

Care Coordinator

NHS England and NHS Improvement has created the following, as a helpful resource:

- Sample job description
- Sample person specification
- Sample job advert
- Sample interview questions

These optional resources are provided to support PCNs in the recruitment or engagement of care coordinators. The content has been developed to ensure it aligns with the requirements set out in the Network Contract DES and where content is in addition to the formal requirements, this is clarified. As this is complementary guidance, PCNs may decide whether or not to use these resources.

Sample Job Description – Care Coordinator

Purpose of the role

Care coordinators play an important role within a PCN to proactively identify and work with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services.

They work closely with GPs and practice teams to manage a caseload of patients, acting as a central point of contact to ensure appropriate support is made available to them and their carers; supporting them to understand and manage their condition and ensuring their changing needs are addressed.

This is achieved by bringing together all the information about a person's identified care and support needs and exploring options to meet these within a single personalised care and support plan, based on what matters to the person.

Care coordinators review patients' needs and help them access the services and support they require to understand and manage their own health and wellbeing, referring to social prescribing link workers, health and wellbeing coaches, and other professionals where appropriate.

Care coordinators could potentially provide time, capacity and expertise to support people in preparing for or following-up clinical conversations they have with primary care professionals to enable them to be actively involved in managing their care and supported to make choices that are right for them. Their aim is to help people improve their quality of life.

The successful candidate will be based in a local cluster of General Practices as part of XX Primary Care Network (PCN). They will be caring, dedicated, reliable and person-focussed and enjoy working with a wide range of people. They will have good written and verbal communication skills and strong organisational and time management skills. They 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.

This role is intended to become an integral part of the PCN's multidisciplinary team, working alongside social prescribing link workers and health and wellbeing coaches to provide an all-encompassing approach to personalised care and promoting and embedding the personalised care approach across the PCN.

There may be a need to work remotely depending on the requirements of the role.

Please note that the role of a care coordinator is not a clinical role.

Salary: TBC by PCN. Reimbursement is based on indicative AfC Band 4 or equivalent.

Key responsibilities

- Work with people, their families and carers to improve their understanding of the patients' condition and support them to develop and review personalised care and support plans to manage their needs and achieve better healthcare outcomes.
- Help people to manage their needs through answering queries, making and managing appointments, and ensuring that people have good quality written or verbal information to help them make choices about their care.
- Assist people to access self-management education courses, peer support, health coaching and other interventions that support them in their health and wellbeing, and increase their levels of knowledge, skills and confidence in managing their health.
- Support people to take up training and employment, and to access appropriate benefits where eligible; for example, through referral to social prescribing link workers.
- Provide coordination and navigation for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals; helping to ensure patients receive a joined-up service and the most appropriate support.
- Work collaboratively with GPs and other primary care professionals within the PCN to proactively identify and manage a caseload, which may include patients with long-term health conditions, and where appropriate, refer back to other health professionals within the PCN.
- Support the coordination and delivery of multidisciplinary teams with the PCN.
- Raise awareness of how to identify patients who may benefit from shared decision making and support PCN staff and patients to be more prepared to have shared decision-making conversations.
- Explore and assist people to access a personal health budget where appropriate.

[To further enhance the role, PCNs may wish to add the following additional responsibilities to the person specification:]

- Work with people, their families, carers and healthcare team members to encourage effective help-seeking behaviours;
- Support PCNs in developing communication channels between GPs, people and their families and carers and other agencies;
- Identify unpaid carers and help them access services to support them;
- Conduct follow-ups on communications from out of hospital and in-patient services;
- Maintain records of referrals and interventions to enable monitoring and evaluation of the service;
- Support practices to keep care records up-to-date by identifying and updating missing or out-of-date information about the person's circumstances;
- Contribute to risk and impact assessments, monitoring and evaluations of the service;
- Work with commissioners, integrated locality teams and other agencies to support and further develop the role.

Key Tasks

1. Enable access to personalised care and support

- a. Take referrals for individuals or proactively identify people who could benefit from support through care coordination;
- b. Have a positive, empathetic and responsive conversation with the person and their family and carer(s) about their needs;
- c. Work towards increasing patients' understanding of how to manage and develop health and wellbeing through offering advice and guidance;
- d. Develop an in-depth knowledge of the local health and care infrastructure and know how and when to enable people to access support and services that are right for them;
- e. Use tools to measure people's levels of knowledge, skills and confidence in managing their health and to tailor support to them accordingly.
- f. Work with the wider PCN, MDTs, and the social prescribing service to look at how carers can support people - this could include the initial identification of carers onto the carer register
- g. Support people to develop and implement personalised care and support plans;
- h. Review and update personalised care and support plans at regular intervals;
- i. Ensure personalised care and support plans are communicated to the GP and any other professionals involved in the person's care and uploaded to the relevant online care records, with activity recorded using the relevant SNOMED codes;
- j. Where a personal health budget is an option, to work with the person and the local CCG team to provide advice and support as appropriate;

