|  |  |
| --- | --- |
| Community GP, Team Up Home Visiting Service | |
| Line Manager | Team Up Clinical Lead/Team Up Operational Lead |
| Hours | 8 hours per week (2 sessions – Fridays) |
| Salary | £10,865 per session per annum |
| Working Pattern | Working in conjunction with Community GP colleagues and other Clinical professionals to cover service hours (initially 08:00-18:30 Monday to Friday) |
| Type of contract | Permanent |
| Location | Coney Green Business Centre, Wingfield View, Clay Cross, S45 9PW |
| Leave Entitlement | 30 days per annum plus bank holidays pro rata |
| Study Leave Entitlement | 5 days per annum pro rata |

## About Us

South Hardwick PCN is a group of 8 forward thinking and progressive practices (population 70,472) who have developed a friendly and effective working relationship with one another. We are committed to working collaboratively to improve outcomes for patients and sustaining General Practice.

South Hardwick is a mix of former mining communities, suburbs, and rural communities to the south of Chesterfield. Your employer would be North Eastern Derbyshire Healthcare Ltd, and you would be entitled to an NHS pension.

A map of a country

AI-generated content may be incorrect.

## Job Summary / Purpose

Are you enthusiastic about providing holistic care for frail patients? Do you want a role which transcends the traditional boundaries of health and social care?

Do you want an alternative to the current model of General Practice, where you can spend more time with the most complex patients? This would be an ideal role for a portfolio GP.

South Hardwick PCN is seeking to recruit a Community GP to support our multi-disciplinary team to provide 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.

To understand more about the role of a Community GP, please see this video:

<https://www.youtube.com/watch?v=OZ_77QcLG_4>

This is an exciting opportunity to be at the forefront of the delivery of our Ageing Well model of care - Team up Derbyshire. The role transcends the traditional health and social care organisational boundaries. It will involve true MDT working, building relationships with GP practices, Community Core and Rapid Response Nursing and Therapy services, Falls services and Adult Social Care, to help clinically deliver the service on a day-to-day basis.

This is an evolving service, so you will have the opportunity to contribute to the development of Team Up and the Home Visiting Service if you wish to.

Key Responsibilities

### Clinical

* Provide day-to-day clinical leadership, advice and support for the multi-disciplinary team including debriefing after visits if needed.
* Maintain a visible clinical profile, having both advisory and clinical input into the medical management of patients presenting to the service.
* Senior clinical triage of patients referred into the PCN's Home Visiting Service. Prioritise patients in terms of urgency and need and allocate to the appropriate clinician to undertake the visit.
* Undertake home visits for clinically complex cases e.g. end of life care, diagnostic uncertainty, complex prescribing decisions.
* Provide holistic comprehensive assessment and enhanced advance planning.
* Maximise best care in the patients’ own homes to reduce the need for hospital or care home admissions.
* Provide end of life care in line with the patients’ wishes.
* Evaluate the effectiveness of therapeutic interventions and modify the patient’s management plan accordingly.
* Maintain accurate and legible patient notes in accordance with local policy and professional guidance.
* Demonstrate empathy and compassion when communicating sensitive information and advice to patients, carers, and relatives.
* Involve patients, families, and carers in the identification of patient-centred concerns and priorities about health and well-being and negotiate approaches available to prevent deterioration or promote comfort and well-being.
* Assess capacity, gain valid informed consent and work within a legal framework with patients who lack capacity to consent to treatment.
* Provide guidance to the clinical team regarding therapeutic interventions, advance care planning and best interest decision-making for patients who lack mental capacity to make informed choices about their care.
* Refer to other practitioners and agencies when necessary.
* Work closely with Derbyshire community and adult social care teams and other system partners to adopt an integrated care approach to meet an individual patient’s needs across services through collaboration with care teams who refer patients to the service and those who provide on-going care.
* Lead and engage in MDT and other team meetings, and quality improvement activities.
* Shape services for older people in accordance with local and national policies and drivers.
* Monitor and challenge risk in relation to their own practice and that of colleagues.
* Act as a champion and advocate for the care of the frail older person.
* Apply best practice policy guidelines where appropriate and in the absence of specific guidance ensure that actions are initiated in line with evidence-based practice and rigorous analytical judgment.

