

## Care Coordinator Job Description

**Responsible to:** OHP Supported PCN

**Accountable to:** PCN Clinical Director and Consultant Pharmacist (OHP)

**Salary:** £21,892-£23,650

### Job Summary

The Care Coordinator will be part of the Primary Care Network (PCN) Multi-Disciplinary Team (MDT) who are responsible for managing the care of people registered with practices within a particular PCN. This will involve coordinating the work of healthcare professionals and non-clinical staff including volunteers involved in the care of patients registered at GP practices within the wider PCN population.

The post holder will contribute to tackling inequalities in health and social care particularly regarding individuals with long-term conditions. An ethos of promotion of independence and partnership-working is integral to this post.

A key part of the role of a care coordinator role is in the care Homes MDT: improving the continuity of care by acting as a point of contact for residents, families and professionals who visit care homes, such as MDT members and in-reach specialists.

They will support the MDT with the weekly virtual home round through identification of people in need of review, or collation of information on people requiring an MDT review in addition to providing coordination, secretarial and administrative support to the MDTs within a single or multiple PCNs.

### Primary Duties and Areas of Responsibility

#### Multi-Disciplinary Teams

- Overall responsibility for arranging the weekly PCN led MDT meetings (including the weekly virtual Care Home(s) MDT) and the smooth running of integrated care within the team setting. The 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.
- Coordinate and manage the administrative functions of MDT meetings.

- Liaise with all clinical and non-clinical members in the MDT to ensure effective MDT function.
- 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 DES specifications for required services.

## **Patient Identification**

- 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

## **Maintenance of IT based information systems and responsibility for key performance data:**

- To ensure the IT requirements for recording activity are adhered to in collaboration with other team members
- Accurate update and maintenance of GP systems within the MDT.
- To provide agreed performance/activity data within the MDT and PCN and wider OHP organisation.

## **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 Patients 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 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, other staff both internal and external and members of the public
- 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 behaviours, carers and or relatives
- Provide information to patients, their carers and/or relatives on behalf of the team

## 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
- MDT members including but not exhaustive: Clinical Pharmacists, technicians, Physician Associates, Physios, Paramedics, Social Prescribing Link Workers,

### 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.

### **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**

- ECDL or equivalent
- Diploma/ HNC level (or relevant experience)
- NVQ Level 3 Business Administration (or relevant experience)
- Ongoing internal and external training to keep up to date with changes/ developments
- Long term conditions training (desirable)
- Welfare Rights basic training (desirable)

### **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
- Vulnerable adults awareness (desirable)
- Experience of care of the elderly (desirable)
- Understanding of current issues facing the NHS (desirable)
- Knowledge of social services structures Training in continuing care criteria (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