FIRST CONTACT CLINICAL
ENABLING HEALTHY BEHAVIOUR CHANGE

ABOUT FIRST CONTACT CLINCIAL

At First Contact Clinical our common purpose is to enable healthy change in the people and places it is needed most.

Our philosophy is that our culture and our leadership behaviours mirror the way in which we support the people we work with. Our desire is to make a real difference to our staff, supporting them to become more aware, more responsible and have a powerful sense of purpose in their work. If you, like us, believe that this approach leads to growth in performance, a growth in learning and a growth in job satisfaction then we want to hear from you.

The beliefs and values we share with you guide your behaviours along with our shared understanding of how we achieve our common purpose, which is that:

We recognise that our people are our biggest assets. We invest time in better health at work activities and actively encourage our staff to develop and share their wellness action plan. Our flexible working scheme supports you to attend the important appointments in life and get the job done.

We continue to develop our values-based recruitment processes to ensure we attract staff with the right mindset and attitude to support us to achieve our common purpose. We invest in training and continuous development, working collaboratively to develop our 'ambition programme' that supports us as individuals and as a team to continue to grow from 'good to great'. Our ambition programme provides a blended set of learning opportunities that support self-directed, personal development in line with our competency framework.

We build strong relationships with our partners and embed within the neighbourhoods we support. Our offer is a key component of the personalised care agenda. Personalised care is everyone's business, providing more options, better support and joined up care at the right time. We offer a holistic approach to health and wellbeing, supporting people to stay well for longer, maximising their potential and that of their families and local communities to affect better health and wellbeing outcomes. We support people with choice and control over the way their care is delivered, based on 'what matters' to them and their individual strengths, needs and preferences.

We strive to make continuous improvement an everyday part of what we do and our staff are empowered to lead on our improvement agenda by adopting our easy-to-use Quality Improvement Framework. We believe that through the use of good quality, time-based, data and personal goal setting that aligns team, locality and organisational goals our performance will continue to improve.

We share a passion to enable healthy change, which means that you will see and experience behaviours that demonstrate our values lived out every day. Our values have remained the same since we began in 2008.

Our Values				
Integrity We mean what we say, and do it.	**Quality** We never compromise on quality.	**Passion** Our beliefs drive our actions	**Together** Strong individuals, stronger team.	**Pioneers** We create new and innovative solutions from problems.

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ABOUT PERSONALISED CARE

Personalised care means people have choice and control over the way their care is delivered, based on 'what matters' to them and their individual strengths, needs and preferences. As such personalised care is everyone's business in Primary Care Networks (PCNs), providing more options, better support and joined up care at the right time. Personalised care has the potential to reduce health inequalities.

To support a positive shift in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities the PCNs are expanding their team to include **Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators.**

Working together through a single point of access, these roles will reduce and support the workload of GPs and other staff by supporting people to take more control of their health and wellbeing and addressing wider detriments of health such as poor housing, debt, stress and loneliness. Their contribution enriches the skill mix of primary care teams. As a result, people have improved lives, benefit from timely access to health services, and are supported to develop skills and confidence to manage their own health and wellbeing.

To work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities.

Educate non-clinical and clinical staff on what other services are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

SOCIAL PRESCRIBING LINK WORKER

As a Link Worker you will you will work with people to support them to develop their knowledge, skills and confidence to become active participants in looking after their own health. You will guide and support people to reflect on and change their health-related behaviours to help them reach their self-identified health and wellbeing goals. You will introduce or reconnect people to community groups and statutory services and work with local partners to identify gaps in local provision. You will be skilled in coaching, communication and behavioural change skills and are able to work alongside people (individually or in groups) at their starting point to encourage and support them to become more engaged in managing their own health.

We have three levels of Link Workers: Link Workers, Link Worker Coaches, Psychosocial Link Workers. Our competency framework describes the set of related knowledge, skills, and abilities that are to be demonstrated in the different roles.

The main duties are:

- To work as part of a multi-disciplinary team to develop a Person Centred, Community Based Behaviour Change Service in South Tyneside
- To provide coaching, establishing what matters to people and support them to implement solutions they can identify with, with the aim of increasing their confidence, knowledge and skills to self-manage

- To provide holistic care to a case load of people, providing personalised psychosocial interventions including, but not limited to, agenda setting, problem solving, motivational interviewing, solution focussed approaches, goal setting and signposting
- To lead in removing potential barriers and stigma associated with the targeted groups to promote equality, diversity and safeguarding system-wide
- Act as an advocate for the patient, guiding them through a complex journey and multi-faceted approach that results in appropriate use of scheduled and unscheduled care services
- Develop robust and active links with primary care network teams and connect well with other partners.
- A further element of the role would be coordination, sharing and learning of the work with colleagues to promote safe practice and sustainability.
- Promote the early identification, adoption and spread of new ideas that are robust enough to remain in practice
- To enthusiastically implement a biopsychosocial framework
- Have an understanding of the different models of patient engagement such as patient activation and health literacy, and confidently use person-centred outcome measures of these
- To deliver face to face sessions, telephone sessions and group programmes
- To understand the boundaries of coaching and ability to identify and act accordingly when coaching is not appropriate and being able to sensitively discuss alternatives or escalate appropriately
- To actively engage in supervision and training with a commitment to personal development
- To act as 'Team Coach' to a team of practitioners (if appropriate). This will include link worker supervision, collaborative case reviews, analysis of caseload size and activities, performance management against individual/ practice/ service-based targets and promoting our culture of continuous improvement.
- To facilitate group sessions, confidently managing group dynamics, and promote mutual aid, where appropriate
- To be familiar and up-to date with the wider offer from local or national health, social care and voluntary sector organisations, as relevant to people
- To ensure accurate reporting and data collection, where appropriate
- To work unsupervised in a manner that promotes excellent person care and experience, while recognising professional and organisational requirements and boundaries
- To contribute to the monitoring and implementation of all policies and systems as they relate to service delivery, in particular: Health and Safety, Safeguarding, Vulnerable Adults and Lone Working
- To be professional with people, colleagues, volunteers and professionals at all times
- Have an understanding of the evidence base around self-management support and person-centred care
- To undertake any reasonable duties/responsibilities required to meet the needs of the developing service with a flexibility to work weekends and evenings if required
- To ensure regular review of risks and issues that could impact on individual care and wider service delivery
- To adopt our quality improvement methodology and seek to continuously improve our systems for the value of our clients

- Contribute to the development and delivery of our high-quality behaviour change training programmes.
- To contribute to the company's marketing, promotion and publicity

This list is not intended as an exhaustive list of duties and responsibilities. The post holder will be asked to carry out other duties which are appropriate to the skills of the post holder and grade of the post as the priorities of the service change.

HEALTH AND WELLBEING COACH

As a Health and Wellbeing Coach you will work with people to support them to develop their knowledge, skills and confidence to become active participants in looking after their own health. You will guide and support people to reflect on and change their health-related behaviours to help them reach their self-identified health and wellbeing goals. You will be skilled in coaching, communication and behavioural change skills and are able to work alongside people (individually or in groups) at their starting point to encourage and support them to become more engaged in managing their own health.

The main duties are:

- To work as part of a multi-disciplinary team to develop a Person Centred, Community Based Behaviour Change Service in South Tyneside
- To provide coaching, establishing what matters to people and support them to implement solutions they can identify with, with the aim of increasing their confidence, knowledge and skills to self-manage
- To provide holistic care to a case load of people, providing personalised psychosocial interventions including, but not limited to, agenda setting, problem solving, motivational interviewing, solution focussed approaches, goal setting and signposting
- To lead in removing potential barriers and stigma associated with the targeted groups to promote equality, diversity and safeguarding system-wide
- Act as an advocate for the patient, guiding them through a complex journey and multi-faceted approach that results in appropriate use of scheduled and unscheduled care services
- Develop robust and active links with primary care network teams and connect well with other partners.
- A further element of the role would be coordination, sharing and learning of the work with colleagues to promote safe practice and sustainability.
- Promote the early identification, adoption and spread of new ideas that are robust enough to remain in practice
- To enthusiastically implement a biopsychosocial framework
- Have an understanding of the different models of patient engagement such as patient activation and health literacy, and confidently use person-centred outcome measures of these
- To deliver face to face sessions, telephone sessions and group programmes
- To understand the boundaries of coaching and ability to identify and act accordingly when coaching is not appropriate and being able to sensitively discuss alternatives or escalate appropriately
- To actively engage in supervision and training with a commitment to personal development

- To act as 'Team Coach' to a team of practitioners (if appropriate). This will include link worker supervision, collaborative case reviews, analysis of caseload size and activities, performance management against individual/ practice/ service-based targets and promoting our culture of continuous improvement.
- To facilitate group sessions, confidently managing group dynamics, and promote mutual aid, where appropriate
- To be familiar and up-to date with the wider offer from local or national health, social care and voluntary sector organisations, as relevant to people
- To ensure accurate reporting and data collection, where appropriate
- To work unsupervised in a manner that promotes excellent person care and experience, while recognising professional and organisational requirements and boundaries
- To contribute to the monitoring and implementation of all policies and systems as they relate to service delivery, in particular: Health and Safety, Safeguarding, Vulnerable Adults and Lone Working
- To be professional with people, colleagues, volunteers and professionals at all times
- Have an understanding of the evidence base around self-management support and person-centred care
- To undertake any reasonable duties/responsibilities required to meet the needs of the developing service with a flexibility to work weekends and evenings if required
- To ensure regular review of risks and issues that could impact on individual care and wider service delivery
- To adopt our quality improvement methodology and seek to continuously improve our systems for the value of our clients
- Contribute to the development and delivery of our high-quality behaviour change training programmes.
- To contribute to the company's marketing, promotion and publicity

This list is not intended as an exhaustive list of duties and responsibilities. The post holder will be asked to carry out other duties which are appropriate to the skills of the post holder and grade of the post as the priorities of the service change.

CARE COORDINATOR

As a Care Coordinator you will work with people to provide coordination and navigation of care and support across health and care services. You will act 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. You will bring 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.

A Care Coordinator will work closely within an integrated team to help and support people who have either 'complex lives' or 'long term conditions'.

'Complex Lives' Care Coordinators will support the PCNs to deliver effective, co-ordinated care for adults with 'complex lives', particularly those who have social difficulties, mental health, substance misuse and/ or physical health issues. Other groups may be identified

'Long Term Conditions' Care Coordinators will support the PCNs to deliver effective, co-ordinated care for vulnerable and frail adults, particularly those who are at high risk of hospital emergency admission, emergency department (ED) attendances or out of hours care. The cohorts of patients will likely be those people with multiple Long-Term Conditions, although other groups may be identified.

'Frailty' Care Coordinators will support the PCNs to deliver effective, co-ordinated care for vulnerable and frail older adults, particularly those who are at high risk of hospital emergency admission, emergency department (ED) attendances or out of hours care. The cohorts of patients will likely be those people with multiple Long-Term Conditions and be resident in nursing and residential homes or housebound, although other groups may be identified.

The main duties are:

- Work as part of a multi-disciplinary team to develop a Person Centred, Community Based Behaviour Change Service in South Tyneside
- Provide coaching, establishing what matters to people and support them to implement solutions they can identify with, with the aim of increasing their confidence, knowledge and skills to self-manage
- Proactively identify and work with a cohort of patients to support their personalised care requirements, using the available decision support aids.
- Work with the GPs and other primary care professionals within the PCN to identify and manage a caseload of patients, and where required and as appropriate, refer people back to other health professionals 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, in line with PCSP best practice.
- Help people to manage their needs, answering their queries and supporting them to make appointments.
- Support people to take up training and employment, and to access appropriate benefits where eligible.
- Assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing.
- Raise awareness of shared decision making and decision support tools, within the PCN and assist people to be more prepared to have a shared decision-making conversation.
- 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.
- Ensure that people have good quality information to help them make choices about their care.
- Tailor the support for each individual based on their "Activation" level as measured by PAM. Support other professionals contributing the individuals personalised care and support plan to understand their level of knowledge, skills and confidence in order that they can adapt their approach for to support engagement.

- Act as a contact to assist with case management of patients at risk of admission, identifying sources of support in liaison with case managers.
- To liaise with acute hospitals, cross-referencing admission data with the 'at risk' list, and coordinating the sharing of key information between the acute hospital teams and the community services.
- Explore and assist people to access personal health budgets where appropriate.
- Provide coordination and navigation for people and their carers across health and care services, alongside working closely with social prescribing link workers, health and wellbeing coaches and other primary care roles.
- Support the coordination and delivery of MDTs within PCNs.
- To work as a key member of the MDT to help support the development of effective MDT meetings.
- To ensure that any action points identified within the MDT are recorded and followed up.
- Under guidance from their line manager, take initiative in the organisation and administration of MDT working to minimise the demands upon the multidisciplinary team.
- To cross reference the patients identified as high risk with the carers register within practices, to support case managers and key workers in developing holistic anticipatory care plans including prevention of carer breakdown.
- To work with the wider MDT to identify appropriate case managers for high risk patients to ensure that patients are reviewed and anticipatory care plans are developed.
- Ensure that all patients' Care Plans, diagnostics results and associated correspondence are available to the MDT, liaising with all agencies as appropriate, accessing IT systems to ensure relevant information is available.
- Under the guidance of case managers, assist with the discharge process to reduce length of stay in the acute/community hospital setting.
- Participate in any training programme implemented by the PCN as part of this employment, such training to include:
    - Participation in an annual individual performance review, including taking responsibility for maintaining a record of own personal and/or professional development.
    - Taking responsibility for own development, learning and performance and demonstrating skills and activities to others who are undertaking similar work.
    - The Personalised Care Institute (live from April 2020) will set out what training is available and expected for Care Coordinators.
- In the course of seeking treatment, patients entrust us with, or allow us to gather, sensitive information in relation to their health and other matters. They do so in confidence and have the right to expect that staff will respect their privacy and act appropriately;
- In the performance of the duties outlined in this Job Description, the post-holder may have access to confidential information relating to patients and their carers, practice staff and other healthcare workers. They may also have access to information relating to the practice as a business organisation. All such information from any source is to be regarded as strictly confidential.

- Assist in promoting and maintaining their own and others' health, safety and security as defined in the practice Health & Safety Policy, to include:
    - Using personal security systems within the workplace according to practice guidelines;
    - Identifying the risks involved in work activities and undertaking such activities in a way that manages those risks;
    - Making effective use of training to update knowledge and skills;
    - Using appropriate infection control procedures, maintaining work areas in a tidy and safe way and free from hazards;
    - Reporting potential risks identified.
- The post-holder will support the equality, diversity and rights of patients, carers and colleagues, to include:
    - Acting in a way that recognises the importance of people's rights, interpreting them in a way that is consistent with practice procedures and policies, and current legislation;
    - Respecting the privacy, dignity, needs and beliefs of patients, carers and colleagues.
- Contribute to and help develop the Person Centred-Care agenda in South Tyneside in line with the Person-Centred Care requirements of the DES.
- To act as 'Team Coach' to a team of practitioners (if appropriate). This will include link worker supervision, collaborative case reviews, analysis of caseload size and activities, performance management against individual/ practice/ service-based targets and promoting our culture of continuous improvement.

This list is not intended as an exhaustive list of duties and responsibilities. The post holder will be asked to carry out other duties which are appropriate to the skills of the post holder and grade of the post as the priorities of the service change.