

# APPLICATION PACK



Live Well Care Co-ordinator



MAYOR OF LONDON



INVESTORS  
IN PEOPLE

# APPLICATION PACK

Using the power of football, Charlton Athletic Community Trust (CACT) worked with over 46,700 people during 2019/20, empowering communities and changing lives. Based on the needs of the community, we work in partnership to deliver high quality programmes that deliver a lasting impact.

CACT is one of the biggest football community trusts in the country; principal areas of work are:

- Early Help and Prevention
- Education
- Equality, Diversity and Inclusion
- Football and Sports Development
- Health Improvement
- Social Action and Enterprise
- Youth Service

This is an exciting time to join CACT as we have recently launched a new three-year strategy for 2019-2022 based on our values:

- Passion – fuels our work
- Trust – safe and sound
- Engagement – stronger together
- Respect – two-way and vital
- Equality – open and fair
- Inclusion – that means you

Employee benefits include:

- Friendly working environment
- Equality, Diversity and Inclusion Staff Working Group (EDISWG)
- 23 days annual leave – this includes 3 days which must be taken at Christmas and an additional 1 day for every full year continuous service up to a maximum of 5 years (plus 8 days statutory bank holidays)
- Flexible Working
- Internal and external training opportunities
- Employee Assistance Programme - includes a range of retail and entertainment discount vouchers
- Eye-care vouchers
- Cycle to Work scheme
- London Living Wage employer
- Healthy Workplace Award accreditation
- Investors In People accreditation

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CACT are committed to embracing and fostering equality, diversity and inclusion in the workplace as well as in the delivery of its services, activities, and programmes, by promoting a positive organisational culture that values all staff and service users. We will strive to create an inclusive environment where everyone feels able to participate and achieve their potential.



## JOB DESCRIPTION

<b>Job Title:</b>	Live Well Care Co-ordinator	<b>Reporting to:</b>	HI Live Well PCN Lead
<b>Pay:</b>	£24,000 - £26,500	<b>Contract type:</b>	Full Time (37.5 Hours a week), Fixed Term Contract
<b>Location:</b>	The Valley, Charlton, plus various Locations within the Royal Borough of Greenwich.	<b>Days and hours of work:</b>	Monday – Saturday, Various
<b>Document created:</b>	10/01/2022	<b>Ref number</b>	CACT/LWCWC PCNL/2021

### Purpose of the Role:

**Be part of a Social Prescribing service supporting individuals, their families and carers to take control of their health and wellbeing and live independently in the London Borough of Greenwich**

CACT is the commissioned provider of a Social Prescribing service for Greenwich, focused on providing support for patients with non-medical needs, often complex, who are frequent visitors to primary care. The service is for adults over the age of 18 whose needs meet referral criteria and is being delivered by CACT but in close partnership with a range of other providers. Care co-ordinators are a new role within the service and 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 are based in GP practices in the borough.

Working as part of the Live Well Team and closely with the Live Well Coaches, the Care Co-ordinators will deliver personalised care and co-ordination of support to patients. They will work closely with GPs and practice teams to manage patients, acting as a central point of contact to ensure appropriate referrals, signposting and support is made available for them and their carers; supporting them to understand and manage their condition and ensuring their changing needs are addressed.

The post holder will be required to support core services delivered by the PCN including: uptake of screening, PCN enhanced services or support for MDTs. Care Coordinators take

time with people and, support them to take pro-active steps to improve the way they manage their physical and mental health conditions, based on what matters to them. They support people to develop their knowledge, skills and confidence – or to build their “patient activation” - in managing their health and care, to improve their health outcomes and quality of life. Care Coordinators will work with a wide range of clients, who may be vulnerable and will require support in with a wide range of issues, likely to be complex and contentious. Live Well Coaches will support them to work with these clients.

CACT Care Co-ordinators will work as a key part of a multi-disciplinary team (MDT) created to plan and deliver targeted support for patients with Long Terms conditions. Care-coordinators will have access to ongoing supervision, skills development, and support so they are able to further build their skills and experience within the role.

**Please note that the Health and Wellbeing Coach role is a non-clinical and not a Social Care role.**

Patients over the age of 18 with Long Term Conditions will be eligible for support. The post holders are expected to have excellent communication skills, a strong understanding of key issues affecting Health and health and wellbeing, and experience that lends itself to working on a one-to-one basis in a health and care context.

#### **Key Responsibilities include (but not limited to):**

- 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.
- Provide one-to-one and group support for people with one or more long-term conditions, based on what is important to them, with the aim of: improving people's levels of 'activation', empowering people to manage their own health and improve their health outcomes. Where required generate referrals into Live Well services – this may include access to self-management education courses, peer support or to take up training and employment, and to access appropriate benefits where eligible.
- Work with patients with new diagnosis of progressive chronic disease dementia, cancer , chronic neurological disease to identify care and support needs
- Provide coordination and navigation for people and their carers across health and care services, working closely with the Live Well Team and other primary care professionals; helping to ensure patients receive a joined-up service and the most appropriate support; including follow ups from hospital and other services.
- Work as part of a multidisciplinary multi-agency team to promote health coaching and to be ambassadors for Personalised Care and Supported Self-Management, modelling the coaching approach in their work.
- 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. Contact individuals by phone, text, email or post where necessary in line with job requirements, eg to confirm or book sessions.
- Manage and prioritise a caseload, in accordance with the needs, priorities and support required by individuals in the caseload. It is vital that you 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 health

and wellbeing coach role – e.g. when there is a mental health need requiring the patient be referred to an appropriately qualified practitioner.

- Accurately record and report the progress of individuals along with statistical information to line manager in the format agreed and on forms developed by the Service and input data directly into IT systems/databases including the bespoke Live Well Data System. Support practices to keep care records up-to-date by identifying and updating missing or out-of-date information about the person's circumstances;
- 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. e that GPs, practice nurses, practice pharmacists and other members of the primary care team understand the health coach role, how to refer to them, and which patients may particularly benefit from health coaching.
- Support local health, social care and voluntary sector professionals to make appropriate referrals to the service. Promote and raise awareness of the health coaching service particularly to groups and communities that experience barriers to access.
- Explore and assist people to access a personal health budget where appropriate.
- Identify unpaid carers and help them access services to support them.
- Contribute to risk and impact assessments, monitoring and evaluations of the service
- Work with and develop Live Well Champions (volunteers) to help them to improve the Live Well Coaching service and support the care coordinator service.
- Attend and contribute to team, practice, and PCN meetings and events as required by the service.
- Participate in regular health coaching supervision and continual learning. This may include, but is not limited to, any or all the following:
  - o Regular contact with service supervisor
  - o Refresher training sessions
  - o Buddying with peers
  - o Peer support sessions
- The post holder will be required to support core services delivered by the PCN including but not limited to uptake of screening/annual health reviews or other general health improvement measures as arise from time to time for the PCN population, PCN enhanced services or support for MDTs

## **Key Tasks**

### **Provide Personalised Support**

- Meet people on a one-to-one or group consultation basis, by phone, video conference, or face-to-face.
- Give people time to tell their stories and focus on 'what matters to me'.
- Build trust and respect with the person, providing non-judgemental and non-discriminatory support, respecting diversity and lifestyle choices.
- Work from a strength-based approach focusing on a person's assets.
- Use a structured framework/model approach to coach individuals across a series of sessions to identify what's important to them; set personal goals and appropriate steps; build skills and confidence to achieve goals; and use problem-solving to work through challenges;
- Work with the principles of self-management to actively support:
  - Shared decision making with healthcare professional.
  - Effective engagement with personalised health and care plan.
  - Proactive engagement with self-management education and peer support.

- Proactive engagement with social prescribing Live Well Coaches, connecting people to community-based activities which support their health and wellbeing;
- Proactive engagement with individually sourced activities and support.
- Access to a care-coordinator and/or a personal health budget, where needed.
- Helping people to understand their confidence level when engaging with their health and wellbeing.

### **Referrals**

- Promote care coordination, its role in self-management as a part of personalised care, in addressing health inequalities and the wider determinants of health.
- As part of the PCN multidisciplinary team, build relationships with staff in GP practices within the local PCN, attending and supporting MDT meetings, giving information and feedback.
- Be proactive in developing strong links with all local organisations to encourage and develop referral routes, recognising what they need to be confident in the service to make appropriate referrals.
- Work in partnership with local agencies to raise awareness of the service and how improving people's knowledge, confidence and skills (patient activation) can enable them to improve their ability to manage their long-term conditions and reduce reliance on clinical services.
- Provide referral organisations with regular updates including information on how to encourage appropriate referrals.
- Seek regular feedback about the quality of service and impact of health coaching on referral agencies.
- Be proactive in encouraging equality and inclusion and case-finding, through self-referrals and connecting with all diverse local communities, particularly those communities that statutory bodies may find hard to reach.
- Work sensitively with people, their families and carers to gather key information, enabling tracking of the impact of health and wellbeing coaching on their health and wellbeing.
- Encourage people, their families and carers to provide feedback and to share their stories about the impact of health coaching on their lives.
- Support referral organisations to provide appropriate information about the person they are referring. Provide appropriate feedback to referral agencies about the people they referred.
- Work closely within the MDT and with GP practices within the PCN to ensure that the relevant SNOMED codes to record activity are inputted into clinical systems (as outlined in the Network Contract DES), adhering to data protection legislation and data sharing agreements.
- Have access to relevant GPs to discuss patient related concerns and be supported to follow appropriate safeguarding procedures.
- Have access to individual and group coaching supervision from a suitably qualified or experienced health coaching supervisor.
- Know and adhere to organisational policies and procedures, including confidentiality, safeguarding, vulnerable adults, lone working, information governance, equality, diversity and inclusion training and health and safety.

