JOB DESCRIPTION

Role	Neighbourhood Frailty Care Coordinator
Line Manager	TBC
Responsible for	No Direct Line Management Responsibility
Date of Description	August 2026

Job Purpose

The Neighbourhood Frailty Care Coordinator plays a pivotal role in the delivery of the Hambleton and Richmondshire Proactive Frailty Model, providing operational coordination across neighbourhood multidisciplinary teams (MDTs).

Working in partnership with General Practice, Community Services, Adult Social Care, Mental Health, Medicines Optimisation, VCSE organisations and other system partners, the post holder will coordinate Neighbourhood MDTs, support proactive population health management and facilitate integrated care planning and delivery.

The role is non-clinical and focuses on operational and service coordination, Individual patient pathway integration, quality improvement and performance monitoring to improve outcomes for people living with frailty and support the delivery of integrated neighbourhood care.

MAIN DUTIES AND RESPONSIBILITIES

Facilitation

The post holder will:

- Facilitate and, where necessary, chair Neighbourhood MDT meetings in partnership with the clinical lead/practice clinicians, ensuring discussions remain focused on proactive care planning, coordinated actions and agreed patient outcomes.
- Coordinate all aspects of the MDT process, including meeting planning, patient identification, agendas, supporting documentation, meeting logistics and follow-up activity, enabling clinical leads to focus on clinical decision-making.
- Gather and present relevant patient information and coordinate appropriate professional representation to support informed multidisciplinary discussion and collaborative decision-making.
- Ensure discussions always keep the patient at the centre of consideration, taking account of their needs, wishes and circumstances.
- Facilitate inclusive and outcome-focused MDT discussions, ensuring decisions, actions, responsibilities and timescales are clearly recorded, communicated and monitored through to completion.
- Act as the operational coordinator and first point of contact for GP practices and partner organisations in relation to Neighbourhood MDT processes, providing advice and support to promote effective and consistent delivery.

- Maintain robust processes for the secure receipt, management and sharing of patient information in accordance with Information Governance, Data Protection and organisational requirements.
- Remain mindful of allotted time by encouraging concise, focussed discussion to ensure meetings are effective.

Population Health Management

The post holder will:

- Utilise agreed population health management tools, clinical systems and reporting dashboards to support proactive case finding and identify individuals who may benefit from multidisciplinary review or early intervention.
- Analyse agreed frailty and deterioration indicators, including hospital admissions, Emergency Department attendances, falls and other locally agreed triggers, to support identification and prioritisation of individuals at increased risk.
- Develop, maintain and regularly review neighbourhood frailty cohorts, patient tracking systems and frailty registers, supporting General Practice to maintain accurate coding, recording and data quality.
- Coordinate the identification and prioritisation of patients for Neighbourhood MDT discussion, ensuring those with the greatest complexity, risk or unmet need are reviewed in a timely manner.
- Maintain operational oversight of the neighbourhood frailty caseload, working with General Practice and system partners to coordinate multidisciplinary assessment, personalised care planning, pathway progression and escalation to the Integrated Neighbourhood Team (INT) where appropriate.

Care Coordination

The post holder will:

- Coordinate the implementation of agreed actions arising from Neighbourhood MDT discussions, ensuring responsibilities are clearly communicated, progressed within agreed timescales and reviewed through subsequent MDT meetings where appropriate.
- Work collaboratively with General Practice, Community Services, Adult Social Care, Mental Health, Medicines Optimisation, VCSE organisations and other partner agencies to coordinate timely referrals, assessments, actions and ongoing service involvement, ensuring patients receive seamless, coordinated care.
- Maintain operational oversight of patients progressing through the Neighbourhood Frailty Model, ensuring agreed actions are implemented, monitored and reviewed, and supporting timely escalation to the Integrated Neighbourhood Team (INT) or other appropriate services where required.
- Act as an accessible point of contact for patients and carers where appropriate, providing information, facilitating communication between organisations and supporting engagement with agreed care plans, services and actions.

- Promote effective communication and information sharing between professionals, working collaboratively to resolve barriers, support continuity of care and reduce unnecessary duplication.

Service Improvement, Performance and Evaluation

The post holder will:

- Identify opportunities to improve operational processes, MDT effectiveness and patient outcomes, working with practices and partner organisations to develop and implement practical solutions.
- Support the development, implementation and review of standard operating procedures, operational guidance, pathways and agreed ways of working across the Proactive Frailty Model.
- Promote consistency and continuous improvement across neighbourhoods by sharing learning, good practice and supporting the adoption of new ways of working.
- Develop and maintain, with appropriate support, neighbourhood frailty dashboards, KPI tracking systems, patient tracking systems and operational performance information to meet agreed reporting requirements.
- Monitor and report on MDT activity, patient pathways, outcomes and agreed performance measures, supporting audit, evaluation and quality improvement through the collection and analysis of operational data.
- Identify and escalate emerging risks, variation, data quality or performance concerns through appropriate governance arrangements and support agreed improvement actions.

