JOB DESCRIPTION

JOB TITLE	**GP with Extended Role (GPwER) in Frailty**
REPORTS TO	**Medical Director**
LOCATION	**Community based provision across Hull and East Riding**

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JOB PURPOSE

The GPwER in Frailty will provide evidence based, comprehensive, person centred and individualised medical care for older people, working as part of a multidisciplinary team within community settings across Hull and East Riding.

The role whilst demanding and challenging and also requiring the post holder to possess the specialist frailty knowledge required to support the medical management of complex and challenging presentations of older frail people, will prove extremely varied and rewarding to the post holder. This care will be provided through our various community frailly workstreams

DUTIES & RESPONSIBILITIES

The post holder will work as part of a multidisciplinary team, which includes Consultant Geriatricians, GPwERs, nurses, therapists, social care, the third sector and care home staff, to deliver high quality care and support for older people within the community. The post holder will contribute to service development, guideline development, research opportunities, and governance activities such as audit and quality improvement processes.

The post holder will be expected to participate in the training and development of other members of the MDT and wider healthcare community and assume a leadership role in the care of older people in the community.

The post holder will be expected to work autonomously but will also have supervision and clinical mentoring provided by the Consultant Community Geriatricians.

RESPONSIBILITY FOR PATIENT CARE

Advice and Guidance Line (Frailty)

- Offering advice and guidance to health professionals through the A&G line to include, Paramedics, GPs, Community nurses, therapists and the wider MDT for patients who are deemed frail.

- To provide an accessible advice line for care home staff in the management of patients in care homes to support timely access to specialists, including same day interventions to prevent health crises, recognise dying and provide timely decision making
- To liaise with GPs and other health care professionals
- To liaise with trusted assessors in stepping patients up from the community and down from hospital to the community beds.
- To help operate digital technology to assist in the management of patients in their own home.

Community Bedded Units

- To provide medical reviews for patients in the community Beds
- Overseeing medical care of these patients.
- The supervision of ANPs and Registrars working in these areas
- To complete face to face reviews of complex patients and development of management plans to assist the therapists in their care.
- To undertake prescribing for patients in the community beds
- Filing and management of diagnostic tests requested through the bedded units.

Comprehensive Geriatric Assessment – Jean Bishop Integrated Care Centre (ICC) and Care homes

- The management of patients referred into the ICC to include, medical, psychosocial, medicines reviews and advanced care planning, in the ICC, care homes and own homes
- The communication of outcomes to the patient and patients GP through the extended MDT.
- To carry out reviews of patients previously seen in the ICC
- To partake in the supervision of staff including ANPs and Registrars
- To show a willingness to explore other specialist roles within the team, examples include the management of Patients with Frailty and Dementia, pain management and falls.
- Filing and management of diagnostic tests requested through the ICC
- To support expansion of the CGA model into East Riding, including face to face and virtual assessments
- To support clinical decision making in the MDT
- Complete onward referrals to other specialities when appropriate

Urgent Community Response

- To offer a 2-hour urgent community response to patients in the community where this is deemed necessary.
- To coordinate clinical support workers (and ACPs) in the provision of this response to keep patients in the community where hospital admission is not necessary

Virtual wards (Frailty hospital at home)

- To provide clinical care to frail patients, who would otherwise be in hospital, managed on a virtual ward in the community according to available clinical pathways. This will include senior decision making and leading the MDT.

- To use digital technology in the management of patients on the virtual ward, as well as participating in face to face assessments
- To liaise with other specialists / virtual ward teams as required

COMMUNICATION

The post holder will be required to demonstrate excellent communication skills when working with patients, carers, members of the public, primary and secondary care colleagues, allied health care professionals, managers up to chief executive level, commissioners and the media.

ANALYTICAL TASKS

Clinical judgment at specialist level is expected in patient management. High level analytical skills will also be required in the day to day operational management, governance and in strategic service development.

