality written or verbal information to help them make choices about their care.

Assist patients and their carers to access support or interventions that improve their health and well being and increase their knowledge, skills and confidence.

Assist patients and their families to consider and record their wishes and preference in regard to future care and treatment in the event of a deterioration when they are no longer able to make decisions for themselves

Provide co-ordination and navigation for people and their carers across health and care services, Social Prescribing Link Workers, Lifestyle Advisors and other primary care professionals.

Identify, report and action any issues of concern relating to safeguarding and quality of care arising from working with patients and referring onwards as appropriate.

Care Co-ordination:

Care Planning:

- Record, action and follow up referrals and care packages agreed for all patients within the PCN, especially those discussed at internal MDT meetings.
- Working with clinicians within your allocated practice, service users/patients, their families and carers, co-design and deliver care plans and ensure that the actions set out are being followed-up and evaluated and are co-ordinated around the needs of the service user.

- Ensure that all individual care plans remain up to date, that they are evaluated and revised as necessary and that record keeping is completed as appropriate.

Identifying vulnerable patients that require an integrated care team approach:-

- Ensure that individual care plans are revised following key events such as hospital admission or discharge, significant improvements or deterioration of their condition or service user/patient/carer concerns.

- Liaise directly with other teams within the health and care sector e.g Worcestershire Acute Hospitals Trust, Worcestershire Health and Care Trust, Worcestershire County Council .on behalf of the clinical team to ensure that actions are followed up.

- Identify networks of local statutory and voluntary and community support services that could be deployed to assist individuals to achieve optimum health and wellbeing. Develop positive relationships in order to co-ordinate effective and responsive packages of care for service users.
- Ensure good communication is maintained with neighbourhood teams, care home staff and other health care professionals to ensure appropriate support is provided to patients upon discharge.
- Act as the first port of call for service users/patients/their families as appropriate in your caseload.

- Make referrals to Social Prescriber, Lifestyle Advisor and other services to patients identified as potentially benefitting from these services.

- Manage and ensure the completion of monitoring, evaluation and assessment processes for all appropriate and relevant services, so that all reporting requirements are met and submitted in line with relevant timescales and NHS Quality and Outcome Frameworks.

- Maintain and develop engagement with all practice and care home staff and encourage 'best practice'.

Job Summary:

- Take a leading role in developing integrated care for patients within the PCN Care Home Team.

- Work with GPs to identify, manage and prioritise a caseload of patients in accordance with needs and, where required and as appropriate, refer people back to other health professionals within the PCN.

- Act as a building block by co-operating with other service providers to share information, jointly plan care and provide a streamlined, integrated service and to reduce variations in service delivery in adherence with confidentiality and data protection legislation and data sharing agreements.

- Have mechanisms in place to engage with patients who are using the service and their carers.

- Using reflective working and continuous improvement practices work collaboratively with other health and care services to continuously improve, develop and evolve the service and the patient experience.

- Ensure at all times, service users experience support and contact that is user friendly, accessible, responsive to individual needs, warm and professional.

Other Responsibilities:

- Contribute to the strategic planning of care co-ordination services within a care home setting.

Confidentiality

- In the course of seeking treatment, patients entrust us with, or allow us to gather, sensitive information in relation to their health and other matters. They do so in confidence and have the right to expect that staff will respect their privacy and act appropriately;

- In the performance of the duties outlined in this Job Description, the post-holder may have access to confidential information relating to patients and their careers, practice staff and other healthcare workers. They may also have access to information relating to the practice as a business organisation. All such information from any source is to be regarded as strictly confidential.

Health & Safety

The post-holder will assist in promoting and maintaining their own and others' health, safety and security as defined in the practice Health & Safety Policy, to include:

- Using personal security systems within the workplace according to practice guidelines;
- Identifying the risks involved in work activities and undertaking such activities in a way that manages those risks;
- Making effective use of training to update knowledge and skills;
- Using appropriate infection control procedures, maintaining work areas in a tidy and safe way and free from hazards;
- Reporting potential risks identified.

Equality and Diversity

The post-holder will support the equality, diversity and rights of patients, carers and colleagues, to include:

- Acting in a way that recognises the importance of people's rights, interpreting them in a way that is consistent with practice procedures and policies, and current legislation;
- Respecting the privacy, dignity, needs and beliefs of patients, carers and colleagues;

Personal/Professional Development

In addition to maintaining continued education through attendance at any courses and/or study days necessary to ensure that professional development requirements are met, the post-holder will participate in any training programme implemented by the practice as part of this employment, such training to include:

- Participation in an annual individual performance review, annual Appraisal including taking responsibility for maintaining a record of own personal and/or professional development;
- Taking responsibility for own development, learning and performance and demonstrating skills and activities to others who are undertaking similar work.