### Professional Clinical Leadership and Consultancy

* Facilitate and promote a learning culture that encourages others to develop their full potential.
* Communicate, motivate, and inspire others to deliver excellent standards of care.
* Act as an acknowledged source of expertise to assist with the development of service delivery models and clinical guidelines and to promote their application throughout the organisation.
* Challenge restrictive cultures and champion new ways of working to deliver enhanced patient focused care and improved productivity amongst the work force.
* Encourage other healthcare professionals to disseminate good practice.
* Support the development of a learning organisation by identifying, challenging, and reporting poor performance and alert managers to resource issues which may affect patient safety.
* Actively contribute to appropriate service developments and quality improvements.
* Develop benchmarks for best practice, identify quality outcome measures and contribute to audit programmes.
* Collaborate with other relevant professionals to develop clinical protocols and integrated care pathways within area of expertise or specialty to benefit the delivery of clinical services.

### Training, Education and Staff Development

* Collaborate with clinical managers to facilitate/lead the delivery of training and development programmes for the multi-disciplinary team.
* Support colleagues to advance clinical skills or to develop new roles.
* Provide mentorship and/or clinical supervision to staff and learners to aid the application of theory to practice.
* Act as a resource for the clinical team and wider Derbyshire system partners.
* Make effective use of learning opportunities whilst contributing to developing the workplace as a learning environment.

The list of duties above is not exhaustive and is intended to outline the main activities of the post-holder. Additional duties and ad hoc requests may be required within this role and the need to be flexible is essential.

This is an evolving role, and the duties and responsibilities may change in accordance with the developing service and needs for the patients.

### Personal / Professional Development

The post-holder will participate in any training programme implemented by the PCN as part of this employment, with such training to include:

* Participation in an annual individual performance (appraisal) review, including taking responsibility for maintaining a record of own personal and/or professional development.
* Assuming responsibility for own continuing professional development, learning and performance and demonstrating skills and activities to others who are undertaking similar work, and contribute to the continuing professional development of other healthcare professionals.
* Evaluating the quality of own work and current practices using evidence-based practice projects, audit and outcome measures and support others in doing so.
* Undertaking annual mandatory training updates and other relevant courses in line with organisational and local policies.

### Equality and Diversity / General

The postholder will:

* Develop a culture that promotes equality and values diversity. The postholder must be aware of and committed to the Equality and Diversity policies of the South Hardwick Primary Care Network and comply with all the requirements of these policies and actively promote Equality and Diversity issues relevant to the post.
* Ensure the principles of openness, transparency and candour are observed and upheld in all working practices.
* The post holder will have, or acquire through training provided by the organisation, the appropriate level of safeguarding, and knowledge, skills and practice required for the post and be aware of and comply with the organisation’s safeguarding protection policies and procedures.
* 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.
  + Behaving in a manner which is welcoming to and of the individual, is non-judgmental and respects their circumstances, feelings priorities and rights.

### Confidentiality

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 duties outlined in this job description, the post-holder may have access to confidential information relating to patients and their carers, PCN/practice staff and other healthcare workers. They may also have access to information relating to the PCN as a business organisation. All such information from any source is to be regarded as strictly confidential.

Information relating to patients, carers, colleagues, other healthcare workers or the business of the PCN may only be divulged to authorised persons in accordance with the PCN policies and procedures relating to confidentiality and the protection of personal and sensitive data.

### Quality

The post-holder will strive to maintain quality within the work, and will:

* Alert other team members to issues of Clinical Governance, quality, and risk, participate in Significant Event Analysis reviews.
* Assess own performance and take accountability for own actions, either directly or under supervision.
* Contribute to the effectiveness of the team by reflecting on own and team activities and making suggestions on ways to improve and enhance the team’s performance.
* Work effectively with individuals in other agencies to meet patients’ needs.
* Effectively manage their own time, workload, and resources. He/she will also contribute to the overall teamworking, putting the needs of the organisation first.

### Health and Safety

The post-holder will assist in promoting and maintaining their own and others' health, safety and security as defined in the PCN Health & Safety Policy and associated documents. This will include:

* Using personal security systems within the workplace according to PCN 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.
* Actively reporting of health and safety hazards and risks immediately when recognised.
* Demonstrate due regard for safeguarding procedures.

