K E W M E D I C A L P R A C T I C E

14 High Park Road • Kew • London • TW9 4BH
Tel: 020 8487 8292
www.kewmedicalpractice.co.uk

Job Title	Care Co-ordinator
Line Manager	Edona Sinanaj
Accountable to	Dr Moj Fitzmaurice
Hours per week	Monday - Friday

Job Summary

Care co-ordinators play an important role within the practice and the PCN to proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide co-ordination and navigation of care and support across health and care services. They work closely with GPs and practice teams to manage a caseload of patients, acting as a central point of contact to ensure appropriate support is made available to people and their carers; supporting them to understand and manage their condition and ensuring their changing needs are addressed. This is achieved by bringing together all the information about a person's identified care and support needs and exploring options to meet these within a single personalised care and support plan, based on what matters to the person. Care co-ordinators could provide time, capacity and expertise to support people in preparing for, or following-up, clinical conversations. Care co-ordinators help people improve their quality of life.

Generic Responsibilities

All staff at Kew Medical Practice have a duty to conform to the following:

Health and Safety/Risk Management:

- The post-holder must always comply with the Practice's Health and Safety policies, in particular by following agreed safe working procedures and reporting incidents using the organisations Incident Reporting System.
- The post-holder will comply with the Data Protection Act (1984) and the Access to Health Records Act (1990).

Equality and Diversity:

- The post-holder must co-operate with all policies and procedures designed to ensure equality of employment. Co-workers, patients and visitors must be treated equally irrespective of gender, ethnic origin, age, disability, sexual orientation, religion etc.

Respect for Patient Confidentiality:

- The post-holder should always respect patient confidentiality and not divulge patient information unless sanctioned by the requirements of the role.

Special Working Conditions:

- The post-holder will have contact with body fluids i.e., wound exudates, urine etc. while in clinical practice.

Job Description Agreement:

- This job description is intended to provide an outline of the key tasks and responsibilities only. There may be other duties required of the post-holder commensurate with the position. This description will be open to regular review and may be amended to consider development within the Practice. All members of staff should be prepared to take on additional duties or relinquish existing duties to maintain the efficient running of the Practice.

- This job description is intended as a basic guide to the scope and responsibilities of the post and is not exhaustive. It will be subject to regular review and amendment as necessary in consultation with the post holder.

Primary Responsibilities

The following are the core responsibilities of a care coordinator. There may be on occasion, a requirement to carry out other tasks; this will be dependent upon factors such as workload and staffing levels:

- Work with people, their families and carers, to improve their understanding of their condition.
- Support people to develop and review personalised care and support plans to manage their needs and achieve better healthcare outcomes.
- Help people to manage their needs by providing a contact to answer queries, make and manage appointments, and ensure that people have good quality written or verbal information to help them make choices about their care.
- Assist people to access self-management education courses, peer support, health coaching and other interventions that support them in their health and wellbeing, and increase their levels of knowledge, skills and confidence in managing their health.
- Provide co-ordination and navigation for people and their carers across health and care services. Helping to ensure patients receive a joined-up service and the appropriate support from the right person at the right time.
- Work collaboratively with GPs and other primary care professionals within the PCN to proactively identify and manage a caseload, which may include patients with long-term health conditions, and where appropriate, refer to other health professionals within the PCN.
- Support the co-ordination and delivery of multidisciplinary teams with the PCN.
- Raise awareness of how to identify patients who may benefit from shared decision making and support PCN staff and people to be more prepared to have shared decision-making conversations.
- Explore and assist people to access a personal health budget where appropriate. [To further enhance the role, PCNs may wish to add the following additional responsibilities to the person specification:]
- Work with people, their families, carers and healthcare team members to encourage effective help-seeking behaviours.
- Support PCNs in developing communication channels between GPs, people and their families and carers and other agencies.
- Identify carers and help them access services to support them.
- Conduct follow-ups on communications from out of hospital and in-patient 2 services.
- Maintain records of referrals and interventions to enable monitoring and evaluation of the service.