PLANNING AND ORGANISATIONAL SKILLS

The post will require a high level of personal organisation to deliver clinical and managerial responsibilities. Specifically, at service level, the post holder will have to plan and organise service development and change in areas of responsibility. Strategically, the post holder will require being a self-starter and taking personal responsibility for the development, organisation and delivery of service development in line with the needs of the contracted population.

PHYSICAL SKILLS

The physical skills requiring to be sustained are those required to achieve the CCT/CESR in their specialty e.g. hearing, vision and dexterity for minor procedures, mobility and legible handwriting.

POLICY AND SERVICE DEVELOPMENT IMPLEMENTATION

The post holder will be responsible for taking an active role in operational and strategic service development, working collaboratively with clinical and managerial colleagues. This will be internally through innovation to provide a forward looking, cost effective and patient-centred service utilising new technologies and the skills of a multidisciplinary workforce working in partnership with the statutory and third sectors. It will also involve external collaboration with public health, commissioners and members of the MDT to provide services appropriate for the local population needs.

RESPONSIBILITIES FOR FINANCIAL AND PHYSICAL RESOURCES

The post holder will have a personal duty of care in relation to equipment and resources and to maintain a secure working environment.

RESPONSIBILITIES FOR HUMAN RESOURCES

The post holder may be involved in the management, supervision, co-ordination, teaching, training and development of employees, students/trainees and others in an equivalent position. S/he will have responsibilities for work planning and allocation, checking and evaluating work.

S/he will engage in and respond to personal development supervision to improve competences and clinical practice, and undertake appraisal and revalidation.

RESPONSIBILITIES FOR INFORMATION RESOURCES

The post holder will be responsible for the development and safe storage of person centred health care assessments, plans and electronic care records. The post holder may also be responsible for the managing and safe storage of electronic staff records, for example clinical supervision records.

RESPONSIBILITIES FOR RESEARCH AND DEVELOPMENT

The post holder will be expected to participate in Quality and audit activity, beyond the minimum required for revalidation, to assure service quality and patient safety.

FREEDOM TO ACT

The post holder will be expected to practice within the policies, procedures and guidelines of the organization and service, and national bodies such as NICE, The Royal College of General Practice.

S/he must practice within the ethical boundaries of 'Good Medical Practice' as laid down by the GMC.

CARE OF OLDER PEOPLE, SERVICE MODEL:

The service model includes the following key principles:

OUR ETHOS:

Our ethos is one of partnership, co-operation and innovation based on population needs. We work with the community teams, secondary care, GP practices, pharmacies, other locally based partners, commissioners and Public Health specialists to ensure the delivery of high quality, person centred and evidence-based care.

ENGAGEMENT AND INVOLVEMENT:

We actively engage with our service users and their families and carers and will utilise feedback from engagement activities to inform service development.

SERVICE USER FEEDBACK

CHCP has a range of processes to capture service user feedback to inform service provision including: Annual Surveys, Consultations, Comment Cards, Patient Opinion and the Friends and Family Test.
The information gathered via these methods is used to inform and shape our service content and delivery.

SERVICE DELIVERY:

Our service model will combine clinical and cost effectiveness by providing access to a skilled and multiprofessional workforce. Care is delivered via community-based clinics, within our intermediate care facilities, local care homes and in the service users own home (for example for housebound service users).

IMPROVING PRACTICE:

- Providing education and support to primary care organisations, constituent practices and Other primary care providers to raise the general standard and consistency of care of the older person across primary care.

- Facilitating and encouraging the spread of good practice from within primary care across the whole health and social care community.

- Providing a link / liaison role to local practices and pharmacists to enable robust Information management / understanding in areas such as the shared Single Assessment Process, and targeted screening assessments.

- Working with general practitioners, pharmacists, primary care nurses, social workers, mental health nurses, specialist community nurses and other health care staff such that current best practice is implemented within effective pathways within primary care.

