**Home Visiting Service Community General Practitioner**

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| **Job Description** | **Community General Practitioner** |
| **Accountable to:**  **Supervised by:**  **Location:**  **Hours:**  **Salary:**  **Type of contract:**  **Annual Leave allowance:** | Clinical Director  Home Visiting Service Clinical Operations Manager  Location will vary within ARCH footprint    20 hours per week negotiable  Working in conjunction with community GP colleagues to cover service hours (Initially 8:00 – 18:30 Monday to Friday)  Some elements of the role will be fixed in the week e.g MDT meetings, some will require more flexibility around time or venue.  To be agreed  Permanent  6 weeks (pro rata) |

**ORGANISTION**

Amber Valley Health is the umbrella organisation for ARCH PCN. The PCN consists of 9 GP practices (89,000 patients) in Alfreton, Ripley, Crich and Heanor, which operates as 3 neighbourhood's. The PCN is committed to improving the care of patients across the geographical area and sustaining General Practice

**KEY RELATIONSHIPS:**

* AVH Directors
* PCN Clinical Director, Clinical Leads & Management
* PCN Board
* PCN Pharmacy Team
* PCN Neighbourhood Teams
* PCN and Practice Multidisciplinary Teams
* Secondary Care
* Community Health Care Providers
* Mental Health Teams
* General Practices
* Practice / DCHS Community Matrons & Care co-ordinators
* Members of the front line integrated teams
* Learning Disabilities Team
* Care Homes
* Independent Living Teams
* Safeguarding Teams
* Hospital Teams / Out of Hours & Urgent Care (A&E / Discharges)
* Voluntary Sector Providers
* Other health and social care service professionals
* Patient, service users, carers and their families.

**ORGANISATION CHART**

AVH Ltd Directors

PCN Clinical Director

Clinical Operations Manager

**Community General Practitioner (This post)**

This post

PCN Manager

**JOB PURPOSE**

To support our multi-disciplinary team to provide effective, efficient and high-quality healthcare to our housebound patients and patients in care or residential facilities across the PCN footprint. The aim for the service is to ultimately provide a holistic approach to acute on the day/rapid response services, enhanced health in care homes and enhanced proactive care for older people with frailty and patients with multi-faceted health problems.

The post holder will also provide medical assessment and management where needed on behalf of, or in conjunction with, team members and deliver the senior clinical triage function for the Acute Home Visiting element of the service, to determine the urgency and type of response needed, according to clinical need.

Working in conjunction with the HVS Clinical Lead and HVS Clinical Operations Manager the post holder will contribute to the development and delivery of a safe and effective service, developing new ways of working and clinical pathways in accordance with key local and national clinical standards, for the service areas of Acute Home visiting, urgent community response, enhanced health in care homes and anticipatory care.

The post holder will work with key stakeholders and partners locally to contribute to the ongoing development of the service, promoting a cross organisational and multi-agency approach to the delivery of care for local residents.

**KEY DUTIES AND RESPONSIBILITIES**

1. Provide day-to-day clinical leadership to provide proactive and reactive general medical services to the housebound population, including those in are homes, in collaboration with registered practices where appropriate;
2. Promote and deliver a multi-skilled team response that includes GP Acute Home Visits, holistic assessment, care, pro-active follow up and care planning;
3. Contribute to the development of the Acute Home Visiting and Community Urgent Response Service.
4. Deliver an efficient, high quality, multi-disciplinary Acute Home Visiting and Community Urgent Response Service to people who have an urgent need that is best provided in their own home, or wherever they call home;
5. Ensure that the Acute Home Visiting and Community Rapid Response Service that supports and links well to system infrastructure provided at a bigger scale e.g. Acute Hospitals, 999, 111, Ambulance services;
6. Ensure Acute Home Visiting and Community Urgent Response Service that links well to routine and proactive services;
7. Developing expertise within the community for improving the lives of people living with frailty;
8. Promoting the use of supportive, non-statutory services to support self-care and social prescribing agendas;
9. Maximize best care in the patient’s own home in order to reduce the need for hospital or care home admissions;
10. Ensure that the care and support people receive is based on their wishes, preferences and aspirations, particularly towards the end of their lives;
11. Provide medical expertise in the management of older people living with frailty in the defined community. To support ACP’s and wider MDT members working in the community by:
    * Providing Senior GP clinical triage for all Acute Home Visit requests to determine the urgency and type of response needed, according to clinical need.
    * Regular debrief sessions for patients on their caseload.
    * Lead and support the ACPs in their role in the MDT
    * Deliver formal and informal education for the ACPs during clinical interactions
    * Advising on complex clinical situations including;
      + Complex prescribing decisions,
      + Where there are difficult clinical risk decisions.
      + Where there is disagreement between professionals, patients or their carers.
      + Diagnosis is uncertain
      + Identification of end of life is difficult;
12. Liaison with GPs and frailty unit when needed;
13. Lead and engage in MDT and other team meetings, and quality improvement activities.
14. Contribute to the development and implementation of new care pathways, systems and processes to support the service delivery;
15. Contribute towards the development and implementation of new standards, policies and procedures;
16. Advise local GP practices within the defined population to implement effective multidisciplinary working for people with frailty;
17. Contribute to CPD programmes for the members of the ageing well team:
    * Clinical Mentorship/educational supervision of the team members including GP Registrars, Trainee ACPs, First contact practitioners;
18. Ensure contemporaneous notes are recorded and clinical tasks are updated and completed within the agreed timescales;
19. To work collaboratively with other teams and services to maintain an effective and efficient service;
20. Participate in quality improvements and innovations, e.g. audits, significant events analysis and development of protocols and new services.

**CONFIDENTIALITY**

All staff working for AVH Ltd have both a common law duty and a statutory duty of confidentiality to protect patient information and only use it for the purposes for which it is intended. The disclosure and use of confidential patient information needs to be both lawful and ethical.

**PROFESSIONAL DEVELOPMENT**

* Work with your line manager to undertake continual personal and professional development.
* Undertake relevant training as required. Continually update own knowledge and skills within the job role.
* Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.
* Participate in annual individual performance review.

**POLICIES & PROCEDURES**

* All staff working for AVH Ltd are bound by the organisation's policies and procedures, a clinical handbook and access to all policies will be provided upon commencement of employment.

**MISCELLANEOUS**

* Work as part of the team to seek feedback, continually improve the service.
* Undertake any tasks consistent with the level of the post and the scope of the role, ensuring that work is delivered in a timely and effective manner.
* Duties may vary from time to time, without changing the general character of the post or the level of responsibility.
* Act at all times in a manner consistent with legislation, policy and procedures in respect of Equality and Diversity, and safeguarding.
* To develop and maintain effective working relationships with colleagues.
* To abide by all relevant policies and procedures.
* An enhanced DBS check will be carried out for all successful candidates.

**The list of duties in this job description is not exhaustive and is intended to outline the main activities of the post holder. Duties and responsibilities may be subject to change taking into account the development needs for Ageing Well Service and ARCH Primary Care Network.**

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| Person Specification | |
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| **JOB TITLE:** | **Community General Practitioner** |

\*Assessed by: A = Application I = Interview R = References T = Testing

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| **ESSENTIAL CRITERIA** | | **\*** | **DESIRABLE CRITERIA** | **\*** | |
| **QUALIFICATIONS, TRAINING & KNOWLEDGE** | | | | | |
| * A vocationally trained and accredited GP * Current registration with GMC * On the GP performers list | | A  A  A | * MRCGP * Recognised qualification in Care of the Elderly * Recognised qualification in medical education/clinical supervision * Evidence of leadership development | A  A  A  A/I | |
| **EXPERIENCE & KNOWLEDGE** | | | | | |
| * Experience and evidence of an interest in care of the Elderly * Understanding of adult safeguarding and Deprivation of liberty procedures * Experience of multidisciplinary working * Experience of senior clinical triage for the Acute Home Visiting to determine the urgency and type of response needed, according to clinical need. | | A/I  A/I  A/I  A/I | * Knowledge and experience of carrying out Comprehensive Geriatric Assessment * Experience of medical education/clinical supervision * Experience of using SystmOne or another clinical device * Experience of working in a multi-disciplinary team. | A/I  A/I  A/I  A/I |
| **SKILLS & ABILITIES** | | | | | |
| * The ability to understand the competencies of others and support them to work within and at the top of those competencies. Also, to recognise and act when others are going beyond their competency. * Ability to work effectively and provide leadership across traditional organisational and professional boundaries. * Ability to demonstrate leadership skills within a multidisciplinary team. * Excellent organisational and communication skills. * Ability to work effectively as a member of a team. * Ability to work effectively with colleagues, patients and external organisations. * Ability to triage patients in order of clinical need. * Effective communication, verbally and in writing. * Full driving license required as travelling required for the role. * Committed to the development of integrated community teams. | | A/I  A/I  A/I  A/I  A/I  A/I  A/I  A/I  A/I  A/I | * Leadership of service delivery / change. | A/I | |
| **APTITUDE & PERSONAL QUALITIES** | | | | | |
| * Flexible, supportive, collaborative. * Recognise the benefits of multiagency & multidisciplinary team working. * Ability to work as part of a multi-disciplinary team. * Willingness to contribute to and participate in a peer support group. | | A/I  A/I  A/I  A/I |  |  | |
| **VALUES, DRIVERS & MOTIVATORS** | | | | | |
| * Committed to the ongoing development of team members * A Passion for excellent, holistic, patient centred care for older people with frailty | | A/I  A/I |  |  | |
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| **JOB HOLDER** | **SIGNATURE** |  | |
| **DATE** |  | |
| **MANAGER** | **SIGNATURE** |  | |
| **DATE** |  | |

Person

**Supporting Information; Ageing Well and Team Up! Derbyshire**

The National Ageing Well programme aims to build upon the progress already made with partners on service provision at the interface between health and social care, with a focus on the prevention of avoidable hospital and residential care admissions and pro-active care provision linked into primary care network services

“Team Up! Derbyshire” is the local approach. The plan is to create one team across Health and Social Care who see all housebound patients in a neighbourhood. It means one team to do it all: urgent, planned or anticipatory care and support.

This is not a new or ‘add on’ to existing services but a “teaming up” of existing services which incorporates all the requirements of the national “Ageing Well Programme”

Our local ambition is greater than the national programme – we’re aiming not only to transform anticipatory care, community urgent response and support to care homes, but also GP acute home visiting

There are three key transformation programmes that constitute the Ageing Well and Team Up! Derbyshire programme:

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| **Community Urgent Response and Home Visiting** |
| Building on existing intermediate care service provision with a goal of implementing 2-hour/2-day targets for community crisis response and reablement. This includes responding to and meeting the needs of people at the end of their life and with dementia. The target is to achieve these access standards by 2023/24.  Locally this service will also include GP acute home visiting. |

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| **Anticipatory Care / Community Teams** |
| Implement 'anticipatory care' for complex patients at risk of unwarranted health outcomes. Target support towards older people with moderate frailty as well as people of all ages living with multiple comorbidities. Develop a proactive population health approach for people with frailty through Primary Care Networks, providing preventative care and supporting early identification and avoidable admissions |

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| **Enhanced Health in Care Homes (EHCH Model)** |
| To improve the provision and quality of NHS healthcare across all care homes in England. The intention is to help reduce avoidable emergency admissions, ambulance conveyances and sub-optimal medication regimes.  The service development and delivery of this work cannot be done in isolation because of the interdependencies and the system collaboration required to realise the programme ambition |