Job Description

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| **Post title:** | PCN care coordinator |
| **Responsible to:** | PCN Clinical lead |
| **Accountable to:** | PCN Business Manager & Clinical Director |
| **Base:** | Clacton Primary Care Network |
| **Hours :** | 37.5 hrs per week over 5 days (some Saturday work may be required) |
| **Annual Salary:** | £26530,00 WTE (£13.57phr)  NHS Pension scheme available. |

**Job Summary**

The primary objective of this role is to collaborate with the Primary Care Network (PCN) Proactive Care Team to enhance the health and well-being of patients within our network. This will involve screening, routine health reviews, taking observations, cancer care reviews, supporting groups and education events, holistic assessments, and implementing proactive approaches to managing frailty and long-term conditions. The role supports individuals to live, age, and die well through a mix of clinics, home visits, meetings, and service development initiatives.

The post holder will work in partnership with general practices, stakeholders, the wider PCN team, and neighbourhood-level resources to address patient needs and support the achievement of PCN objectives. They will act as a role model for the PCN demonstrating a compassionate and caring approach.

**Clacton PCN**, located in North East Essex, comprises six practices: East Lynne Medical Centre (Lead Practice), North Clacton Medical Group, Old Road Surgery, Thorpe Surgery, Fronks Road Surgery, and Harewood Surgery. This dynamic and busy network offers opportunities for personal development, with a focus on supporting the local community and addressing health areas of interest to team members.

The Care Coordinator role is pivotal in providing enhanced care to our patient population, serving as a critical link between the GP practices, Patients and the PCN.

**Primary Duties and Responsibilities**

* **Collaboration and Communication**:
* Establish and maintain strong communication channels between PCN and practice staff.
* Work with the Clinical Lead and Proactive team to embed the proactive care pathway across the PCN, addressing health inequalities and promoting healthy aging.
* Develop strong working relationships with member practices to understand population needs and support patients in reducing crises, improving screening uptake, and enabling care in preferred settings.
* **Service Coordination and Support**:
* Review and process new referrals, ensuring criteria are met before presenting to the multidisciplinary team (MDT).
* Liaise with community workers and care coordinators to maximise awareness and utilisation of available services.
* Use risk stratification tools to identify high-need patients, such as frequent service users, and present findings during MDT meetings.
* Ensure accurate coding of care records to optimise practice and PCN performance (e.g., flu vaccinations, proactive care assessments, ethnicity recording).
* **Service Delivery and Development**:
* Support compliance with Direct Enhanced Services (DES) guidance, particularly in Proactive, Health inequality and personalised care domains.
* Collaborate with social prescribers and specialist teams to connect patients with voluntary services, improving physical, mental, and social well-being.
* Assist practice managers with vaccination, booster, and immunisation follow-ups.
* Encourage attendance at preventive screenings, including bowel, breast, and cervical cancer checks.
* Support the delivery of cancer care reviews and patients on the pathway that may require some guidance and sign posting.
* Organise and participate in health education events, screenings, and community outreach initiatives.
* **Clinical Support**:
* Work with the MDT to undertake regular clinical reviews ie: Mental health, learning disability, hypertension supporting the practice and clinical team to manage acute and chronic conditions using both pharmacological and non-pharmacological treatment plans.
* Support patients in adhering to prescribed treatments and completing advanced care planning where appropriate.
* Support patients to complete RESPECT form and liaise with clinical team at practice level to complete with patients.
* Refer patients to appropriate resources, such as social prescribers, frailty assessments, or occupational therapists, ensuring a holistic approach to care.

**Administrative and Compliance Responsibilities**

* Maintain accurate, legible, and timely documentation in patient records using SystmOne/EMIS.
* Adhere to infection control standards in diverse environments, following organisational policies.
* Report incidents and near misses in line with risk management policies to ensure patient and staff safety.
* Stay current with mandatory training and safeguarding guidance for adults and children, ensuring appropriate processes are followed to protect those at risk.
* Comply with organisational corporate and clinical policies, always maintaining professional standards.

**When Required:**

* Perform administrative tasks in line with practice policies and procedures, including patient deductions, record updates, and scanning of patient documentation.
* Support the primary care team with physical health checks, such as measuring blood pressure, taking blood samples, and providing basic wound care to ensure the right care is delivered at the right time and by the right person.

**Communication and Collaborative Working Relationships**

* Demonstrate effective teamwork by contributing positively to team objectives.
* Communicate clearly and professionally with team members, patients, and carers, ensuring recognition of individual communication needs, including the use of alternative methods when necessary.
* Recognise personal limitations and appropriately refer patients to colleagues with the necessary expertise.
* Foster strong working relationships with practice and PCN colleagues, promoting collaboration and cooperation.
* Liaise with multi-disciplinary teams across organisational boundaries, including primary care, social services, and secondary care providers, to ensure patients receive appropriate care according to their needs.
* Maintain seamless communication with healthcare professionals and external agencies to ensure the continuous delivery of patient-centred services.
* Ensure patients receive the appropriate level of care, working to prevent unnecessary hospital admissions where possible.
* Approach sensitive topics with empathy and tact, ensuring clear, compassionate communication.
* Positively promote health advice and lifestyle changes to enhance patient well-being.
* Demonstrate a proactive attitude in all aspects of the role.