2. Coordinate and integrate care

- a. Making and managing appointments for patients, related to primary, secondary, community, local authority, statutory, and voluntary organisations
- b. Help people transition seamlessly between secondary and community care services, conducting follow-up appointments, and supporting people to navigate through wider the health and care system;
- c. Refer onwards to social prescribing link workers and health and wellbeing coaches where required;
- d. Regularly liaise with the range of multidisciplinary professionals and colleagues involved in the person's care, facilitating a coordinated approach and ensuring everyone is kept up to date so that any issues or concerns can be appropriately addressed and supported;
- e. Actively participate in multidisciplinary team meetings in the PCN as and when appropriate;
- f. Identify when action or additional support is needed, alerting a named clinical contact in addition to relevant professionals, and highlighting any safety concerns.
- g. Record what interventions are used to support people, and how people are developing on their health and care journey,

[To further enhance the role, PCNs may wish to add the following additional responsibilities to aid in data and information capture:]

- a. Keep accurate and up-to-date records of contacts, appropriately using GP and other records systems relevant to the role, adhering to information governance and data protection legislation;
- b. Work sensitively with people, their families and carers to capture key information, while tracking of the impact of care coordination on their health and wellbeing;
- c. Encourage people, their families and carers to provide feedback and to share their stories about the impact of care coordination on their lives;
- d. Record and collate information according to agreed protocols and contribute to evaluation reports required for the monitoring and quality improvement of the service.

3. Professional development

- a. Work with a named clinical point of contact for advice and support.
- b. Undertake continual personal and professional development, taking an active part in reviewing and developing the role and responsibilities, and provide evidence of learning activity as required;
- c. Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, equality, diversity and inclusion training and health and safety.

4. Miscellaneous

- a. Establish strong working relationships with GPs and practice teams and work collaboratively with other care coordinators, social prescribing link workers and health and wellbeing coaches, supporting each other, respecting each other's views and meeting regularly as a team;
- b. Act as a champion for personalised care and shared decision making within the PCN;
- c. Demonstrate a flexible attitude and be prepared to carry out other duties as may be reasonably required from time to time within the general character of the post or the level of responsibility of the role, ensuring that work is delivered in a timely and effective manner;
- d. Identify opportunities and gaps in the service and provide feedback to continually improve the service and contribute to business planning;
- e. Contribute to the development of policies and plans relating to equality, diversity and reduction of health inequalities;
- f. Work in accordance with the practices' and PCN's policies and procedures;
- g. Contribute to the wider aims and objectives of the PCN to improve and support primary care.

Person Specification – Care Coordinator			
Criteria		Essential	Desirable
Personal qualities and attributes	Ability to actively listen, empathise with people and provide personalised support in a non-judgemental way	✓	
	Ability to provide a culturally sensitive service supporting people from all backgrounds and communities, respecting lifestyles and diversity	✓	
	Commitment to reducing health inequalities and proactively working to reach people from diverse communities	✓	
	Ability to support people in a way that inspires trust and confidence, motivating others to reach their potential	✓	
	Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders	✓	
	Ability to identify risk and assess / manage risk when working with individuals	✓	
	Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when what the person needs is beyond the scope of the care coordinator role – e.g. when there is a mental health need requiring a qualified practitioner	✓	
	Ability to work from an asset-based approach, building on existing community and personal assets	✓	
	Ability to maintain effective working relationships and to promote collaborative practice with all colleagues	✓	
	Ability to demonstrate personal accountability, emotional resilience and work well under pressure	✓	
	Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines	✓	
	High level of written and verbal communication skills	✓	
	Ability to work flexibly and enthusiastically within a team or on own initiative	✓	
	Ability to provide motivational coaching to support people's behaviour change		✓
Knowledge of, and ability to work to policies and procedures, including	✓		

