AGENDA FOR CHANGE
NHS JOB EVALUATION SCHEME

NHS Highland

JOB DESCRIPTION

1. JOB IDENTIFICATION

Job Title: Health and Social Care Coordinator

Reports to: Line Manager in Integrated Team

Department, Ward or Section: Integrated Care

CHP, Directorate or Corporate Department: North and West /South and Mid Operational Units

Job Reference: CSNHSHASSHADCA03

No of Job Holders: 14

Last Update (insert date): 11th November 2015

2. JOB PURPOSE

This role will work at Assistant Practitioner level as defined within NHS Scotland Career Development Framework and is set in the context of the SSSC Framework for Continuous Learning and The NHS Knowledge and Skills Framework

As part of the integrated team, this role provides a standardised first point of access to health and social care services in a district. The role will have face to face direct patient/user contact, however the post holder may contribute to the initial assessment process and some ongoing communications with patients/users

To coordinate and support the safe, efficient and effective management of referrals from and for health and social care professionals, providing a baseline generic assessment of health and social care needs appropriately identifying the need for professional/specialist assessment.

This puts the service user at the heart of decision making whilst ensuring carers views are also taken into account, signposting to other services as appropriate

To provide and contribute to simple, needs led assessments e.g. Personal Outcome Plan.

To provide coordination of referrals/caseload in the short term, to respond to health and social care crisis situations within own competence as the need arises, and to refer complex or specialist cases to an appropriately trained and qualified person.

To support the provision of person-centred, safe and effective care which is monitored, delivered and reviewed in line with all statutory requirements and NHS Highland policies, procedures and guidelines, supported by existing professional governance and leadership structures.

This role will be subject to review and evaluation and may in the future include delivery of an extended service

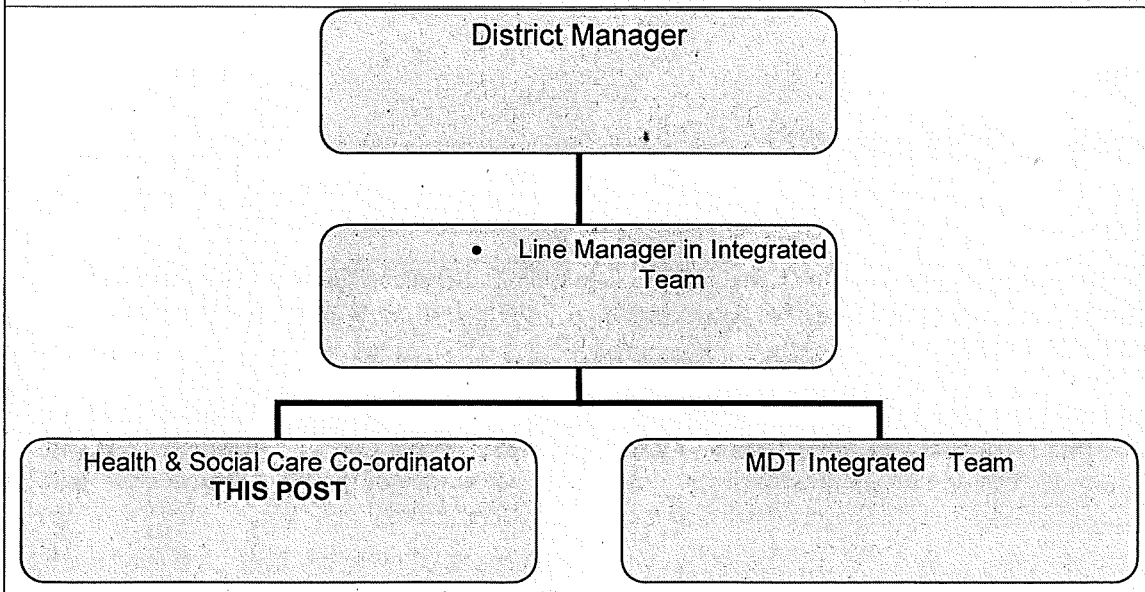
3. DIMENSIONS

The integrated team includes all adult community health and social care professionals and includes all community nursing, social work, community mental health services, allied health professions, community care services, care at home and administrators and working closely with independent and 3rd sector providers, primary care services, and local hospitals.