**Other Responsibilities**

* Adhere to anti-discriminatory practices in all aspects of work.
* Effectively manage workload priorities in accordance with operational needs.
* Undertake any required training to maintain competency, including mandatory training sessions.
* Contribute to the maintenance of a safe working environment.
* Follow the GP Practice’s equal opportunity policies and procedures, acting in accordance with these standards at all times.
* Take responsibility for personal development, including on-the-job training and self-directed learning.
* Understand and comply with the Health and Safety at Work Act, promptly reporting any accidents, incidents, or hazardous conditions.

**Patient Care**

* Communicate effectively and sensitively with patients, carers, and relatives, adapting language to suit their condition and level of understanding.
* Utilise various communication methods and effectively manage any barriers to communication.
* Manage challenging behaviours from patients, carers, or relatives with professionalism and respect.
* Provide information to patients and their carers/relatives on behalf of the team, ensuring clarity and accuracy.
* Collaborate actively with the proactive care team to improve patient health and well-being outcomes.

**Key Relationships**

**Internal Key Working Relationships**

* Clinical Lead for MDT
* Proactive Care Nurse
* GPs and general practice teams within the PCN
* PCN Clinical Director
* MDT members, including community nursing teams, clinical pharmacists, physiotherapists, paramedics, and social prescribing link workers

**External Key Working Relationships**

* Neighbourhood Team Lead
* GPs from neighbouring PCNs
* Care home managers
* Service providers
* Social care organizations
* Voluntary services
* Patients/service users
* Carers/relatives

**Health, Safety, and Security**

* Adopt a risk-assessment approach in all activities, ensuring a proactive stance on safety.
* Report any perceived risks to the appropriate responsible person in a timely manner.
* Adhere to the lone worker policy to ensure personal safety when working independently.
* Ensure patient records are securely recorded and stored, in compliance with organisational policies.
* Transport patient-identifiable information, laptops, and smartcards in accordance with the information governance policy.

**Quality**

* Raise any concerns regarding quality or risk in patient care with the Clinical Lead or other relevant team members.
* Ensure that actions are of high quality and aligned with clinical governance standards.
* Practice in accordance with agreed care standards and protocols.
* Facilitate patient access to the appropriate professionals within the team, ensuring timely and efficient care.
* Monitor and manage stock levels under your control, ensuring that items are replenished or reported as needed.
* Be familiar with and adhere to practice-specific policies and procedures.
* Demonstrate effective time and workload management, ensuring tasks are prioritized and completed efficiently.

**Equality and Diversity**

* Act in a manner that respects and supports patient choices, wishes, and preferences.
* Uphold the privacy, dignity, needs, and beliefs of patients and their carers at all times.
* Be aware of the basic legal and communication issues surrounding abuse, violence, vulnerable adults, substance abuse, and addictive behaviours, ensuring appropriate action is taken when necessary.

**Information Processes**

* Accurately and promptly record daily activities and information, utilising IT systems as appropriate.
* Maintain accurate and contemporaneous electronic patient records on SystmOne/EMIS, ensuring proper documentation of patient care.
* Safeguard the confidentiality of sensitive information related to patients, relatives, staff, and the practice.
* Ensure patient-identifiable information is omitted when sharing data, in line with privacy and data protection guidelines.

**Note**: This job description provides an outline of the main responsibilities and is not exhaustive. The role may evolve to meet the changing needs of the service.

**Person Specification**

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|  | **Essential** | **Desirable** |
| **Professional** | NVQ Level 3 in Health and Social Care or equivalent qualification. | Personalised care training  Social prescriber training |
| **Skills and Attributes** | * Proven ability to demonstrate excellent written and verbal communication. * Proficiency in Microsoft Office Suite. * Ability to interact with service users in a sensitive and empathetic manner. * Capability to work collaboratively as part of a team. * Strong organisational skills, with the ability to prioritise and manage workload effectively. * Excellent motivational and influencing abilities. * Car user, with the ability to travel between GP practices and undertake home visits. * Excellent interpersonal skills and a professional approach to all interactions. * Experience providing advice and signposting to service users. | * Completed care certificate * Completed Healthcare Assistant clinical course * Completed phlebotomy training. |
| **Education/ experience** | * Minimum of 2 years' experience working as a healthcare professional. * Demonstrate understanding of the personalised care approach. * Knowledge of public health issues relevant to the local population. * Familiarity with the Primary Care Network Direct Enhanced Service (DES), local Integrated Care Board (ICB) vision and values, and the role of primary care in the NHS Long-Term Plan. * Strong understanding of current issues within the wider NHS. * Ability to manage time efficiently and prioritise tasks effectively. * Ability to work effectively with others, managing the demands of a fast-paced, ever-changing environment. * Willingness to work flexibly to deliver clinically effective and cost-effective healthcare. * Understanding of the Quality and Outcomes Framework (QoF) and the Investment and Impact Framework (IIF). * Willingness to learn and develop professionally. * Ability to act autonomously while remaining within the scope of practice. | * Previous experience working in the NHS, social care, or a related field. * Good working knowledge of SystmOne/EMIS. * Awareness of safeguarding vulnerable adults. * Experience in the care of elderly patients. * Familiarity with medical terminology. |
| **Additional Requirements** | * Full UK driving license. * Ability to work independently and take initiative. |  |