

# RURAL WEST PRIMARY CARE NETWORK

## Job Description

<b>Job title:</b>	Care Coordinator for Long-Term Conditions (LTC)-Diabetes
<b>Professionally accountable to:</b>	The Network Partners
<b>Managerially accountable to:</b>	The Network Manager
<b>Hours per week:</b>	37.5 hours

### Job Summary

The main purpose of this role is to support patients with Long-Term Conditions (LTC), specifically those people with pre-Diabetes and Diabetes, within the Rural West Primary Care Network (PCN). Rural West PCN consists of Tadley Medical Partnership and Watership Down Health. The post holder will assist in improving the quality of care these patients receive and to provide coordination and navigation of care and support across health and care services. The post holder will perform these duties in line with best practice with reference to and collaboration with the clinical leads, GPs and Practice Nurses for the service and the strategic needs of the Practices. The Care Co-ordinator will work closely with the 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(s) and ensuring their changing needs are addressed.

### Key Responsibilities

The Care Coordinator will work as an integral part of the PCN's multidisciplinary team (MDTs), working alongside the Social Prescribers and the Health and Wellbeing Coaches to provide an all-encompassing approach to personalised care, and promoting and embedding the personalised care approach across the PCN. They will be based within both Practices.

The post holder will:

1. Work collaboratively with the Partnership Diabetic Leads, GPs and other primary care professionals within the PCN to proactively identify and manage a caseload of patients with long-term health conditions, specifically those people with pre-Diabetes/Diabetes, and where appropriate, refer back to other health professionals within the PCN. This will involve regularly running reports from our clinical systems i.e. EMIS and managing the Partnerships' day to day call/recall programme for pre-Diabetes/Diabetes.
2. Actively participate in the monthly Multi-Disciplinary Team (MDT) Diabetes meetings with the PCN/Practices teams and community services.
3. Provide coordination and navigation for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals to help ensure patients receive a joined up service and the most appropriate support.
4. Work with people, their families and carers to improve their understanding of the patients' condition to manage their needs and achieve better healthcare outcomes.

5. Ensure that allocated patients are able to access services available in the community – both free and where charges apply - based on the Co-ordinator's detailed knowledge of the relevant access arrangements, eligibility criteria and service content. To connect the services that already exists locally – both statutory and voluntary, so that services 'wrap-around' the patient.
6. 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. Refer onwards to social prescribing link workers and health and wellbeing coaches and other services where required.
7. Assist people to access an assessment for Adult Social Care where appropriate and provide information in connection with personal budgets.
8. Conduct follow-ups on communications from out of hospital and in-patient services.
9. Maintain records of referrals and interventions to enable monitoring and evaluation of the service.
10. Support the PCN in developing communication channels between GPs, people and their families and carers and other agencies.
11. Support practices to keep care records up to date by identifying and updating missing or out-of-date information about the person's circumstances.
12. Contribute to risk and impact assessments, monitoring and evaluations of the service.
13. Review and update personalised care and support plans at regular intervals and ensure these 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 (system) codes.
14. 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.
15. Take referrals for individuals or proactively identify people who could benefit from support through care coordination.

This job description is a summary of the main duties of the post and is, therefore, not exhaustive. The duties of the post will be reviewed regularly in conjunction with the post holder and the job description may be amended accordingly.

#### **Key Non Clinical Aspects (risk management, health & safety, Information technology)**

1. Ensure accurate, clear and concise records are recorded and maintained on every patient and to uphold confidentiality of the same.
2. Maintain databases to facilitate patient care and ensure accurate data and fulfil clinical governance.
3. Contribute to evaluation reports required for the monitoring and quality improvement of the service.
4. Participate in meetings to ensure the service runs smoothly and information is shared.
5. Contribute to the development of the service within the Practices and the community.
6. Promote and participate in an environment that seeks to continually improve and deliver quality patient focused care.

<b>Professional Development</b> <ol style="list-style-type: none"> <li>1. Take part in mandatory training.</li> <li>2. Ensure own skills and knowledge are updated by undertaking continual personal and professional development, in line with the requirements of the post and the service.</li> <li>3. Contribute to the PCN strategies ensuring that the views of all staff are represented.</li> <li>4. Demonstrate clear understanding and awareness of national policy in relation to the post.</li> </ol>
<b>Miscellaneous</b> <ol style="list-style-type: none"> <li>1. Establish strong working relationships with GPs and practice teams and work collaboratively with other Care Coordinators, Social Prescribers and Health &amp; Wellbeing Coaches.</li> <li>2. Attend department meetings and take part in them, using the skills and knowledge of your area to inform and guide the team.</li> <li>3. Be flexible in meeting the needs of the role in both hours worked and tasks undertaken.</li> <li>4. Contribute to the wider aims and objectives of the PCN to improve and support primary care.</li> </ol>
<b>Generic Responsibilities</b> <p>Tadley Medical Partnership is the employing Partnership for Rural West PCN under a joint contract working across the PCN in both Tadley Medical Partnership and Watership Down Health. All staff have a duty to conform to the following:</p> <p><b>Equality, Diversity &amp; Inclusion</b></p> <p>A good attitude and positive action towards ED&amp;I creates an environment where all individuals are able to achieve their full potential. Creating such an environment is important for three reasons: it improves operational effectiveness, it is morally the right thing to do, and it is required by law.</p> <p>Patients and their families have the right to be treated fairly and be routinely involved in decisions about their treatment and care. They can expect to be treated with dignity and respect and will not be discriminated against on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. Patients have a responsibility to treat other patients and our staff with dignity and respect.</p> <p>Staff have the right to be treated fairly in recruitment and career progression. Staff can expect to work in an environment where diversity is valued and equality of opportunity is promoted. Staff will not be discriminated against on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. Staff have a responsibility to ensure that you treat our patients and their colleagues with dignity and respect.</p> <p><b>Safety, Health, Environment and Fire (SHEF)</b></p> <p>This practice is committed to supporting and promoting opportunities for staff to maintain their health, well-being and safety. You have a duty to take reasonable care of health and safety at</p>