Relationships and Communication

The post holder will be expected to:

- Build and maintain effective working relationships with General Practice, Community Services, Adult Social Care, Mental Health, Medicines Optimisation, VCSE organisations, Secondary Care and other partner agencies to support integrated neighbourhood working.
- Act as the key operational link between partner organisations, facilitating effective communication, information sharing and collaborative problem-solving to support coordinated, person-centred care.
- Promote partnership working and joint decision-making, ensuring effective communication between organisations and supporting continuity of care across the neighbourhood pathway.
- Develop positive relationships with patients and carers, ensuring they remain at the centre of care planning and service delivery where appropriate.
- Represent the Neighbourhood Frailty Model positively across partner organisations, promoting engagement, consistency, innovation and continuous improvement.

General Responsibilities

Confidentiality and Information Governance

The post holder will:

- Maintain the highest standards of confidentiality at all times, recognising that the role involves access to sensitive information relating to patients, carers, colleagues and partner organisations.
- Ensure that confidential information is handled, stored and shared appropriately in accordance with Data Protection legislation, Information Governance requirements and organisational policies.
- Only disclose confidential information where there is a legitimate business need to do so and in accordance with organisational policies and information sharing agreements.

Health, Safety and Risk Management
The post holder will:

- Take reasonable care of their own health, safety and wellbeing, and that of colleagues, patients and members of the public.
- Work in accordance with organisational Health and Safety policies, identifying and managing risks associated with day-to-day activities.
- Report accidents, incidents, near misses and hazards promptly through the appropriate reporting procedures and support the implementation of agreed actions where required.
- Contribute to the maintenance of a safe working environment across all locations in which the role is undertaken.

Equality, Diversity and Inclusion
The post holder will:

- Promote equality, diversity and inclusion in all aspects of their work, ensuring services are delivered fairly and without discrimination.
- Treat patients, carers, colleagues and partner organisations with dignity, compassion and respect, recognising and valuing individual differences.
- Work in accordance with relevant equality legislation, organisational policies and the principles of person-centred care.

Quality
The post holder will:

- Maintain high standards of quality and professionalism in all aspects of their work, taking personal responsibility for the accuracy and quality of information, records and operational processes.
- Identify, report and escalate quality, safety or operational concerns through the appropriate governance arrangements, supporting the implementation of agreed actions where required.
- Take responsibility for their own performance, recognising the limits of their competence and seeking advice or support where appropriate.
- Contribute to the continuous improvement of the service by reflecting on individual and team performance, identifying opportunities for learning, sharing good practice and supporting service development.
- Work collaboratively with colleagues and partner organisations to support the delivery of safe, effective and person-centred care.
- Effectively manage their own workload, prioritising work to meet service demands and organisational objectives.

Flexibility

The duties and responsibilities outlined in this job description are intended to provide an overview of the role and are not intended to be exhaustive. The post holder will be expected to undertake other duties appropriate to the grade of the post, following discussion and agreement with their line manager, to meet the changing needs of the organisation and the service.

PERSON SPECIFICATION

Knowledge & Skills	
Essential	**Desirable**
• Excellent written, verbal and interpersonal communication skills. • Excellent organisational and planning skills, with the ability to manage competing priorities. • Ability to build productive working relationships across a broad range of stakeholders and work effectively within multidisciplinary teams. • Ability to facilitate meetings, coordinate operational activity and support collaborative decision-making. • Confident in leading discussions and summarising key points to ensure actions and decisions are identified. • Competent in Microsoft Office applications, including Outlook, Word, Excel and Teams. • Understanding of confidentiality, Information Governance, Data Protection and the secure handling of sensitive information.	• Knowledge of SystmOne or other NHS clinical systems. • Knowledge of Population Health Management approaches and proactive case finding. • Understanding of frailty, ageing well and integrated neighbourhood working. • Knowledge of the wider NHS and health and care system.

Experience	
Essential	**Desirable**
• Working within a health, social care or wider public sector environment. • Coordinating multidisciplinary or multi-agency working across organisational boundaries. • Planning, organising, facilitating and supporting meetings involving multiple stakeholders. • Managing competing priorities and delivering work within agreed timescales.	• Experience of working within Primary Care, including General Practice, Primary Care Networks or GP Federations. • Supporting frailty, ageing well, long-term conditions or older people's services. • Working with Population Health Management approaches, proactive case finding or Neighbourhood MDTs. • Contributing to service improvement, transformation, pathway redesign or quality improvement initiatives.

• Building effective working relationships across organisations to achieve shared outcomes. • Maintaining accurate records, handling confidential information and producing operational reports. • Using operational data and information to support planning, service delivery and decision-making.	• Supporting integrated neighbourhood or community-based models of care.
Personal Attributes	
Essential	**Desirable**
• Professional, approachable, tactful and diplomatic, with the ability to build credibility and trust with a wide range of stakeholders. • Flexible, adaptable and able to respond positively to changing priorities. • Self-motivated, enthusiastic and able to work independently using own initiative. • A collaborative team player who values partnership working and shared decision-making. • Excellent attention to detail and a commitment to delivering high-quality work. • Committed to delivering person-centred care and improving outcomes for people living with frailty. • Demonstrates resilience and remains calm under pressure. • Ability to engage with a diverse range of professionals. • Committed to continuous learning, innovation and service improvement. • Ability to travel independently across Hambleton and Richmondshire to meet the operational requirements of the role.	• Full UK driving licence and access to a vehicle for business use. • Positive ambassador for integrated neighbourhood working and collaborative care.