	confidentiality, safeguarding, lone working, information governance, and health and safety		
Qualifications and training	NVQ Level 3 in adult care - advanced level or equivalent qualifications or working towards		✓
	Demonstrable 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	✓	
	Proficient in MS Office and web-based services	✓	
Experience	Experience of working directly in a care coordinator role, adult health and social care, learning support or public health / health improvement		✓
	Experience of working in health, social care and other support roles in direct contact with people, families or carers (in a paid or voluntary capacity)	✓	
	Experience of working within multi-professional team environments	✓	
	Experience of supporting people, their families and carers in a related role	✓	
	Experience or training in personalised care and support planning		✓
	Experience of data collection and using tools to measure the impact of services	✓	
	Experience of working with elderly or vulnerable people, complying with best practice and relevant legislation		✓
Skills and knowledge	Knowledge of the personalised care approach	✓	
	Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities, individuals, their families and carers	✓	
	Understanding of, and commitment to, equality, diversity and inclusion	✓	
	Strong organisational skills, including planning, prioritising, time management and record keeping	✓	
	Knowledge of how the NHS works, including primary care and PCNs	✓	
	Knowledge of Safeguarding Children and Vulnerable Adults policies and processes		✓

	Ability to recognise and work within limits of competence and seek advice when needed	✓	
	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	✓	
	Understanding of the needs of older people / adults with disabilities / long term conditions particularly in relation to promoting their independence	✓	
Other	Meets DBS reference standards and criminal record checks	✓	
	Willingness to work flexible hours when required to meet work demands	✓	
	Access to own transport		✓
	Ability to travel across the locality on a regular basis		✓
	Proficient speaker of another language to aid communication with people in the community for whom English is a second language		✓

Sample Job Advert

Job Title: Care Coordinator
Working hours:
Rate of pay:
Contract:
Closing date:
Interview date:

We are looking to recruit to the post of care coordinator, to work within our Primary Care Network multidisciplinary healthcare team.

The successful candidate will play a key role in proactively identifying and working with people, including the frail/elderly and those with long-term conditions, to provide coordination and navigation of care and support across health and care services.

They will work closely with GPs and practice teams, making sure that appropriate support is made available to people; supporting them to understand and manage their condition and ensuring their changing needs are addressed. They will enable people to access the services and support they require to meet their health and wellbeing needs, helping to improve people's quality of life.

They will work alongside social prescribing link workers and health and wellbeing coaches to provide an all-encompassing approach to personalised care and enable people navigate through the health and care system.

The postholder will work with a diverse range of people from different cultural and social backgrounds. The ability to work confidently and effectively in a varied, and sometimes challenging environment is essential.

The successful candidate will have excellent interpersonal and communication skills, and be organised, patient and empathetic. They will have experience of working in health, social care or other support roles including direct contact with people, families or carers.

For more information and a job pack:

Call us on:
Email:
Website:

Sample Interview Questions

Example Scenario (or substitute a real-life example from your practice)

Please ask all candidates to arrive 15 minutes early, give them this scenario and ask them to prepare some points to discuss at interview:

Catherine is 69 years old and has a diagnosis of Parkinson's Disease. She is seen regularly by her GP and specialist Parkinson's nurse at the practice. She also attends routine appointments with her consultant at the local hospital.

Catherine lives alone and has been struggling with loneliness and anxiety since her husband died 3 years ago. She has also started to notice some memory problems and is worried that she does not always remember the advice from doctors and nurses - she thinks she may not always be taking her medication correctly. Because of her Parkinson's Disease, her mobility is now starting to deteriorate, and she is worried she may not be able to continue to drive herself to all her appointments - her children live far away and are unable to provide regular support.

How would you go about supporting this person and what would your approach be?

You have 10 minutes at the start of the interview to outline your approach.

1. Why do you want this role and what experience do you bring to it?
2. What skills / qualities will you bring to the role?
3. Can you tell us about a time when you supported someone who was experiencing complex personal circumstances, such as managing a long-term health condition, anxiety or practical issues such as difficulty arranging medical appointments – how did you support them and what were the challenges in providing support?
4. Can you tell us about a time when you were sensitive or compassionate towards someone who was experiencing a difficult time – what did you do and how did you feel you were able to offer support?
5. Some people need more help to overcome exclusion or disadvantage and you may come across situations where people you are supporting are actively being discriminated against. Can you give us an example of how you have helped someone overcome exclusion, disadvantage or discrimination?
6. Can you describe a time where you completed a piece of work which required good teamwork? Please explain your role in this. What were the challenges and how did you resolve them?

7. Can you tell us about a piece of work where you have had to record information and monitor the impact of the work? How did you go about this, what did you learn from the process?
8. This role involves close partnership working with different professionals in a busy primary care team. What would you do to ensure you work well as part of this team?
9. Tell us about a time when you improved a process – what was the issue, what did you do and what was the outcome?
10. If someone were to describe your approach to work in three words, what would the three words be?