

Care Coordinator

Job Description

Purpose of the role

Care coordinators play an important role within a PCN to proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide coordination 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 them 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 coordinators review patients' needs and help them access the services and support they require to understand and manage their own health and wellbeing, referring to social prescribing link workers, health and wellbeing coaches, and other professionals where appropriate.

Care coordinators could potentially provide time, capacity and expertise to support people in preparing for or following-up clinical conversations they have with primary care professionals to enable them to be actively involved in managing their care and supported to make choices that are right for them. Their aim is to help people improve their quality of life.

The successful candidate will be based in a local cluster of General Practices as part of Trowbridge Primary Care Network (PCN). 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 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 PCN. There may be a need to work remotely depending on the requirements of the role.

Please note that the role of a care coordinator is not a clinical role.

Salary: TBC by PCN.

Key responsibilities

- Work with people, their families and carers to improve their understanding of the patients' condition and support them to develop and review personalised care and support plans to manage their needs and achieve better healthcare

outcomes.

- 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.
- 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 back to other health professionals within the PCN.
- Support the coordination 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 patients to be more prepared to have shared decision-making conversations.
- 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;
- Conduct follow-ups on communications from out of hospital and in-patient 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 Tasks

1. Enable access to personalised care and support

- a. Take referrals for individuals or proactively identify people who could benefit from support through care coordination;
- b. Have a positive, empathetic and responsive conversation with the person and their family and carer(s) about their needs;
- c. Work towards increasing patients' understanding of how to manage and develop health and wellbeing through offering advice and guidance;
- d. 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 to 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;

2. Coordinate and integrate care

- a. Making and managing 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 wider the health and care system;
- c. Refer onwards to social prescribing link workers and health and wellbeing coaches where required;
- d. Regularly liaise with the range of multidisciplinary professionals and colleagues involved in the person's care, facilitating a coordinated approach and ensuring everyone is kept up to date so that any issues or concerns can be appropriately addressed and supported;
- e. Actively participate in multidisciplinary team meetings in the PCN as and when appropriate;
- 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,
- h. 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;
- i. Work sensitively with people, their families and carers to capture key information, while tracking of the impact of care coordination on their health and wellbeing;
- j. Encourage people, their families and carers to provide feedback and to share their stories about the impact of care coordination on their lives;
- k. Record and collate information according to agreed protocols and contribute to evaluation reports required for the monitoring and quality improvement of the service.

3. Professional development

- a. Work with a named clinical point of contact for advice and support.
- b. 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;
- c. Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, equality, diversity and inclusion training and health and safety.
- d.

4. Miscellaneous

- a. Establish strong working relationships with GPs and practice teams and work collaboratively with other care coordinators, 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 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;
- 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.

5. Person Specification – Care Coordinator			
Criteria		Essential	Desirable
Personal qualities and attributes	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, community groups, 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 coordinator 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	✓	
	High level of written and verbal communication skills	✓	
	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		
Qualifications and training	NVQ Level 3 in adult care - advanced level or equivalent qualifications or working towards		✓
	Demonstrable commitment to professional and personal development is enrolled in, undertaking or qualified from appropriate training as set out in the core curriculum by the Personalised Care Institute	✓ Training will be given	
	Proficient in MS Office and web-based services	✓	
Experience	Experience of working directly in a care coordinator 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	Knowledge of the personalised care approach	✓	
	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		✓
	Understanding of the needs of older people / adults with disabilities / long term conditions particularly in relation to promoting their independence	✓	
Other	Meets DBS reference standards and criminal record checks	✓	
	Willingness to work flexible hours when required to meet work demands	✓	