#### JOB DESCRIPTION

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| JOB IDENTIFICATION |
|  Job Title: Peripatetic Patient Flow Co-ordinator – Fife community hospitals and Ninewells ( Band 6 )Responsible to: Team Leader – Community Patient Flow HubAccountable to: Hub Service Manager Department(s): Community Hub Directorate: Health and Social Care Partnership Operating Division: East Division Job Reference: No of Job Holders: 1 WTELast Update (insert date): Oct 2023 |
| 2. JOB PURPOSE |
| * Working in collaboration and partnership with Health and Social Work colleagues, ensure efficient patient flow between Fife community hospitals, NWH and the wide range of community services including ICASS and Social Work Department.
* Within the Fife Community Hospitals and NWH, carry out a comprehensive assessment for patients on the wards ensuring the appropriate patient pathway is established for each individual, including the assessment for homecare services, put in place any requirement from external agencies, equipment and support required to facilitate discharge or transfer to another facility. Liaise with MDT and support patients, their families and their significant others.

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| **3. DIMENSIONS** |
| The Peripatetic Patient Flow Co-ordinator will be responsible to the Team Lead within the Community Hub and professionally responsible to the Clinical Service Manager. There is no financial responsibility with this post, however the post holder is expected to ensure effective utilisation of resources. The post holder will be expected to work within the community hospitals in Fife, VHK and Ninewells Hospital, Dundee if required.The peripatetic PFC will provide relief for existing PFC staff during planned and unplanned leave and support existing PFC staff when required.In conjunction with other Intermediate Care staff, the Patient Flow Co-ordinator will provide a service to assist allocation of appropriate community support for patients when leaving hospital, or to prevent admission to hospital, addressing complex health and social care needs and ensuring equity of service across the Health and Social Care Partnership.Assist and advise, where required, with the community bed management and patient flow issues. |

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| **4. Organisational Position**Clinical Service Manager Team Leader - Patient Flow Community Hub

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| Patient Flow Co-ordinator |

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| Administrator  |

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| 5. ROLE OF DEPARTMENT |
| The Fife wide Community Hub supports a wide range of services as an alternative to acute hospital admission and to support hospital discharge at the earliest opportunity. This includes support at home, ICASS, STAR, START, interim/permanent placement within a care facility. The Community Hub will ensure that early decisions are made for patients within community hospital settings and NWH, to ensure return home is not delayed. The main role of the Community Hub is to eliminate delays and ensure an effective seamless pathway out of hospital or another facility for patients with more complex needs. Supported Discharge is available to Fife residents and the role of the Community Hub is to work closely with the multi-disciplinary teams within community settings identifying appropriate patients to facilitate early supported discharge. |

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| 6. KEY RESULT AREAS |
| **6.1 Clinical*** Working within the Community Hub will involve assessment on the wards and assessment based on information given by referrers and decision making with regard to appropriateness of each referral.
* Facilitate discharge through liaison and negotiation with patients, relatives/ carers and the multi-disciplinary team, identifying and arranging the most appropriate support for each individual once they are medically fit for discharge from community hospitals or NWH.
* Act as lead practitioner for Fife patients using skills and knowledge for assessment and use clinical judgement and reasoning skills to co-ordinate safe discharge home or care facility and thereby reducing the number of patients becoming delayed.
* Initiate and co-ordinate multidisciplinary/agency assessment process and subsequent care and support packages to facilitate discharge.
* Carry out comprehensive assessment of patient need through use of Single Shared Assessment (SSA) and other assessment tools.
* Work collaboratively with all relevant members of the multi-professional and multi-agency team (including doctors, nurses, occupational therapists, physiotherapists, social work staff, (both hospital and community based staff), private support agencies and voluntary organisations.
* Apply a high level of understanding of the effect that physical/mental illness and disability can have on a patient’s life.
* Work closely with the patient and their relatives/carers to ensure their full understanding of the planned support.
* Operate within the framework of the Health and Social Care Discharge Protocol
* Develop clinical expertise within area of responsibility.

**6.2 Documentation*** Ensure that up to date written and electronic records are maintained in accordance with NMC/HPC and NHS Fife policies
* Ensure that all documentation reflects accurate record of patient information whilst maintaining confidentiality and dignity
* Comply with relevant national legislation e.g. Freedom of Information Act, Data Protection Act
* Contribute to the collection of data for performance indicators.
* Maintain patient documentation, records and accurate statistical information to reflect care provided and meet professional standards.

 **6.3 Clinical Governance*** Implement and maintain appropriate clinical guidelines ensuring clinical effectiveness to optimise patient care
* Contribute to Clinical Governance and local improvement targets
* Broaden research and development skills by participating in local audit and research projects
* Comply with all relevant NHS Fife and local policies and procedures including those relating to Health and Safety, Risk Management, Confidentiality of Information, Complaint handling and Infection Control
* Comply with relevant code of conduct and agreed standards of practice.
* Demonstrate continued Professional Development through participation in internal and external development opportunities in order to meet Revalidation requirements.
* Attend local groups, meetings, conferences and events that enhance or impact on the service and increase knowledge and skills as relevant.

**6.4 Managerial*** Review and reflect on own practice and performance through effective use of professional and operational supervision and appraisal.
* Participate in professional development planning
* Follow departmental guidelines and procedures

6.5 Service Planning* Contribute to the service and the efficient delivery of patient flow in Fife hospitals within the Health and Social care partnership. .
* Contribute to the evaluation of the service in collaboration with Health and Social Work colleagues.
* Participate in the operational planning and implementation of service delivery
* Effectively manage competing demands within an unpredictable environment.
* Respect the individuality, values, cultural and religious diversity of patients and staff and contribute to the provision of a service sensitive to those needs.

