**Care Coordinator Job Description**

**Reports to:** PCN Clinical Lead and Practice Management Team

**Hours:** 37.5 hours p/w

**Primary Duties and Areas of Responsibility**

**Multi-Disciplinary Teams**

* Overall responsibility for arranging the PCN led MDT meetings (including the weekly virtual Care Home(s) MDT and the cancer and palliative care meetings) and the smooth running of integrated care within the team setting. A key role of the Care Coordinator will be to schedule the weekly MDT meetings, manage the meeting agenda items; ensuring that all new referrals are identified, and information circulated to team members in advance of the meeting.
* Take minutes of MDT meetings and disseminate; chase progress against actions identified in these meetings and ensure follow up where necessary.
* Manage reporting required and associated within the NHSE DES specifications for required services.
* Patient Identification Utilise population health intelligence to proactively identify and work with a cohort of patients to deliver personalised care.
* Receive and collate information from transfers of care (including hospital admissions and discharges) plus out of hours calls and present this information to the MDT as required.
* Liaise with service providers and clinicians to identify ‘frequent flyers’, and new service users utilising risk stratification tools provided and present this information to the weekly MDT meetings.
* Support the completion of new referrals by checking criteria, and where criteria have been met, direct referral to the MDT.
* Signpost team members, service users and carers to relevant services

**Direct patient facing work**

* Manage a caseload of patients identified through the MDT
* Provide support to patients to facilitate access to screening and assist with early diagnosis of cancer
* Support patients to utilise decision aids in preparation for a shared decision-making conversation.
* Holistically bring together all of a person’s identified care and support needs, and explore options to meet these within a single personalised care and support plan (PCSP), in line with PCSP best practice, based on what matters to the person.
* 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.
* Support people to take up training and employment, and to access appropriate benefits where eligible.
* Support people to understand their level of knowledge, skills and confidence (their “Activation” level) when engaging with their health and wellbeing, including through the use of the Patient Activation Measure.
* Assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing and increase their activation level.
* Explore and assist people to access personal health budgets where appropriate.

**Communication and collaborative working relationships**

* Demonstrates ability to work as a member of a team.
* Is able to recognise personal limitations and refer to more appropriate colleague(s) when necessary.
* Actively work toward developing and maintaining effective working relationships both within and outside the PCN or group of PCNs.
* Liaises with other stakeholders as needed for the collective benefit of patients including but not limited to Patient’s GP, Nurses, other practice staff and other healthcare professionals including pharmacists and pharmacy technicians from provider and commissioning organisations.
* Work with service users, PCN practices and partners e.g. Care Homes to ensure new referrals are logged and allocated
* Develop excellent working relationships with the all partners, wider service networks including the voluntary sector, GP practices, adult social care, hospitals, community pharmacists and other members of the MDT
* Acting as a point of contact for residents, families, carers and professionals who visit the care home, such as MDT members and in-reach specialists.
* Meet regularly with the clinical lead and review case load and MDT function.
* Keep the MDT and OHP organisation abreast of ‘good news’ stories.
* Provide background information about individuals for the weekly MDT meetings
* Communicate effectively with service users and their families/carers, and provide coordination across health and care services working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals.
* Manage and prioritise workload on a daily basis and deal with the competing demands of the MDT

**Other responsibilities**

* To act at all times in an anti-discriminatory manner
* To be able to plan and respond to workload according to operational priorities
* To support the delivery of these functions across wider locality areas where necessary
* To undertake any training required in order to maintain competency including mandatory training
* To contribute to, and work within a safe working environment.
* The Care Coordinator must at all times carry out duties and responsibilities with due regard to the GP Practice’s equal opportunity policies and procedures
* The Care Coordinator is expected to take responsibility for self-development on a continuous basis, undertaking on-the-job training as required
* The Care Coordinator must be aware of individual responsibilities under the Health and Safety at Work Act, and identify and report as necessary any untoward accident, incident or potentially hazardous environment.

**Patient Care**

* Communicate effectively and sensitively and use language appropriate to a patient and carer/relative’s condition and level of understanding
* Effectively use all methods of communication and be aware of and manage barriers to communication
* Effectively recognise and manage challenging behaviors, carers and or relatives
* Provide information to patients, their carers and/or relatives on behalf of the team
* The PCN will ensure the PCN’s Care Coordinator can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

**Supporting Care Delivery**

* Be the point of liaison for service users and interface with all health and social care professionals, including keeping everyone informed and updated
* Follow through actions identified by the MDT including arranging tests, referrals, signposting, etc.
* Follow through with service users and others involved to ensure all services and care arrangements are in place

**Autonomy/Scope within Role**

* The post holder will be required to work within clearly defined organisational protocols, policies and procedures

**Key Relationships**

**Key Working Relationships Internal:**

* Clinical Lead for the MDT
* GPs and General practice teams within the PCN
* PCN Clinical Director
* PCN Manager
* MDT members including but not exhaustive: Clinical Pharmacists, technicians, District Nurses, LARCH Team, OPMH, IRT, Adult Social Care, Paramedics, Social Prescribing Link Workers, Village Agents

**Key Working Relationships External:**

* GPs from neighbouring PCNs
* Service providers
* Social care
* Voluntary services
* Patients/service users
* Carers/relatives

**Health and Safety/Risk Management**

* The post-holder must comply at all times with the organisation and Practice’s Health and Safety policies, in particular by following agreed safe working procedures and reporting incidents using the organisation’s Incident Reporting System.
* The post-holder will comply with the Data Protection Act (1984), The General Data Protection Regulations (2018) and the Access to Health Records Act (1990).
* The post-holder will comply with all necessary training requirements relevant to the role as identified by the organisation; in particular the post holder must complete the specified care coordinator training delivered by the Personalised Care Institute

**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 is required to travel independently between practice sites (where applicable), and to attend meetings etc. hosted by other agencies.

**Job Description Agreement**

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.

**Person Specification**

**Education, Qualifications and Training**

* GCSEs/Diploma/ HNC level (or relevant experience)
* ECDL or equivalent
* NVQ Level 3 Business Administration (or relevant experience)
* Ongoing internal and external training to keep up to date with changes/ developments

**Experience and Knowledge Required**

* Minimum of 2 years’ experience of working with healthcare professionals and or previous experience in the NHS or social care or relevant field (desirable)
* Experience in use of databases
* Experience of administrative duties
* Able to demonstrate a clear understanding of working with confidential information and an understanding of service user confidentiality
* Working in a multi-disciplinary setting where influence and negotiation is required
* Knowledge/familiarity with medical terminology
* Working in a busy and demanding environment whilst delivering in a timely manner
* Understanding of current issues facing the NHS (desirable)
* Understanding of health and social care processes (desirable)

**Skills and Attributes**

* Proven record of excellent written and verbal communication skills and interpersonal skills
* Evidence of excellent knowledge of Microsoft Office
* Able to deal with service users sensitively
* Able to work as part of a team
* Able to prioritise and manage own workload
* Excellent motivational and influencing skills
* Excellent negotiating skills
* Car user (to travel between more than one GP practice)
* Excellent interpersonal skills
* Strong analytical and judgement skills
* Ability to analyse and interpret information and present results in a clear and concise manner
* Excellent organisational and administration skills
* Experience providing advice/signposting to users
* Able to use NHS Choices website effectively (desirable)

**Aptitude and Personal Qualities**

* Professional attitude and assertive approach
* Committed to development
* Conscientious, hardworking and self- motivated to work with minimal supervision
* Creative and tenacious in finding solutions to difficult problems
* Ability to work with information, clinicians, social workers and managers
* Ability to meet deadlines and work under pressure
* Ability to engage and sustain relationships with all professionals, other organisations and service-users
* Approachable and flexible
* Honest and reliable
* Enthusiastic
* Sensitive to patients needs

**Values, Drivers and Motivators**

* Willingness to undergo further training or development
* Requires a flexible approach, and a highly motivated post holder. The role may need to be reviewed and developed in the future in line with changing priorities
* Access to and ability to use transport as travel between sites across the county will be required for meetings and training
* Willingness to undergo further training and development as the job develops