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**Job Description and Person Specification**

**Job Title:** Care Coordinator (PCN Services)

**Reports To:** Managing Partner (Business Development) – interim arrangement

**Hours:** 37.5 pw (working pattern within the work to be defined)

**Location**: Likely based at the non-clinical site, and to attend any of the practice sites as needed

**Contract:** Fixed Term Contract – 2 years

**Salary:** £26,000 - £28,000 (based on experience)

North Bedford Primary Care Network is a unitary primary care network serving a population of circa. 50,000 patients across five sites of The De Pary’s Group in the Bedford area. Our principle clinical site is the Enhanced Services Centre, with other clinical sites (Church Lane, Bromham) and a non-clinical site at De Parys Avenue. Our teams work together to delivery high quality primary care services, at scale, for our registered patients. We are passionate about the NHS and the essential role that primary care plays in the wider healthcare system.

The Care Coordinator (PCN Services) will work as part of a new team within the practice, with specific responsibility for the smooth running of new services that are being created and provided by the PCN to its own population and also to the population of other GP practices and organisations (known as ‘new services’) as well as the full organisation and management of Group sessions for our PCN population and potentially for the population of other GP practices and organisations.

We are looking for someone who has excellent interpersonal and communication skills, is organised, patient and empathetic. You will have experience of working in health, social care or other support roles including direct contact with people, families or carers and be a positive team player who strives to go the extra mile to help colleagues and others who come into contact with the organisation.

**Job Purpose**

The Care Coordinator plays an important role within both the practice and the PCN to proactively identify and work with a range of teams to ensure that new services and group sessions are delivered in a positive, fulfilling, engaged and supportive environment that delivers a good outcome for the patient, while being safe, meeting all IG and IPC requirements. Clear and effective communication will be key, for patients and across the PCN, as well as ensuring that all parts of the process are fully understood and acted upon (i.e. no step in the process is too big or too small to be completed by the person that fulfils this role).

Please note that the role of a Care Coordinator (PCN Services) is not a clinical role.

* Care Coordinator (PCN Services) will have a deep understanding of the ‘new service’ pathways and all steps within them
* The Care Coordinator (PCN Services) will have a deep understanding of the Group sessions pathways and processes and all steps within them
* For the new service pathways and for Group Sessions, the CC will be responsible for (although this list is not exhaustive)
  + Identification of suitable patients for the service within TDPG
  + Receiving incoming referrals – either from TDPG patients, or patients of other practices / organisations
  + Liaison with GPA (Admin) leads to ensure proper scheduling
    - Ensuring referrals meet the requirements of the service provision
    - Managing waiting list(s) for each service, and ensuring equity of access
    - Booking appointments for each service
    - Clear and accurate communication with patients when booking appointments, and when reminding them of their appointments (to minimise DNA rate)
    - Prompt rebooking of any cancellations to ensure clinic appointments are maximised
  + Liaison with rota team manager to ensure appropriate clinics are scheduled
  + Creation of any associated referrals arising from these appointments
  + Creation of any associated blood test forms arising from these appointments
  + Creation of any associated letters or other administrative matters arising from these appointments (including safeguarding referrals)
  + Communication to partner practices / organisations in line with defined protocols
  + Reporting risks or governance or IPC issues to the appropriate team, while taking appropriate mitigation measures (seeking support and guidance as necessary)
  + Audit of service provision and usage
  + Audit of DNA’s, and identification of opportunities to reduce and minimise
  + Patient satisfaction survey – creation of, administration of, collation of results and recommendation of improvements
* For the Group sessions particularly (although this list is not exhaustive)
  + There is the potential to also facilitate the session in support of the clinician – clear and articulate communication skills will be needed for this
  + There is the potential to also support the session, as in patients need to be directed from the group session to ‘break out’ sessions or to individual consultations that follow on – this co-ordination and management of the group will need to be undertaken by this role
* You will be caring, dedicated, reliable and person-focussed and enjoy working with a wide range of people.
* Support and raise awareness of national screening and immunisation programmes (i.e. Make Every Contact Count)
* Support Impact and Investment funds framework (IIF) and quality and outcome framework (QoF) alongside the PCN DES requirements (i.e. Make Every Contact Count).
* You will have good written and verbal communication skills and strong organisational and time management skills.
* You 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.
* There is possibility of weekend work requirements.

*This job description is not exhaustive and may be adjusted periodically after review and consultation. You will also be expected to carry out any reasonable duties which may be requested from time-to-time.*

**Care Coordinator (PCN Services) Person Specification**

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| **Qualifications** | **Essential** | **Desirable** |
| GCSEs Grade A-C in Maths and English or key skills level 2 in Maths and English (to be evidenced by a test if relevant qualifications not available) | ✓ |  |
| NVQ Level 3 in adult care - advanced level or equivalent qualifications or working towards | ✓ |  |
| Demonstratable 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 | ✓ |  |
| **Experience** | **Essential** | **Desirable** |
| Ability to use Microsoft Office applications including Word, Excel, PowerPoint, Outlook | ✓ |  |
| Experience of working within multi- professional team environments | ✓ |  |
| Experience of data collection and using tools to measure the impact of services | ✓ |  |
| Understanding of the wider determinants of health, including social, economic, and environmental factors and their impact on communities, individuals, their families, and carers | ✓ |  |
| Experience of working directly in a care coordinator role, adult health, and social care, learning support or public health / health improvement | ✓ |  |
| Experience of working with elderly or vulnerable people, complying with best practice and relevant legislation | ✓ |  |
| Experience of read coding within a primary care environment |  | ✓ |
| **Skills & Knowledge** | **Essential** | **Desirable** |
| Knowledge of how the NHS works, including primary care and PCNs | ✓ |  |
| Strong organisational skills, including planning, prioritising, time management and record keeping | ✓ |  |
| 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 | ✓ |  |
| Effectively able to communicate and understand the needs of the patient | ✓ |  |
| Proactive, motivated, and forward thinker | ✓ |  |
| Ability to work well in a team however also able to work independently without supervision | ✓ |  |
| Ability to work under pressure/in stressful situations | ✓ |  |
| Sensitive and empathetic in distressing situations | ✓ |  |
| Strong listening and communication skills | ✓ |  |
| Good knowledge of clinical terminology | ✓ |  |
| Knowledge of Safeguarding Children and Vulnerable Adults policies and processes |  | ✓ |
| Ability to provide motivational coaching to support people’s behaviour change |  | ✓ |
| **Other requirements** | **Essential** | **Desirable** |
| Hold a Valid UK Driving License and have access to own transport with business insurance and ability to travel across the locality on a regular basis, including visiting people in their own home or care home | ✓ |  |
| Proficient speaker of another language to aid communication with people in the community for whom English is a second language |  | ✓ |