### Stakeholder Management

Develop effective working relationships with professionals both internal and external to the PCN/service.

Act as an integrator ensuring care is co-ordinated across the interface with Primary Care and other health and social care partners, to ensure an effective, efficient and high-quality service for service users.

### Key Relationships

* Patients, Service Users, Carers and their families
* Service Clinical & Operational Leads
* Members of the Team Up Home Visiting team
* PCN Senior Leadership Team and Core team
* PCN Member Practices
* Professionals across the System Services including Mental Health, Community Nursing, Therapy and Specialist Community Teams and their Managers, East Midlands Ambulance Service
* Social Care Teams and their Managers
* Other Primary Care Networks
* Acute Hospitals
* Voluntary Sector Organisations
* Other local Partner Organisations and Personnel
* Local Service Commissioners and other Partners in the Joined Up Care Derbyshire system.

### Disclosure and Barring Service Check

This post is subject to the Rehabilitation of Offenders Act (Exceptions Order) 1975 and as such it will be necessary for a submission for Disclosure to be made to the Disclosure and Barring Service (formerly known as CRB) to check for any previous criminal convictions.

### Employer details

### *Employer name/Address*

North Eastern Derbyshire Healthcare Limited

Unit 131, Coney Green Business Centre

Wingfield View

Clay Cross

Chesterfield

S45 9JW

**For questions about the role, contact:**

Julie Caunt [J.caunt@nhs.net](mailto:J.caunt@nhs.net) or

Katie Bowman [katie.bowman1@nhs.net](mailto:katie.bowman1@nhs.net)

Please email CVs to [j.caunt@nhs.net](mailto:j.caunt@nhs.net)

## Person Specification

Post: Community GP, Team Up Home Visiting Service

Key: The following key shows at which stage each criterion needs to be evidenced.

1. = Application Form, **(I)** = Interview **(T)** = Test

|  |  |  |
| --- | --- | --- |
| **Attributes** | **Essential** | **Desirable** |
| Qualifications and Training | A vocationally trained and accredited GP **(A)**  Current registration with GMC **(A)**  On the GP performers list **(A)** | MRCGP **(A)**  Recognised qualification in Care of the Elderly **(A)**  Recognised qualification in medical education / clinical supervision **(A)**  Evidence of leadership development **(A/I)** |
| Experience and Knowledge | Experience and evidence of an interest in care of the Elderly **(A/I)**  Understanding of Adult Safeguarding and Deprivation of Liberty Procedures **(A/I)**  Experience of multi-disciplinary working, and of working effectively as a member of a team **(A/I)**  Experience of senior clinical triage for the Home Visiting Service to determine the urgency and type of response needed, according to clinical need  **(A/I)** | Knowledge and experience of carrying out Comprehensive Geriatric Assessment **(A/I)**  Experience of medical education/ clinical supervision **(A/I)**  Experience of using SystmOne or another clinical system **(A/I)** |
| Skills and Abilities | Ability to understand others' competencies and support them to work within/at the top of those competencies, and to recognise/act when others are going beyond their competency **(A/I)**  Ability to work as part of a multi-disciplinary team **(A/I)**  Ability to triage in order of clinical need **(A/I)**  Excellent organisational and communication skills, verbally and in writing **(A/I)**  Ability to work effectively across traditional organisational and professional boundaries. Committed to the development of integrated community teams **(A/I)**  Ability to work effectively with colleagues, patients and external organisations **(A/I)**  Full driving licence required as travelling required for the role **(A/I)** | Leadership of service delivery / change **(A/I)** |
| Aptitude and Personal Qualities | Flexible, supportive and collaborative **(A/I)**  Recognise the benefits of multi-agency and multi-disciplinary team working **(A/I)** |  |
| Values, Drivers and Motivators | A passion for excellent, holistic patient-centred care for older people with frailty **(A/I)** |  |

Successful candidates will be required to undertake roadmap training/clinical supervision training via Health Education Derbyshire or Health Education England East Midlands to enable them to supervise clinicians for training and supervisory purposes if they have not already completed this.

## Appendix

**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 even 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:

* **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.
* **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.
* **Enhanced Health in Care Homes** (EHCH) model – to scale up the successful vanguard EHCH approach 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.