**Works with:**

- Live Well Coaches
- Live Well Operations Manager
- GP practice staff
- Primary Care Networks
- Wider CACT Health Improvement team
- PCN Leads
- Other Social Prescribing Services
- Live Well Champions
- Workers in the local health, local authority, community and voluntary sector
- Other related local services
- Communities
- Faith Groups
- General Practitioners and medical centres
- Disadvantaged groups and individuals

**Specific Tasks:**

- Engage people on a one to one basis who have been referred through various channels to provide support, information, motivation and advice that will enable and promote behaviour change through setting SMART goals to achieve the individuals' required health improvement outcomes.
- Monitor and summarise progress of project. Prepare reports for Live Well Operations Manager regarding progress of project.
- Coordinate with the practices, Live Well Coaches, CACT team members and health Improvement advisers to ensure all aspects of the project are compatible.
- Accurately record and report the progress of individuals along with statistical information to the Line Manger and GP in the format agreed and on forms and in reports developed by the Service and/or input data directly into IT systems/databases.
- Produce quarterly programme monitoring reports provide feedback referring to ways of monitoring and ensuring the quality of a service.
- Use motivational interviewing techniques to motivate and set goals.
- Use self-management techniques enabling clients to take more responsibility and control of their lifestyle choices and health improvements aims.
- Contact individuals by phone, text, email or post to arrange and manage one to one client sessions.
- Signpost individuals to other health service providers, and services, who are able to provide specific targeted support that supplements, or supplants, the service provided by the Live Well Coaches. For example, Time to Talk, Welfare Rights, and Housing support.
- When required attend community and other promotional events to
  - a. Promote the Service including the Care Coordinator role
  - b. Identify and encourage individuals who need support to register for the Social Prescribing Services
  - c. Signpost individuals to other services
  - d. Perform brief opportunistic interventions at public events
- Attend meetings and events representing the Social Prescribing and Live Well Service
- Initiate and maintain dialogue with groups (community, voluntary, public sector) that will allow the Live Well team to engage with individuals from those groups.
- Prepare and deliver presentations/workshops to groups focussing on the services provided by Live Well.
- Provide support to other Live Well staff and volunteers as required.

- Undertake the appropriate risk assessments associated with conducting on-site client meeting and promotional events.
- Manage own time and resources to deliver a reliable value for money service.
- Engage in supervision meetings, team meetings, objective setting, appraisals and learning activities.
- Undertake any other duties as may be reasonably required, commensurate with the role and grade/level within the organisation.
- Perform other duties as required by line manager to the deliver the service, this may include, engaging members of the public, contacting Live Well clients through the call centre, community engagement, blood pressure or lifestyle checks community health worker services for other organisations.

**General Responsibilities:**

- Provide the service with due regard to the CACT policies, including those relating to confidentiality, data protection, Health and Safety and Equal Opportunities.

**Data capture:**

- Ensure all programme data and case notes are complete, accurate and up to date.
- Produce and present regular monitoring reports
- Work sensitively with people, their families and carers to capture key information, enabling tracking of the impact of social prescribing on their health and wellbeing.
- Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.
- Support referral agencies to provide appropriate information about the person they are referring. Provide appropriate feedback to referral agencies about the people they referred.
- Work closely with the Operations Manager, Call Centre Manager and with GP practices within the PCN to ensure that the social prescribing notes of the patients last appointment are approved and sent to the correct patients practice via Docman adhering to data protection legislation and data sharing agreements.

**Referrals:**

- Promote social prescribing, its role in self-management, and the wider determinants Health
- As part of the PCN multi-disciplinary team, build relationships with staff in GP practices within the local PCN, attending relevant practice and MDT meetings, giving information and feedback on case load and social prescribing.