**6.6 Education and Training*** Contribute to the promotion of Supported Discharge and Intermediate Care by participating in presentations and teaching of health care and social work staff
* Promote the effective use of the Health and Social Care Discharge Protocol thereby contributing to the reduction of delayed discharges
* Be aware of the NHS staff governance standards and ensure that duties undertaken comply with staff governance.
* Participate in induction and orientation programmes.

**6.7 Health and Safety*** Ensure the health and safety of self, patients and other staff
* Use own initiative and discretion to assess risk when recommending patient pathway.
* Comply with NHS Fife organisational policies, procedures and training
* Ensure that practices and procedures are carried out within the regulations of the Health & Safety at Work
* Independently complete the reporting of accidents, incidents or near misses.
* Ensure own actions support local policies on equality, diversity and human rights.
* Undertake Risk assessment of own practice and workplace activities.
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| 7a. EQUIPMENT AND MACHINERY |
|  The post holder may use various pieces of equipment including:-* Personal Computer (including Intranet, email, Word, Excel, PowerPoint and database management)
* Mobile phone
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| **7b. SYSTEMS** |
| The post holder will be responsible for:-* Computer systems (Health and Social Work)
* Patient access database
* Statistics spreadsheets/excel
* Power point presentations (occasionally)
* E-expenses
* Specialised assessment tools
* Maintaining clear, up to date and accurate records, sharing necessary information with other agencies as required (with permission of the patient), with due regard to confidentially
* Ensuring up to date written and electronic data is maintained in accordance with Professional and NHS Fife standards
* Single Shared Assessment (SSA)
* Administrative systems e.g. incident reporting system, change forms.
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| 8. ASSIGNMENT AND REVIEW OF WORK |
| * Work autonomously and prioritise own work as part of whole system flow including the Victoria Hospital Discharge Hub, Ninewells and community hospitals to ensure effective patient flow.
* Work will be generated by the need for discharge, prevention of admission and general referrals for social care pathways.
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| **9. DECISIONS AND JUDGEMENTS** |
| The post holder will:* Make daily decisions in conjunction with the multi-agency team relating to whether patients can be safely managed at home.
* Practice autonomously as detailed within the NMC/Health Professions Council Code of Practice
* Accountable for decisions and actions taken.
* Contribute to the development and evaluation of the service making recommendations for future service delivery and provision.
* Be responsible for ensuring continuity of service during periods of absence.
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| 10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB |
| * Making clinical decisions on a daily basis affecting patient care pathways.
* Working autonomously
* Working in different locations often at short notice and for variable periods of time.
* Avoiding conflict when questioning clinical reasoning of MDT regarding timing of discharges and patient pathways.
* Make decisions during triage regarding the correct patient pathway for patients with complex needs.
* Multi-agency working across traditional professional boundaries.
* Assessment and management of risk.
* Prioritising competing demands.
* Participate in the introduction and consolidation of changes to practice.
* Participating in the development of a whole system approach to the management of older people and those with mental health issues.
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| **11. COMMUNICATIONS AND RELATIONSHIPS** |
| * Communicate with patients who may have complex medical problems and require highly developed interpersonal skills,
* Identify and modify the most appropriate communication method depending on the individual requirements e.g. hearing or visual impairments, learning difficulties, cognitive impairments, language differences, disinterest, anxiety or perceptual problems.
* Communicate with empathy, information which may be sensitive or contradictory to patient/carer expectation
* Negotiate appropriate support based on an assessment of the patient's needs.
* Promote awareness of the service and generate appropriate referrals for supported discharge.
* Meet regularly with other members of the extended team.
* Negotiate and interact effectively within the MDT to optimise patient care.
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| **12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB** |
| **Physical Skills:*** Key board skills
* Ability to travel within Fife and to Ninewells Hospital if required
* High level of observation skills.
 | **Physical Demands:*** A significant element of walking, standing and sitting on a daily basis
* Regular driving between sites
* Travelling in adverse conditions
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| **Mental Demands:*** Frequently responding to changes in patients condition – this requires being alert in order to undertake a high standard of clinical reasoning involving constant reassessment and decision making regarding clinical management.
* Concentration required when attending MDT meeting and inputting information into databases/IT systems
* Continuous levels of motivation and encouragement are required to keep the patient focussed during the assessment process.
* Unpredictable interruptions.
* Compilation of written reports to meet deadlines.
* Exposure to unpredictable questions from the patient/carers, which require immediate answers.
* Long periods of intense concentration when participating in and facilitating multi agency meetings.
 | **Emotional Demands:*** Communicating with distressed/anxious/worried patients/relatives throughout shift
* Providing ongoing emotional support for staff, patients and carers.
* Dealing with unrealistic expectations of the MDT and carers
* Working in isolation
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| **Environmental Conditions:*** Occasional exposure to a degree of verbal abuse from patients, relatives and members of the public
* Frequent lone working
* Frequent daily use of keyboard / IT skills for extended periods
* Needs led service which leads to peaks and troughs in activity
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| 13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB |
| * 1st Level Registered Nurse or AHP equivalent *(with current registration with appropriate professional body)*
* Relevant post registration experience
* Experience of a Care of the Elderly and/or rehabilitation setting
* Advanced clinical reasoning and assessment skills
* Teaching, presentation and training skills
* Time management and organisational skills
* Computer literacy
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| **14. JOB DESCRIPTION AGREEMENT** |
| A separate job description will need to be signed off by each jobholder to whom the job description applies. Job Holder’s Signature: Head of Department Signature: | Date:Date: |