The post links with a range of in-house and externally-provided services including care homes, individual's own homes, and other institutional settings

The post holder will not manage or supervise any staff, although they may co-ordinate rota's and there may be an occasional requirement to demonstrate the duties of the post to others. The post holder will not hold a budget, although there will be a need to be aware of any budgetary constraints within the integrated team.

4. ORGANISATIONAL POSITION



- Social Work Team Lead
- Nursing Team Lead
- Integrated Team Lead

5. ROLE OF DEPARTMENT

The role of the Integrated Team is to provide for the health and social care wellbeing of individuals working within the context of a multi professional, person centred care model.

- promote self management and independence,
- maximise health and well being,
- minimise social, emotional, psychological and behavioural complexities and
- work towards shifting the balance of care providing care as close to individuals' homes as possible, avoiding unplanned hospital and care home admissions.

6. MAIN TASKS, DUTIES AND RESPONSIBILITIES

Practice

1. A first point of contact, screening, prioritising and co-ordinating referrals and taking responsibility for collection and collation of referral information for individuals, passing information on to the appropriate service or the integrated team where care needs are complex.

2. Contribute to assessments by gathering initial information and responding to any requests from colleagues for additional information.

3. Signpost individuals to appropriate services if not appropriate for the integrated team such as Befriending, Connecting Carers, etc.

4. Following training and where appropriate, ensure simple person centred care is identified to meet assessed needs but in complex or urgent situations where individuals may be experiencing e.g. acute medical crises or vulnerable adults at serious risk of harm, the post holder must identify and act to ensure immediate attention from professional staff.

5. Access Care First system, recording, checking and collating person data; inputting referrals, assessments, care requirement details for allocation of cases and completing all relevant processes, liaising with the finance team where appropriate.

6. Use other relevant healthcare information systems to check person data, create records, record requests and activity and track progress of ongoing care, ensuring all information is accurate, up to date and factual.

7. Collate, input and produce relevant data for statistical analysis in conjunction with the teams responsible for the various information systems supporting the provision of services to individuals

8. Provide a person centred approach to ensure the views and opinions of all individuals and carers are considered and that all persons who make an enquiry are given respect, dignity and understanding.

9. Be aware of the role boundaries and know when to seek professional advice

10. Prioritise own workload based on individual's needs, ensuring that when there is a requirement to leave the office this will not have a detrimental effect on colleagues/.service being offered via the single point of contact (SPOC)

11. Request/carry out initial information gathering (Part A of the Personal Outcome Planning process)

and contribute to an individual's assessments and reviews as appropriate, via telephone, or (only where necessary) a visit to the individual in accordance with NHS Highland's lone working policies and within scope of practice.

12. As directed, arrange appropriate health, social care and enabling services or placement in residential/nursing homes or intermediate care settings within strict time constraints and as agreed with the individual by the team

13. Commission appropriate health and social care services that fall within scope of practice e.g. telecare, Apetito meals, in accordance with current standards and liaise with individuals, carers, families and other members of the integrated team

14. Attend and actively contribute to meetings e.g. District Care Planning, Hospital discharge planning, virtual ward under the direction of the line manager, contributing to other meetings as required e.g. service development and improvement groups.

15. Contribute to implementation of assisted living and the use of technology e.g. telecare and telehealth , accessing this on behalf of patients through the appropriate referral pathways.

16. Act as a champion for telecare and telehealth, encouraging health and social care colleagues to look at new and different ways for delivering services to individuals, and to support individuals in taking responsibility for their own care.

17. Have an understanding of Self Directed Support (SDS) options and promote the use of these with individuals, carers and colleagues.

18. Understand the NHS Highland Charging Policy/the role of the Business Support Team and be able to explain these to individuals and other key people.

19. Deliver a high quality, effective and safe service at all times, complying with equality and diversity policies and legislation.

20. The post holder is bound by the Health Care Support Worker Code of Conduct and NHSH duty of confidentiality and must comply with the Policy for Information Sharing at all times.

Facilitation of Learning

1. Be responsible for keeping own knowledge and skills up to date through continuing personal development, engagement with supervision and reflective practice
2. Provide guidance to individuals and their carers to promote active self-management
3. Seek networking opportunities to further own knowledge and development
4. Contribute to team/service learning/development and quality improvement e.g. around local guidelines and policy
5. Demonstrate research awareness

Leadership

1. Promote implementation of the single point of contact and agreed model of service integration

2. Where appropriate, participate in the induction and training of new members of staff and contribute to multi-disciplinary team development
3. Provide cross-cover to other teams as required covering leave, sickness and training
4. Act as a positive role model supporting integrated working at all levels within scope of role
5. Give and receive feedback in a constructive, open and honest manner
6. Identify opportunities for service change, making suggestions for improving outcomes for individuals and quality improvement
7. Work effectively across professional and agency boundaries.
8. Recognise own accountability and act where practice of self should be improved.
9. Provide daily guidance to enable a high standard of service to people contacting the service at the front end.