This job description is not meant to be exhaustive. It describes the main duties and responsibilities of the post. It may be subject to change in the light of developing organisational and service needs and wherever possible change will follow consultation with the post holder

EFFORT AND ENVIRONMENT
Physical Effort This will vary from day to day but is not excessive. Standard clinical duties require driving, walking, sitting and bending from the waist for some clinical examination. Episodes of working at a desktop will not be prolonged. There is no routine commitment to heavy lifting or carrying e.g. case notes. Outreach work may lead to working in unpredictable environments e.g. an awkward or confined space.
Mental Effort On a daily basis, the post holder must be able to cope under pressure as a clinician providing both reactive and proactive medical advice to either patients, their carers or a wide variety of healthcare professionals involved in the care of older people. Frequent intense concentration will be required clinically and managerially. There are shared workspaces so the ability to concentrate and the ability to work with ambient noise in the background is essential.
Working Conditions Exposure to adverse working conditions is not common. Outreach clinics and domiciliary care in service users own home and residential care settings, may be in environments with poor temperature, noise and humidity control. There will predictable and unpredictable episodes of aggressive client behaviour secondary to personality, mental health issues or dementia, drugs and/or alcohol.

Emotional Effort

Clinical duties will result in emotionally charged situations due to anxiety, fear or grief. The post holder will have to deal with challenging situations such as caring for people living with advanced dementia, those approaching end of life and those in need of support in relation to advanced care planning. The leadership aspect of this post requires resilience to an environment of persisting change. This can have an adverse effect on the behaviour of some staff members and requires an honest cheerful and open relationship with in and out with the team. In terms of behaviour, leadership by example is expected of the post holder.

PERSON SPECIFICATION
GP with Extended Role (GPwER) in Older Peoples Care

Attributes and requirements	Essential	Desirable	How identified?
Qualifications & Training	• Full and current unrestricted GMC (UK) registration on the GP Register A • medical degree qualification	• A teaching qualification e.g post graduate diploma in post graduate education A post • graduate qualification in older peoples care, e.g. Diploma Geriatric Medicine (or willing to work towards	Application Form Interview

Experience	• Post GMC registration training in care of older people • 3 Years or more post GP specialist registration experience • Experience of supervising clinical staff to ensure clinical standards are met. • Experience of continuing professional development. • Evidence of attendance at courses or self directed learning to meet learning gaps identified through the professional development plan and through annual appraisal • Experience of conducting clinical audit	• Experience of designing, organising, teaching and training healthcare professionals and teaching patients	Application Form Interview
Knowledge & Understanding	• Up to date knowledge of all the latest guidelines and evidence in older peoples medicine. • Understand the importance of evidence based practice and clinical effectiveness • • Understanding of clinical governance • Sound clinical knowledge. Ability to use the evidence base and clinical audit to support decision-making	• Experience of SystmOne, Emis and Lorenzo clinical systems	Application Form Interview

Practical & Intellectual skills	• High level of clinical skills. • Ability to motivate and develop the multi-disciplinary team, • High level of communication skills. • Good organisational skills.IT competency Ability to make good clear concise medical notes, both computerised and manual Able to work under pressure and within an • ever changing environment Ability to balance service and personal objectives.	• Interest in research	Application Form Interview

Attitude & Behaviour	• Sensitive to the needs of others and has an awareness and responsiveness to other people's feelings and needs • Excellent command of the English Language – both verbal and written • Values differences: regards people as individuals and appreciates the value of diversity in the workplace Able to • work as part of a team, cooperating to work together and in conjunction with others and willing to help and assist wherever possible and appropriate. • Able to develop, establish and maintain positive relationships with others both internal and external to the organisation. • Able to work under pressure, dealing with peaks and troughs in workload. • Positive attitude to dealing with change; flexible and adaptable, willing to change and accept change and to explore new ways of doing things and approaches Highly motivated, • enthusiastic and reliable Has a strong degree of personal integrity; able to • adhere to standards of conduct based on a sense of right and wrong and be dependable and reliable Demonstrates values consistent with those of the • Organisation Ability and willingness to adopt a • flexible approach to work on the occasions it may be required.		Application Form Interview References
Teaching and Training experience	• • Ability to teach clinical skills to medical and nursing staff and other disciplines. The ability to appraise junior doctors and other staff		Application form Interview