Job Description

Care Coordinator – Care Homes

Hours of work: 37.5 hours

Annual Leave: 25 days

Salary: £20,400 to £22,440, dependent on experience

Contract: Permanent

Employed by: Involve Kent

Responsible to: Additional Roles Team Lead

Based: Sittingbourne Primary Care Network

Purpose of the job

To empower and support people living in residential care homes, enabling them to navigate services and community support and take an active role in their care, promoting independence, wellbeing and choice.

This role provides time, capacity and expertise to support patients living in residential care homes in; navigating the system, taking an active role in care, linking up care professionals, providing information and support and following-up and reflecting on clinical conversations they have with primary care professionals. This role will work closely with the GPs and other primary care professionals within the PCN to identify and manage a caseload of identified patients, making sure that appropriate support is made available to them and their carers, and ensuring that their changing needs are addressed and that their care and support is joined up across the system. The role will also involve working within GP practices to engage, refer and connect patients living in residential care homes to relevant services and community support groups. Giving people time and focusing on "what matters to me", supporting them to gain and use knowledge, skills, and confidence to become active participants in their care. Ensure people feel supported when planning their care, moving into and living in residential care.

The role will also involve some support to the PCN coordinator with administration and PCN events to support the delivery of high-quality primary health care within the Sittingbourne PCN.

Key tasks and responsibilities

- Proactively manage your own health, wellbeing, and resilience as a positive role model to patients and to ensure you are able to provide consistent, quality support to our clients
- Ensure all necessary data and information about Clients is recorded accurately and entered on NHS collection systems, with awareness of information governance best practice.
- Monitor the state of wellbeing of each resident, being aware of any change impacting on care and care plans, ensuring that new needs are met, and written records are amended to reflect any changes.
- Work in partnership with key staff in GP practices within the local Primary Care Network (PCN), attending relevant meetings, becoming part of the wider network team, giving information and feedback on interventions for patients living in residential care ensuring this is joined up with community services, secondary and primary care.

- Be a friendly, professional, and engaging source of information about residential care approaches used in primary care network and available to patients.

- Take referrals from a wide range of agencies, working with GP practices within primary care networks, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals etc. Provide personalised support to individuals, their families, and carers to ensure that people have choices and independence when moving into/living in residential care.
- Proactively identify and work with a cohort of people living in or planning to move into residential care and maintain a point of contact for those patients within the PCN.
- Bring together all of a person's identified care and support needs and explore their options to meet these into a single personalised care and support plan.
- Help people to manage their needs, answering their queries and supporting them to make appointments.
- Raise awareness of shared decision making and decision support tools and assist people to be more prepared to have a shared decision-making conversation.
- Discuss appointments and give people time to reflect on appointments.
- Ensure that people have good quality information to help them make choices about their care
- Explore and assist people to access personal health budgets, and support for carers where appropriate.
- Support the coordination and delivery of MDTs within PCNs for patients in residential care.
- Build relationships and bring together professionals working with patients you are supporting to ensure a personalised care approach throughout the primary care networks
- Confirm that the appropriate SNOMED codes are used on GP patient note systems with awareness of information governance best practice.
- Work with GP practices to review data on GP appointments and hospital admissions to track statistical improvements at practices.
- Support the PCN coordinator with administration, events and minutes where required.
- Any other tasks and responsibilities that may be identified as necessary as the service evolves and develops.

Person Specification	**Essential**	**Desirable**
Experience of supporting people one to one	x	
Experience of working or caring for people living in residential care	x	
Driven, target focused, highly motivated	x	
Experience empowering and supporting people.	X	
Experience of supporting people moving into residential care		x
Able to follow processes and systems, and with training develop and review support plans.	X	
Excellent communication skills, able to negotiate, build relationships, advocate for people and inspire people.	X	

Resilient and confident, able to work in a busy environment (GP practice) with colleagues under pressure and champion the service to health professionals	X	
Outgoing, energetic, and empathetic	X	
Experience of providing clear information / guidance to people	x	
Ability to learn and implement systems, policies and processes	X	
Good IT skills and experience of using a database or CRM system and accurately able to enter sensitive data	X	
Adaptable, flexible with a can-do attitude	X	
Experience of working in a multi-disciplined team or working with other professionals	X	
Driving licence and a car	x	