Evidence, Research and Development

1. Contribute to the development of information materials for individuals and carers and for service delivery improvements
2. Assess own practice and activity against person-centred outcomes
3. Par ticipate in team/ service monitoring and review through data gathering and participation in audit and evaluation
4. Contribute ideas for research/development activity.
5. Contribute to review of impact of integrated team interventions on the individual and carer experience
6. Have an awareness and understanding of resources available to meet the needs of the people in the community and support information needs within the community, to assist the development of appropriate resources.

7a. EQUIPMENT AND MACHINERY

- Telephone, answering machine and fax machine for communication needs.
- Mobile telephone to maintain contact outside the office.
- Computer to access e-mail, letter writing, recording data, and research based literature.
- Data screens relating to hospital, GP and community health information
- Photocopier and shredder for photocopying and destroying paper waste, confidential material.
- Car – used for visits, transportation of supplies and equipment
- Appropriate skills necessary to operate office equipment

7b. SYSTEMS

- Personally generated service user and carer information e.g. Personal Outcome Plans, Care Plans, Anticipatory Care Plans, Special Notes

- IT systems e.g. Adastra, Vision, Care First, PMS.
- Telehealth and telecare systems – advise on what is available, the use, application of and arrange installation
- Completion of own monthly time sheet.
- Completing incident/accident forms as required.
- Risk assessment
- Use of electronic diaries
- Involvement in the coordination of the supply and decontamination of equipment

8. ASSIGNMENT AND REVIEW OF WORK

Works to the line manager but has day to day autonomy within their role, working as a core member of the integrated team in liaison with all professional staff.

As this role continues to evolve and develop, the post holder will have regular contact with a wide range of professional leads and their manager to allow on going discussion about how the role needs to operate in practice and about any additional learning needs the post holder may have

The Health & Social Care Co-ordinator will regularly communicate with a wide range of NHS Highland and external contacts through face-to-face, on the telephone or in written correspondence.

9. DECISIONS AND JUDGEMENTS

- Makes judgements as a core team member about which health and social care practitioners need to be involved in the care of individuals
- Uses own knowledge and judgement to develop non complex packages of care for individuals
- First/single point of contact for a large majority of initial assessment of referrals.
- Liaises directly with all relevant staff involved in transitions and provision of care
- Works independently as well as in integrated team(s) to coordinate and delegate care for designated individuals
- Identifies, prioritises and manages own time effectively to ensure that quality of care is maintained or enhanced
- Demonstrates an ability to undertake duties in an autonomous manner with advice from the Line Manager as appropriate and following agreed protocols.
- Through the above - supports the determination of an individual's/carers crisis and organises a care package accordingly.
- Ensures close liaison with line manager regarding issues related to risk and service pressures.

10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB

- Acts as first point of contact for health and social care referrals to a district/team. This can be very pressurised and stressful and may include working with vulnerable adults, stressed carers and at risk clients.

- Taking health and social care referral information in a consistent manner which involves

interviewing callers and taking referrals from other agencies, professions and members of the public on a daily basis, ensuring accuracy and non judgmental, objective working practice and consideration of individuals' and carers' views at all times.

- Identifying tensions and boundaries between person centred support versus individual care needs, rights and responsibilities and the need to seek professional advice e.g. adult support and protection
- Knowing own boundaries and when to seek professional advice
- Effective communication across the integrated team as a whole regarding all cases
- Balancing competing priorities of multiple aspects of the role (admin, coordination, liaison with broad group and multiple professions).
- Being able to work in an extremely demanding and potentially stressful environment with constant interruptions, sometimes conflicting information and all relating to current or new referrals. This in turn creates additional work and HSCCs need to be flexible in their approach. Each contact usually involves reappraising priorities and workload. For example, processing new referrals, setting up packages of care, listening to feedback or arranging transitions of care

11. COMMUNICATIONS AND RELATIONSHIPS

On a daily basis communicating with clients who suffer with varying degrees of communication difficulties and using a variety of communication methods. HSCCs need to ensure that empathy, tact, negotiation and sensitivity are always exercised, for example, frequently having to communicate with clients who are in low mood, lacking in motivation and unable to accept recent diagnosis or a change in their health and social care circumstances. In addition, the ability and training to deal with angry and aggressive individuals.

