Job Description

Job Title: Care Navigator (Diabetes)
Responsible to: Community Development Manager
Responsible for: As assigned
Salary: £27,527 - £30,831 per annum + 6% pension
Hours: 36 Hours per week
Holiday: 25 days plus bank holidays per annual
Based at: Haringey GP Federation offices (or as assigned)
Contract: 12 months (possible extension)
Job Reference: 2024006

Background
North Central London Clinical Commissioning Group in Haringey and local providers have come together to re-think the way diabetes care is being delivered to our local residents. The new Pan-Haringey Diabetes Care Navigation Service will facilitate improvements in care for all individuals living with diabetes and reduce the variation in care across the borough. The care navigation role is a key element of this service.

Purpose of Job
The Care Navigators will provide support to people whose diabetes is not well managed or who are not engaging with health professionals, in particular, deprived and vulnerable groups within this cohort.

The overarching aim is to support vulnerable people or those whose diabetes is poorly controlled, to optimise the management of their diabetes by accessing the right care at the right time in a mode that suits them, wherever possible. The Care Navigators will support people to access diabetes information and/or education in their own language, improve their ability to navigate the health and care system and improve their confidence to self-manage their condition.

This is a new and exciting approach to working with people with diabetes in Haringey and the care navigators will also be involved in the development of clear pathways to and from the service. The post holder will work with primary and secondary care clinicians to improve engagement with services, care achievements and outcomes for people with diabetes.

The Care Navigator role will work in the West and Central localities of Haringey, so knowledge of these geographical areas would be useful.

As a Care Navigator, you will be working closely with people whose diabetes is poorly managed or who are not engaging with services, to better access resources and care. You will enable people to better utilise resources in the voluntary and community sector. This will in part be by direct work with individuals, and also by collating information about

voluntary and community resources locally, to share with individuals and health professionals in clinics and GP practices. In particular, you will:

1. Focus on helping people with diabetes 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 Multi-Disciplinary Team (MDT), general practice teams and other agencies are fully informed of the full range of local opportunities available, to increase their uptake.

Principal Tasks

Service delivery and co-ordination

1. To take referrals from secondary care for individual patients who are in need for further support to access community and voluntary care services
2. To develop lines of communication with primary care, secondary care and community and voluntary care services to increase awareness of this service and ensure that there is cross-communication regarding service users.
3. To follow up people who have not attended their diabetes-related appointments, in order for them to re-engage with specialist diabetes services.
4. To discuss with the person their needs, based on their individual care plan, 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 through a personal budget.
5. To provide the person and their carer where appropriate with a plan on what is recommended and how to access it.
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 GPs and other healthcare professionals about the holistic range of services available in the community and how they can access them directly.
8. To keep accurate and up-to-date records of contacts with clients (including use of EMIS).
9. To contribute towards the development of the project, attending meetings and doing presentations as requested by their line manager or Locality Lead.
10. To work collaboratively with the other Care Navigators supporting each other and meeting regularly as a team.

Leadership and management of people

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

Income generation and fundraising

14. 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

15. To increase the participation and involvement of service users in the activities of the service and other Bridge activities.
16. 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

17. 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.
18. 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

19. To take part in The Bridge Renewal Trust events and activities as agreed with your line manager.
20. 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.
21. 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

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

Equality

23. 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

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

General

25. 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.
26. To be able to work flexible hours to meet the service needs including working occasional evenings and weekends.
27. To undertake appropriate training as and when required.
28. 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 Navigator (Diabetes)

	Criteria	Essential/ Desirable	Assessment Method
1. **Qualifications and special requirements**	a) Nationally recognised qualification in social care, social prescribing or similar b) Commitment to/evidence of continuous professional development	Desirable Essential	AF AF
2. **Experience**	a) Experience of working with people with diabetes. b) Experience of project or service delivery including performance monitoring and reporting. c) Experience of partnership working, preferably within a multi-disciplinary team working	Desirable Essential Essential	AF/I/A AF/I/A AF/I/A
3. **Skills, Knowledge & Abilities**	a) Excellent listening, verbal and written communication skills. b) Excellent team working skills including being tactful and diplomatic, and ability to build relationships with people from a wide range of backgrounds. c) Ability to plan, organise and prioritise work to meet tight deadlines. d) Understanding and knowledge of the equality legislation and health and safety regulations. 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. 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.	Essential Essential Essential Essential Essential Essential Essential	I/A I I I AF/I AF/I I

	k) Language skills in Somali, Bengali or another Haringey community language l) Understanding of West and Central Haringey geography, demography and needs.	Desirable Desirable	AF/I AF/I
4. **Other requirements**	a) Willingness to undergo enhanced CRB/DBS Disclosure.	Essential	I

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