**Professional development:**

- Work with your supervising line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the

**Roles and responsibilities.**

- Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.
- Work with your supervising GP to access regular 'clinical supervision', to enable you to deal effectively with the difficult issues that people present.

# PERSON SPECIFICATION

**Job title: Live Well Care Co-ordinator**

Criteria	Essential	Desirable
<b>Knowledge/Skills/Abilities</b>		
Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental way.	X	
Ability to work effectively on your own initiative and as part of a team.	X	
Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity.	X	
Commitment to reducing health inequalities and proactively working to reach people from all communities.	X	
Good verbal communication skills to communicate clearly with people from different backgrounds.	X	
Able to support people in a way that inspires trust and confidence, motivating others to reach their potential.	X	
Good written communication skills to keep accurate notes/records of meetings and client consultations.	X	
Knowledge of one or more local ethnic groups and ethnic language	X	
Ability to make use of using basic IT packages (i.e. Microsoft Office).	X	
Ability to identify risk and assess/manage risk when working with individuals.	X	
Ability to, and experience of, researching and identifying appropriate information.	X	
Knowledge of health issues and the wider determinants of health.	X	
Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports.	X	
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 Live Well Coach role – e.g. when there is a mental health need requiring a qualified practitioner.	X	

<p>Ability to maintain effective working relationships and to promote collaborative practice with all colleagues.</p> <p>Commitment to collaborative working with all local agencies (including VCSE organisations and community groups). Able to work with others to reduce hierarchies and find creative solutions to community issues.</p> <p>Can demonstrate personal accountability, emotional resilience and ability to work well under pressure.</p> <p>Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines.</p> <p>Ability to work flexibly and enthusiastically within a team or on own initiative.</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p>	
<p><b>Experience</b></p> <p>Minimum 3 years' experience of co-ordinating or managing staff to deliver health improvement programmes.</p> <p>Experience of managing staff/volunteers including motivation, training, mentoring, performance management and development.</p> <p>Experience of data collection and collating reports to measure and understand performance.</p> <p>Experience of supporting people, their families and carers in a related role (including unpaid work)</p> <p>Experience of working in, and knowledge of, the various communities within the Royal Borough of Greenwich.</p> <p>Local knowledge of VCSE and community services in the locality</p> <p>Experience of successfully undertaking face to face, one to one health sessions, in either a paid or unpaid capacity, that have led to health improvements.</p> <p>Ability to engage with colleagues across an organisation, including those in other teams, and volunteers.</p> <p>Experience of participating in safeguarding practice (experience of safeguarding leadership is desirable but not essential)</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	
<p><b>Training/Education</b></p> <p>NVQ Level 3, Advanced level or equivalent qualifications or working towards</p>	<p>X</p>	

RSPH Level 2 Understanding Health Improvement	X	
RSPH Level 2 Improving the Public's Health or working towards	X	
Motivational Interviewing training	X	
Mental Health First Aid training	X	
Demonstrable commitment to professional and personal development	X	
Training in motivational coaching and interviewing or equivalent experience	X	
<b>Personal Attributes</b>		
Self confidence	X	
Flexible	X	
Ability to act as an ambassador for the service	X	
Ability to travel and work at different locations within the Borough	X	
<b>Other</b>		
An understanding of, and commitment to the CACT Equal Opportunities Policy.	X	
An understanding of GDPR, and commitment to the CACT Information Governance Policy and data protection policies.	X	
Meets DBS reference standards and criminal record checks	X	
Willingness to work flexible hours when required to meet work demands	X	
Access to own transport and ability to travel across the locality on a regular basis, including to visit people in their own homes	X	
Experience of working as part of an integrated team, and demonstrable ability to work collaboratively with colleagues in different roles, reporting on progress and sharing insight	X	X
Experience of problem solving and making decisions within role boundaries.	X	
Highly competent with electronic communications, word processing and excel		
A demonstrable personal commitment to the Mission, Vision and Values of CACT		



**CACT is committed to the safeguarding of its staff, volunteers and young people. Any job offer made is subject to satisfactory references and Disclosure and Barring Service (DBS) check.**

Application forms are available from <http://cact.org.uk/job-opportunities>

To apply for this role, please send a completed application form detailing how you meet the requirements of the role and an equal opportunities monitoring form to [Jobs@cact.org.uk](mailto:Jobs@cact.org.uk)

Please note: CVs will **not** be considered.

Closing date for applications: 24<sup>th</sup> January 2022