Quality

The post-holder will strive to maintain quality within the practice, and will:

- Alert other team members to issues of Clinical Governance issues, quality and risk; participate in Significant Event Analysis reviews
- Assess own performance and take accountability for own actions, either directly or under supervision;
- Contribute to the effectiveness of the team by reflecting on own and team activities and making suggestions on ways to improve and enhance the team's performance;
- Work effectively with individuals in other agencies to meet patient's needs;
- Effectively manage own time, workload and resources. He/she will also contribute to the overall team-working of the Practice putting the needs of the Practice first.

Contribution to the planning and implementation of services

The post-holder will:

- Apply practice policies, standards and guidance;
- Discuss with other members of the team how the policies, standards and guidelines will affect own work;
- Participate in audit where appropriate.
- Work with the Lead GP(s) to achieve standards of quality, performance standards, without compromising levels of patient healthcare.
- Contribute towards the development and implementation of new standards, policies and procedures that are/will be required of GP Practices now and in the future (as directed by NHS/ DoH/, new legislation etc.)

Communication

- Be able to effectively communicate at all levels of the organisation to a variety of health professionals, users and carers, independent and voluntary sector to provide the best outcomes for users of the services.
- Provide interface between hospital, primary, community and social settings, participate where appropriate in clinical meetings relating to patient care and outcomes
- Communicate effectively with patients and carers
- Be able to keep accurate contemporaneous documentation, both written and computerised, inpatient records and will need to be familiar with EMIS Web.
- Recognise people's needs for alternative methods of communication and respond accordingly

Clinical Governance

- To participate and operate within the clinical governance framework for the organisation at all times, incorporating service users and carers, audit, guidelines and risk management.
- To actively participate in the practices, becoming familiar with and abiding by its plans, policies and procedures.

This job description may be reviewed in the light of changing organisational and service needs. Any changes will be fully discussed with the post holder. The post holder may also be required to carry out other work appropriate to the grade of the post.

LOCATION

Your role will be based at **Grey Gable Surgery, Inkberrow** a part of the Vale of Evesham PCN – covering Evesham Town, Broadway Bredon and Inkberrow. It will require some travel amongst PCN member practices and business meeting locations in Worcestershire. Working from home for some elements of the role will be considered. The post holder should be flexible in their working hours which may include some evening and weekend work

Signed…… Date……

Print
Name……...

Person Specification

Qualifications

Essential

- Good general standard of education

Desirable

- Health and social care qualification
- Training around care planning and co-ordination
- Training around residential care

Experience

Essential

- Working with people to empower them to become more confident and develop coping skills
- Working with people who have complex health and care needs to improve their wellbeing
- Experience of working in a dynamic and creative way, solving problems and prioritising work
- Maintaining accurate, up to date records of activities and interventions
- Experience of working in a health and/or social care setting

Desirable

- Experience of working in a multi disciplinary team
- Working with people with dementia, Alzheimer's or other conditions that affect their ability to communicate, and their carers and advocates
- Experience of advocating for vulnerable adults and/or people with complex needs
- Experience of Mental Capacity Issues
- Awareness of issues relating to Advance Care Planning and the ReSPECT process
- Experience of facilitating or leading change in organisations, systems or ways of working
- Monitoring and evaluating services and approaches

Skills

Essential

- Good communication and interpersonal skills
- Ability to build trust and offer a holistic, solutions focused approach to individual issues
- Able to network and build effective working relationships
- Strong influencing skills and the confidence to constructively challenge to effect change
- Able to work on own initiative and manage own time
- Excellent organisational skills and an ability to prioritise workload
- Maintaining boundaries and ensuring clarity and understanding of the role
- Ability to self-manage and be creative in your approach to problem solving

Desirable

- Use of IT systems including EMIS, Care Notes, Microsoft office, email and database systems (external and internal) although further training will be available

Knowledge

Essential

- Person centred approaches
- Health care systems and processes
- Local primary care health services and support, both statutory and third sector
- Safeguarding, confidentiality and GDPR
- Issues affecting the lives of adults facing disadvantage
- Issues relating to empowerment and disempowerment
- Equal opportunities and diversity