Job Description

Job Title: Bilingual Care Navigator (English and Turkish speaking)
Responsible to: Chief Executive
Responsible for: As assigned
Salary: £25,000 - £28,000 per annum + 6% pension
Hours: 36 Hours per week
Holiday: 25 days plus bank holidays per annum (pro rata)
Based at: Various GP Surgeries as assigned by the East Haringey CHIN Lead
Contract: Permanent

The Care Navigators will provide support to patients living with type 2 diabetes in Haringey as part of a new programme of work emerging called Care and Health Integrated Networks (CHINs). The East Haringey CHINs is formed from providers across several sectors: primary care, community health, hospital, social care and the voluntary sector. Amongst these member organisations there are 20 general practices, with a combined list size of around 150,000.

The East Haringey CHINs (East A and East B) have been working with Haringey Public Health (PH) and Haringey Clinical Commissioning Group (HCCG) to develop a new pathway of care for people living with type 2 diabetes; for newly diagnosed patients and those with an established diagnosis, but have poor control. The aim of this post is to work in a multidisciplinary team to provide holistic care for people living with diabetes in East Haringey CHIN.

This is a new and exciting opportunity for Haringey to lead transformational work in diabetes care. The post holder will work with East CHIN leads and diabetes specialist nurse to support the new diabetes pathway of care.

Purpose of Job

As the Care Navigator, you will be working closely with patients who have had a new diagnosis and patients who are poorly managing their diabetes to better access resources and care. You will also be working closely with the wider diabetes services in Haringey to help patients navigate their diabetes journey and access respective services and care.

You will enable patients to better utilise resources in the voluntary and community sector. This will in part be by direct work with individual patients, and also by collating information about voluntary and community resources locally, to share with patients and health professionals in the clinics and GP practices. In particular, you will:

1. Focus on helping patients to make full use of local community and voluntary sector resources available locally, as well as those provided by health and social care providers.
2. Be familiar with voluntary and community services, and also with relevant statutory services, so that they can respond holistically to patients' needs.
3. Produce a summary of these resources, so that residents, family, the MDT, general practice teams and other agencies are fully informed of the full range of local opportunities available, to increase their uptake.
4. Work with the CHIN members to increase their awareness and use of local services, develop new opportunities, and problem solve to improve access.

Principal Tasks

Service delivery and co-ordination

1. To take referrals from GPs and other members of the multi-disciplinary team for individual patients.
2. To discuss with the person their needs, based on GP guidance, and to direct them to appropriate services. In addition to sources of direct support and help, this includes wider services and activities that may help to promote patients' health, wellbeing and independence. Services may be open access or require payment, either through a personal budget or own funds.
3. To provide the patient and their carer where appropriate with a plan on what is recommended and how to access it.
4. To arrange own visit appointments as appropriate.
5. To provide information, after your visit, on some of the outcomes of the service, and to the GP.
6. To develop knowledge of local services, using existing databases and developing links with service providers, keeping up-to-date with service changes and developments.
7. To inform the GPs and other healthcare professionals about the holistic range of services available in the community and how they can access them directly.
8. To support the development of care planning and case management to support patients in their management of care and avoid unnecessary hospital admissions.
9. To actively participate in practice level multi-disciplinary team meetings.
10. To identify when there is a need for urgent action or for a step-up in care and alert the relevant professional(s)
11. To assist with gathering information for evaluation.
12. To keep accurate and up-to-date records of contacts with clients (including use of EMIS).
13. To contribute towards the development of the project, attending meetings and doing presentations as requested by their line manager or CHIN Lead.
14. To work collaboratively with the other Care Navigators supporting each other and meeting regularly as a team.

Leadership and management of people

15. To support and supervise volunteers (as assigned) to ensure performance targets are met.
16. To lead by example, upholding Bridge codes of conduct, policies, working practices.
17. To lead by example by modelling healthy living practices whilst in work.

Income generation and fundraising

18. To support income generation, fundraising applications and tenders to extend or expand the service in line with the Trust's fundraising strategy.

Wider Community involvement

19. To increase the participation and involvement of older people in the activities of the service and other Bridge activities.
20. To contribute to work with local communities to build and sustain community capacity and seeking local solutions to community identified issues and priorities; and ensure that the Trust acts as a 'voice' for local residents.

Wider Partnership working

21. To contribute to initiatives to develop partnerships including developing and maintaining effective working relationships with local residents, Trust service users, voluntary and community groups, statutory and public sector organisations, businesses and funding bodies.
22. To work collaboratively with internal and external partners to identify and secure funding streams and resources to support delivery of the Trust's objectives.

Team working

23. To take part in The Bridge Renewal Trust events and activities as agreed with your line manager.
24. To promote a positive team environment and work well as part of the Trust staff team to co-ordinate activities and resources in order to meet Trust charitable purpose.
25. To use and contribute to the effective use of: outlook, shared drives and the website to ensure good internal communications and a team approach

Customer care

26. To be responsible for promoting high levels of customer care within your own areas of work.

Equality

27. To understand, promote and implement the Trust's equality policy, recognising social and cultural diversity in the delivery of services, access to facilities and volunteer supervision

Safeguarding

28. To understand, promote and implement the Trust's safeguarding policy, recognising that safeguarding is everyone's responsibility.

General

29. To comply with the statutory provisions of all Health and Safety, associated legislations and all Trust policies and procedures including commitment to ethical and environmentally sustainable practices.
30. To be able to work flexible hours to meet the service needs including working occasional evenings and weekends.
31. To undertake appropriate training as and when required.
32. To recognise that the above-mentioned responsibilities are neither exclusive nor exhaustive and the post holder may be required to carry out other duties commensurate with the grade of the post.

Disclosure & Barring This post will require a DBS check at Enhanced level.

Person Specification – Care Navigation Co-ordinator

	Criteria	Essential/ Desirable	Assessment Method
1. **Qualifications and special requirements**	a) Bilingual ability to speak English and Turkish due to the patient demographics.	Essential	AF/I
	b) Nationally recognised qualification in social care or similar.	Desirable	AF
	c) Commitment to/evidence of continuous professional development.	Essential	AF
2. **Experience**	a) Experience of working with older people providing person-centred care, preferably in care homes or their own homes.	Essential	AF/I/A
		Essential	AF/I
	b) Experience of project or service delivery including performance monitoring and reporting.	Essential	AF/I
	c) Experience of partnership working, preferably within a multi-disciplinary team working	Essential	AF/I/A
3. **Skills, Knowledge & Abilities**	a) Excellent listening, verbal and written communication skills.	Essential	I/A
	b) Excellent team working skills including being tactful and diplomatic, and ability to build relationships with people from a wide range of backgrounds.	Essential	I
	c) Ability to plan, organise and prioritise work to meet tight deadlines.	Essential	I
	d) Understanding and knowledge of the equality legislation and health and safety regulations.	Essential	I
		Essential	AF/I
	e) Understanding and up-to-date knowledge of policy and practice in Adult Social Care and Health, including the principles of personalisation and social prescribing.	Essential	AF/I
		Essential	I

	j) Proficient in the use of Information Communications Technology including MS Office and social media tools. l) Readiness to work flexibly, recognising the need to work occasional evenings and weekends.		
4. **Other requirements**	a) Willingness to undergo enhanced CRB/DBS Disclosure.	Essential	I

- AF – application form / supporting statement
- I – interview
- A – assessment exercise