work for you, your team and others, and to cooperate with employers to ensure compliance with health and safety requirements. All personnel are to comply with the Health and Safety at Work Act 1974, Environmental Protection Act 1990, Environment Act 1995, Fire Precautions (workplace) Regulations 1999 and other statutory legislation.

### **Confidentiality**

This practice is committed to maintaining an outstanding confidential service. Patients entrust and permit us to collect and retain sensitive information relating to their health and other matters, pertaining to their care. They do so in confidence and have a right to expect all staff will respect their privacy and maintain confidentiality at all times. It is essential that if the legal requirements are to be met and the trust of our patients is to be retained, that all staff protect patient information and provide a confidential service.

### **Quality & Continuous Improvement (CI)**

To preserve and improve the quality of our output, all personnel are required to think not only of what they do, but how they achieve it. By continually re-examining our processes, we will be able to develop and improve the overall effectiveness of the way we work. The responsibility for this rests with everyone working within the practice to look for opportunities to improve quality and share good practice.

This practice continually strives to improve work processes which deliver health care with improved results across all areas of our service provision. We promote a culture of continuous improvement, where everyone counts and staff are permitted to make suggestions and contributions to improve our service delivery and enhance patient care.

### **Induction Training**

On arrival at the practice all personnel are to complete a practice induction programme; this is managed by the Practice Training Manager, your line manager and the PCN Manager.

### **Learning and Development**

The effective use of training and development is fundamental in ensuring that all staff are equipped with the appropriate skills, knowledge, attitude and competences to perform their role. All staff will be required to partake and complete mandatory training as directed by the training coordinator, as well as participating in the practice training programme. Staff will also be permitted (subject to approval) to undertake external training courses which will enhance their knowledge and skills, progress their career and ultimately, enable them to improve processes and service delivery.

### **Collaborative Working**

All staff are to recognise the significance of collaborative working. Teamwork is essential in multidisciplinary environments. Effective communication is essential and all staff must ensure they communicate in a manner which enables the sharing of information in an appropriate manner.

**Service Delivery**

Staff at Tadley Medical Partnership and Watership Down Health must adhere to the information contained with these practices' policies and regional directives, ensuring protocols are adhered to at all times. Staff will be given detailed information during the induction process regarding policy and procedure.

**Security**

The security of the practice is the responsibility of all personnel. Staff must ensure they remain vigilant at all times and report any suspicious activity immediately to their line manager. Under no circumstances are staff to share the codes for the door locks to anyone and are to ensure that restricted areas remain effectively secured.

**Professional Conduct**

All staff are required to dress appropriately for their role.

Person Specification		
Qualifications	Essential	Desirable
Educated to GSCE or equivalent standard A-C /Grade 4 or above in English and Maths	✓	
A-Level standard /NVQ Level 3 in Health and Social Care - advanced level or equivalent		✓
Demonstrable commitment to professional and personal development	✓	
Experience	Essential	Desirable
Experience of working in a health or social care setting in a support role in direct contact with people, families or carers (in a paid or voluntary capacity), preferably those patients with pre-Diabetes/Diabetes	✓	
Experience of working directly in a care coordinator role, adult health and social care, learning support or public health / health improvement		✓
Experience of working within multi-professional team environments	✓	
Experience of supporting people with pre-Diabetes/Diabetes, their families and carers in a related role		✓
Experience or training in personalised care and support planning		✓
Experience of data collection, running reports 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	Essential	Desirable
Excellent communication skills (written and oral)	✓	
Strong IT skills including competency in the use of Office and Outlook	✓	
EMIS (clinical system) user skills		✓
Understanding of clinical coding		✓
Clear, polite telephone manner	✓	
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		✓
Basic knowledge of long term conditions and the complexities involved: medical, physical, emotional and social	✓	

<b>Skills and Knowledge (con't)</b>	<b>Essential</b>	<b>Desirable</b>
Understanding of the needs of older people / adults with disabilities / long term conditions particularly in relation to promoting their independence	✓	
Ability to work as a team member and autonomously	✓	
Good interpersonal skills	✓	
Problem solving & analytical skills	✓	
Ability to follow policy and procedure	✓	
<b>Personal Qualities</b>	<b>Essential</b>	<b>Desirable</b>
Polite and confident	✓	
Flexible and cooperative	✓	
Motivated	✓	
Forward thinker	✓	
High levels of integrity and loyalty	✓	
Sensitive and empathetic in distressing situations	✓	
Ability to work under pressure	✓	
<b>Other requirements</b>	<b>Essential</b>	<b>Desirable</b>
Flexibility to work outside of core office hours		✓
Disclosure Barring Service (DBS) check	✓	
Access to own transport and ability to travel across the PCN on a regular basis	✓	

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/s.