The postholder needs developed listening skills to understand the individual's situation and participate in the development of an appropriate package of care for that individual.

To liaise, work closely and form strong links with all members of the Integrated Team and work closely with all agencies and the independent and third sector on a regular basis. For example HSCCs on a daily basis communicate with other professionals in all fields, including GPs, hospital staff, district nurses, social workers, AHPs, specialist nurses, consultants, community mental health nurses, learning disability nurses, care providers and carers.

On a daily basis communicate health and social information to the above via sources including telephone, letters, email or face to face contact. This information is always confidential, frequently sensitive and can be contentious and as a result needs to be provided in a professional, appropriate and polite manner. Any information communicated has to comply with Data Protection and be relevant to the source, for example, need to know basis.

To contribute daily to integrated team meetings in relation to the current caseload. For example, linking into hospital and community huddles, planning and arranging home visits, transitions of care and formulating person-centred goals, outcomes, and care plans in partnership with individuals, carers, and service providers.

.As a member of the integrated team, continue developing and expanding on the good working relationships that exist between all services.

12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB

This is a demanding post requiring excellent organisational skills and significant decision making ability in the context of the coordination and administration of services

Physical Demands:

- Driving and Keyboard skills
- Moving and carrying light equipment
- Geographical distances involved in delivering care necessitate driving alone in urban and rural environments and occasionally in adverse (but safe) weather conditions

Mental Demands:

- Unpredictable workload
- Concentration, decision making and organisational skills to cope with competing demands and frequent interruptions
- Mental and emotional stability to be able to respond to high demands of the post
- Particular challenges of communicating with a large number of staff working over 24 hours, 7 days/week
- Juggling competing demands of day to day coordination and administration of services with the need to develop and improve specific aspects of service delivery on an ongoing basis
- Mental agility to understand the complexities of individuals and their carers circumstances as the initial point of contact
- Manage multiple roles and conflicting priorities and demands on time, having to frequently re-prioritise the working day in response to changing demands
- Working in an extremely demanding and potentially stressful environment with constant interruptions, all relating to current or new referrals

Emotional Demands:

- Dealing with individuals and their carers and families at times of great stress in their lives.
- Working with colleagues in the integrated team who are dealing with stressful situations that may affect their role
- Dealing with the pressures of other staff absence
- Being the first point of contact for individuals and/or carers who may have complaints
- Coping with the emotionally draining effect on self following contact with service users and carers who may be abusive and aggressive. The ability to diffuse such situations is essential

13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB

- Minimum of SVQ 3 in Health and Social care or in business and administration or able to demonstrate relevant knowledge at that level
- In possession of or studying toward HNC or D or equivalent qualification in a relevant area, or able to demonstrate relevant knowledge at that level
- Demonstrate excellent admin and clerical skills
- Highly developed communication and interpersonal skills sufficient to influence and negotiate

changing roles/service delivery with managers and other staff

- Understanding of the professional roles of team members and an awareness and understanding of how health and Social care is delivered
- Experience in a coordinating role involving people and service delivery
- Able to influence and negotiate with individuals, carers, staff in the Integrated Team, independent and third sector agencies and others
- Awareness and understanding of health and social care terminology and familiarity with symptoms of common medical conditions, e.g. urinary tract infections, respiratory distress
- Awareness of current local care pathways in relation to for example, stroke pathway, diabetes care, falls, dementia, older people and end of life care
- Good knowledge of local initiatives in tele-health and tele-care and a commitment to help extend the provision of these in the local area.
- Awareness of financial processes
- Development skills – to support service improvements.
- IT literate – email, word, excel, etc and information management orientated
- Confidence and self-belief with ability to recognise own strengths and weaknesses
- Innovative thinking with ability to problem solve
- Evidence of ability to work in partnership
- Ability to earn confidence and respect within the team and wider relevant services.

14. JOB DESCRIPTION AGREEMENT	
I agree that the above Job Description is an accurate reflection of my duties and responsibilities at the date of signing.	
Job Holder's Signature:	Date:
Manager's Signature:	Date: