CANDIDATE INFORMATION

Care Co-ordinator

WestMendip
PRIMARY CARE NETWORK

WHO WE ARE AND WHAT WE DO

Primary Care Networks (PCNs)

Primary Care Networks (PCNs) were established in July 2019 as part of the NHS Long Term Plan to improve the quality and accessibility of care by encouraging collaboration among various healthcare services and community organisations.

West Mendip Primary Care Network

One of 13 PCNs in Somerset, we are a collaboration of five GP practices in West Mendip: Glastonbury Health Centre, Glastonbury Surgery, Wells City Practice, Wells Health Centre and Vine Surgery Partnership (Street).

Our purpose, values and vision underpin our beliefs on the necessities of a healthcare service, and what we aim to achieve, both now and in the future. They guide the actions and decisions made by our whole team, ensuring they align with our commitment to prioritise personalised care for the people of West Mendip.

Clarks Chimney
STREET

Community Outreach
MENTAL HEALTH AWARENESS WEEK

PURPOSE

To create an integrated and sustainable healthcare environment through a collaborative approach that prioritises the health and wellbeing of both patients and healthcare professionals.

VALUES

Autonomy
Service users have the right to make their own decisions regarding their health and wellbeing.

Collaboration
Working together with healthcare providers and community organisations to deliver the highest quality of care.

Transparency
Acting with openness and honesty, fostering trust within the community and those we work with.

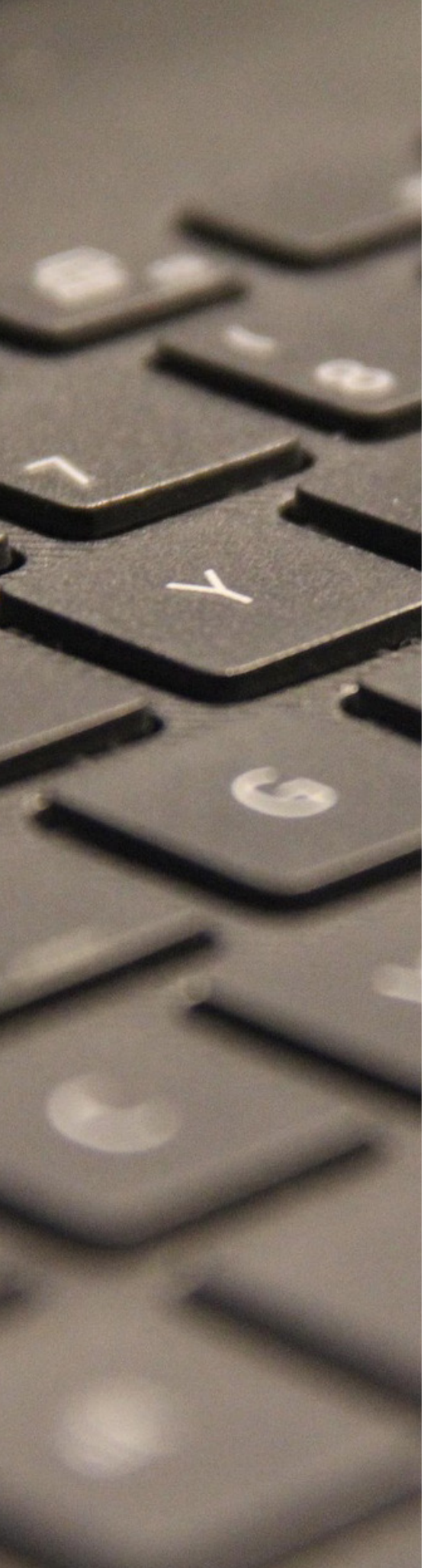
Adaptability
Adjusting to changing environments by being flexible and open to new ideas, approaches, and situations.

Compassion
Communicating with service users and each other in an empathetic and respectful manner. Always.

Equity
Addressing and eliminating barriers that lead to health disparities, such as socioeconomic status, race, gender, and geographic location.

VISION

To empower individuals to confidently make informed decisions about their own health and wellbeing through a compassionate, equitable, and collaborative environment that can adapt to the evolving needs of our community.



CARE CO-ORDINATOR

TERMS OF EMPLOYMENT

RATE OF PAY

Up to £13.00 per hour, dependent on experience

WORKING HOURS

35 hours per week: 8.30am-4.30pm, Monday-Friday

LOCATION

Vine Health Suites, Hindhayes Lane, Street, BA16 0ET. *This role is based in the West Mendip area. While the exact office location may change, it will remain within this area.*

CONTRACT LENGTH

Fixed Term 12 months - with a view to becoming permanent

HOLIDAY ENTITLEMENT

5 weeks per year plus bank holidays (pro rata for part-time employees)

REPORTS TO

Hub Manager

Community Outreach
MENS' HEALTH AND WELLBEING EVENT

ABOUT THE ROLE

This non-clinical role is an integral part of our Primary Care Networks' multidisciplinary team, working alongside social prescribing link workers and health and wellbeing coaches to provide an all-encompassing approach to personalised care. Our Care Co-ordinators are the first point of contact for our community, offering direct support via the telephone, emails and EMIS tasks. There is also scope for some work to be carried out at community events.

Working with GPs and practice teams, our Care Co-ordinators facilitate additional support for the residents of West Mendip from within the wider PCN team or external organisations, helping them to understand and manage their own care requirements and ensure changing needs are addressed. Promoting shared decision-making, they ensure people are able to access suitable guidance and gain confidence to make informed decisions about their health and wellbeing.

They liaise with neighbourhood teams from across health, social, and wellbeing sectors, to streamline care, collating information about a person's identified care and support needs and exploring options to meet these.

Additionally, our Care Co-ordinators proactively identify people in the community who would benefit from support, and connect them with appropriate care, services and resources.

Our Care Co-ordinators work under delegation of a registered health professional.

ABOUT YOU

Passionate about caring for others, you will bring a dedicated and collaborative approach to delivering person-centred care. Good written and verbal communication skills are essential as you'll be providing guidance and advice to a wide demographic of people, working with patients, and their families and carers, with sensitivity and empathy.

Strong organisational and time management skills will be key to working with multidisciplinary teams, recording, collating and communicating accurate patient information, managing appointments, and facilitating a co-ordinated approach to appropriately addressing any issues or concerns.

Strong motivation is required to develop an in-depth knowledge of the local health and care infrastructure, keeping up-to-date with changing landscapes to ensure people are receiving the right care and support for them, at the right time.

Flexibility and adaptibility will aid you in overcoming any obstacles in helping people access services and support, while proactively identifying alternative pathways to connect them with the help they need.

The ability to work confidently in a varied, and sometimes challenging environment is essential, as is flexibility to work from any location within the West Mendip area.

The Tor
GLASTONBURY

PERSON SPECIFICATION

PERSONAL QUALITIES AND ATTRIBUTES

ESSENTIAL

- 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, 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 co-ordinator role – e.g. when there is a mental health need requiring a qualified practitioner
- 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
- Ability to work flexibly and enthusiastically within a team or on own initiative
- Knowledge of, and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety
- Demonstrable commitment to professional and personal development
- Completed a two-day PCI accredited care co-ordination training course or be willing to complete one
- Proficient in MS Office and web-based services.

EDUCATION AND QUALIFICATIONS

ESSENTIAL

- 5 GCSE's or equivalent, to include English and Maths: A*- C or 9 - 4 grade

EXPERIENCE

ESSENTIAL

- 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

DESIRABLE

- Experience of working directly in a care co-ordinator role, adult health and social care, learning support or public health / health improvement
- 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

The Cathedral
WELLS

SKILLS AND KNOWLEDGE

ESSENTIAL

- Understanding of personalised care and the comprehensive model of personalised care
- 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
- Understanding of the needs of older people / adults with disabilities / long term conditions particularly in relation to promoting their independence
- Ability to recognise and work within limits of competence and seek advice when needed

DESIRABLE

- Experience using EMIS
- Experience using RiO
- Knowledge of primary care and PCNs
- Knowledge of Safeguarding Children and Vulnerable Adults policies and processes
- Basic knowledge of long-term conditions and the complexities involved: medical, physical, emotional and social

Delivering presents donated by our team THE SALVATION ARMY CHRISTMAS PRESENT APPEAL

OTHER

ESSENTIAL

- Meets a Disclosure and Barring Service (DBS) reference standards and criminal record checks
- Willingness to work flexible hours when required to meet work demands
- Access to own transport and full driving licence

DESIRABLE

- 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

KEY TASKS AND RESPONSIBILITIES

KEY TASKS

1. ENABLE ACCESS TO PERSONALISED CARE AND SUPPORT

- Take referrals or proactively identify people who could benefit from support through care co-ordination.
- Have a positive, empathetic and responsive conversations with people and their families and carer(s), about their needs.
- Increasing patients' understanding of how to manage and improve health and wellbeing by offering advice and guidance.
- 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.
- Use tools to measure people's levels of knowledge, skills and confidence in managing their health and tailor support to them accordingly.
- 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.

2. CO-ORDINATE AND INTEGRATE CARE

- Help people transition seamlessly between secondary and community care services, supporting people to navigate through the wider health and care system.
- Refer onwards to social prescribing link workers and health and wellbeing coaches where required and to clinical colleagues where there is an unaddressed clinical need.
- Regularly liaise with the range of multidisciplinary professionals and colleagues involved in the person's care, facilitating a co-ordinated approach and ensuring everyone is kept up to date so that any issues or concerns can be appropriately addressed and supported.
- Actively participate in multidisciplinary team meetings in the PCN.
- Identify when action or additional support is needed, alerting a named clinical contact in addition to relevant professionals, and highlighting any safety concerns.
- Record what interventions are used to support people, and how people are developing on their health and care journey.
- 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.

- Work sensitively with people, their families and carers to capture key information, while tracking of the impact of care co-ordination on their health and wellbeing.
- Encourage people, their families and carers to provide feedback and to share their stories about the impact of care co-ordination on their lives.
- Record and collate information according to agreed protocols and contribute to evaluation reports required for the monitoring and quality improvement of the service.

3. SUPERVISION/PROFESSIONAL DEVELOPMENT

- Work with a named clinical point of contact for advice and support.
- 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.
- Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, equality, diversity and inclusion training and health and safety.
- Access relevant GPs to discuss patient related concerns, and be supported to follow appropriate safeguarding procedures.

4. MISCELLANEOUS

- Establish strong working relationships with GPs and practice teams and work collaboratively with other care co-ordinators, social prescribing link workers and health and wellbeing coaches, supporting each other, respecting each other's views and meeting regularly as a team.
- Act as a champion for personalised care and shared decision making within the PCN.
- 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.
- Identify opportunities and gaps in the service and provide feedback to continually improve the service and contribute to business planning.
- Contribute to the development of policies and plans relating to equality, diversity and reduction of health inequalities.
- Work in accordance with the practices' and PCN's policies and procedures.
- Contribute to the wider aims and objectives of the PCN to improve and support primary care.

Joining with other organisations to provide community support
WELLS COFFEE MORNING

KEY RESPONSIBILITIES

- Work with people, their families and carers, to improve their understanding of their condition.
- Help people to manage their needs by providing a contact to answer queries and ensure 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.
- Provide co-ordination and navigation for people and their carers across health and care services. Helping to ensure patients receive a joined-up service and the appropriate support from the right person at the right time.
- Work collaboratively with GPs and other primary care professionals within the PCN.
- Support the co-ordination 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 people to be more prepared to have shared decision-making conversations.
- 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 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.

TO APPLY

Thank you for your interest in this role and in joining us at West Mendip Primary Care Network.

If you would like to talk to someone about this role before you apply, please contact us by phone on 01458 553 025 or by email at somicb.westmendippcn.hr@nhs.net

We are accepting applications through NHS Jobs - just sign in or create an account to get started. Please outline your suitability for the role following the criteria in the person specification.

You do not have to complete all of your application in one go. You can save and return to it later. NHS Jobs send you an email when you start applying with a link that will take you back to your application.

The NHS Jobs application link can be found at www.westmendippcn.co.uk/vacancies

Closing Date:
2nd November 2025

Expected Interview Date:
21st November 2025

WestMendip
PRIMARY CARE NETWORK

WEST MENDIP PRIMARY CARE NETWORK

VINE HEALTH SUITES, HINDHAYES LANE, STREET, SOMERSET, BA16 0ET

GET IN TOUCH

01458 551 042

somicb.westmendippcn.hr@nhs.net