- Support practices to keep care records up-to-date by identifying and updating missing or out-of-date information about the person's circumstances.
- Contribute to risk and impact assessments, monitoring and evaluations of the service.
- Work with commissioners, integrated locality teams and other agencies to support and further develop the role. Key tasks1.Enable access to personalised care and support. Take referrals or proactively identify people who could benefit from support through care co-ordination. b. Have a positive, empathetic and responsive conversations with people and their families and carer(s), about their needs. c. Increasing patients' understanding of how to manage and improve health and wellbeing by offering advice and guidance. Develop an in-depth knowledge of the local health and care infrastructure and know how and when to enable people to access support and services that are right for them. e. Use tools to measure people's levels of knowledge, skills and confidence in managing their health and tailor support to them accordingly. f. Support people to develop and implement personalised care and support plans. g. Review and update personalised care and support plans at regular intervals. h. Ensure personalised care and support plans are communicated to the GP and any other professionals involved in the person's care and uploaded to the relevant online care records, with activity recorded using the relevant SNOMED codes. Where a personal health budget is an option, work with the person and the local ICS team to provide advice and support as appropriate. Co-ordinate and integrate care a. Make and manage appointments for patients, related to primary, secondary, community, local authority, statutory, and voluntary organisations. b. Help people transition seamlessly between secondary and community care services, conducting follow-up appointments, and supporting people to navigate through the wider health and care system. c. Refer onwards to social prescribing link workers and health and wellbeing coaches where required and to clinical colleagues where there is an unaddressed clinical need. d. Regularly liaise with the range of multidisciplinary professionals and colleagues involved in the person's care, facilitating a co-ordinated approach, and ensuring everyone is kept up to date so that any issues or concerns can be appropriately addressed and supported.3 e. Actively participate in multidisciplinary team meetings in the PCN. f. Identify when action or additional support is needed, alerting a named clinical contact in addition to relevant professionals, and highlighting any safety concerns. g. Record what interventions are used to support people, and how people are developing on their health and care journey. [To further enhance the role, PCNs may wish to add the following additional responsibilities to aid in data and information capture:]
    - Keep accurate and up-to-date records of contacts, appropriately using GP and other records systems relevant to the role, adhering to information governance and data protection legislation.
    - Work sensitively with people, their families and carers to capture key information, while tracking of the impact of care co-ordination on their health and wellbeing.
    - Encourage people, their families and carers to provide feedback and to share their stories about the impact of care co-ordination on their lives.
    - Record and collate information according to agreed protocols and contribute to evaluation reports required for the monitoring and quality improvement of the service.Supervision/professional development a. Undertake continual personal and professional development, taking an active part in reviewing and developing the role and responsibilities, and provide evidence of learning activity as required. Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone

working, information governance, equality, diversity and inclusion training and health and safety. Access relevant GPs to discuss patient related concerns, and be supported to follow appropriate safeguarding procedures. Access regular supervision. The workforce development framework for care co-ordinators

Person Specification – Care Coordinator

They will be caring, dedicated, reliable, and person-focussed and enjoy working with a wide range of people. They will have good written and verbal communication skills and strong organisational and time management skills. They will be highly motivated and proactive with a flexible attitude, keen to work and learn as part of a team and committed to providing people, their families and carers with high quality support.

This role is intended to become an integral part of the Practices and PCN's multidisciplinary team, working alongside social prescribing link workers and health and wellbeing coaches to provide an all-encompassing approach to personalised care and promoting and embedding the personalised care approach across the practice and PCN. There may be a need to work remotely depending on the requirements of the role. Please note that the care co-ordinator works under delegation of a registered health professional.
Salary: TBC by PCN. Reimbursement under the Additional Roles Reimbursement Scheme is based on Band 4.
Key responsibilities include more information on supervision and professional development.4. Miscellaneous a. Establish strong working relationships with GPs and practice teams and work collaboratively with other care co-ordinators, social prescribing link workers and health and wellbeing coaches, supporting each other, respecting each other's views and meeting regularly as a team. b. Act as a champion for personalised care and shared decision making within the practice or PCN. c. Demonstrate a flexible attitude and be prepared to carry out other duties as may be reasonably required from time to time within the general character of the post or the level of responsibility of the role, ensuring that work is delivered in a timely and effective manner. 4
d. Identify opportunities and gaps in the service and provide feedback to continually improve the service and contribute to business planning. e. Contribute to the development of policies and plans relating to equality, diversity and reduction of health inequalities. f. Work in accordance with the practices' and PCN's policies and procedures. g. Contribute to the wider aims and objectives of the PCN to improve and support primary care. Personalised Care Institute (PCI) training The PCI was launched in September 2020. It is a virtual organisation accountable for setting the standards for evidence-based training in personalised care in England. Details of PCI accredited training for care co-ordinators and organisations that provide the training can be found on the PCI website. On completion of training, learners will be registered with the PCI and receive a completion certificate.

Personal qualities and attributes

Person specification – care coordinator	**Criteria Essential**	**Criteria Desirable**
Ability to actively listen, empathise with people and provide personalised support in a non-judgemental way.	✓	
Ability to provide a culturally sensitive service	✓	

supporting people from all backgrounds and communities, respecting lifestyles and diversity		
Commitment to reducing health inequalities and proactively working to reach people from diverse communities	✓	
Ability to support people in a way that inspires trust and confidence, motivating others to reach their potential	✓	
Ability to communicate effectively, both verbally and in writing, with people, their families, carers, partner agencies and stakeholders	✓	
Ability to identify risk and assess / manage risk when working with individuals	✓	
Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when what the person needs is beyond the scope of the care co-ordinator role – e.g., when there is a mental health need requiring a qualified practitioner	✓	
Ability to maintain effective working relationships and to promote collaborative practice with all colleagues	✓	
Ability to demonstrate personal accountability, emotional resilience and work well under pressure	✓	
Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines	✓	
Ability to work flexibly and enthusiastically within a team or on own initiative	✓	
Ability to provide motivational coaching to support people's behaviour change	✓	
Knowledge of, and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety Demonstrable commitment to professional and personal development	✓	
Completed a two-day PCI accredited care co-ordination training course or be willing to complete one prior to taking referrals.	✓	
Proficient in MS Office and web -based services	✓	
Experience of working directly in a care co-ordinator role, adult health and social care, learning support or public health / health improvement	✓	
Experience of working in health, social care and other support roles in direct contact with people, families or carers (in a paid or voluntary capacity)	✓	
Experience of working within multi - professional team environments	✓	
Experience of supporting people, their families and carers in a related role	✓	
Experience or training in personalised care and	✓	

support planning		
Experience of data collection and using tools to measure the impact of services	✓	
Experience of working with elderly or vulnerable people, complying with best practice and relevant legislation	✓	
Skills and knowledge Understanding of personalised care and the comprehensive model of personalised care	✓	
Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities, individuals, their families and carers	✓	
Understanding of, and commitment to, equality, diversity and inclusion	✓	
Strong organisational skills, including planning, prioritising, time management and record keeping	✓	
Knowledge of how the NHS works, including primary care and PCNs Knowledge of Safeguarding Children and Vulnerable Adults policies and processes	✓	
Ability to recognise and work within limits of competence and seek advice when needed.	✓	
Understanding of the needs of older people / adults with disabilities / long term conditions particularly in relation to promoting their independence	✓	
Basic knowledge of long -term conditions and the complexities involved: medical, physical, emotional and social	✓	

Other requirements	**Essential**	**Desirable**
Disclosure Barring Service (DBS) check	✓	
Occupational Health Clearance	✓	
Willingness to work flexible hours when required to meet work demands	✓	
Access to own transport	✓	
Ability to travel across the locality on a regular basis	✓	
Proficient speaker of another language to aid communication with people in the community for whom English is a second language	✓	

This document may be amended following consultation with the post holder, to facilitate the development of the role, the practice and the individual. All personnel should be prepared to accept additional, or surrender existing duties, to enable the efficient running of the practice.

Please apply by sending covering letter and current CV to Edona Sinanaj edona.sinanaj@nhs.net