**JOB DESCRIPTION**

**Phoenix Health PCN**

**Social Prescribing Link Worker**

**About Phoenix Health PCN**

Phoenix Health PCN is one of 13 PCNs in Buckinghamshire. It covers the population of its 3 member practices; Cross Keys Practice, Haddenham Medical Centre and Unity Health, with a combined registered population of just over 46,000. We have a diverse population with a large frail elderly population, lots of young families and small pockets of deprivation.

The PCN provides a range of community based support services and supports its member practices in the delivery of primary care. The PCN is still in its early stages of development and this post provides the right person with a great opportunity to contribute to a growing organisation. We currently have a team of 12 people but have plans to expand by making the most of the Additional Roles available to PCNs, building a strong multi-professional team.

The role is based at the PCN offices in Chinnor but will involve travel throughout the PCN area. We are a great place to work with a supportive team environment, committed to the development of our team and providing great care for our community.

Our values as a PCN are:

* Making a difference
* Teamwork
* Integrity and honesty
* Kindness
* Fun

**About FedBucks**

FedBucks is a federation of 45 GP practices covering a population of over 485,000 patients across Buckinghamshire. We began in 2016 and now employ around 200 members of staff across our head office sites, and our planned and unplanned care services.

As a GP Federation, we are proud to represent our member practices and PCNs, and to champion primary care by working with local general practice and system partners in the provision of community-based healthcare services. We are dedicated to providing safe and compassionate care to our patients across our range of primary and unplanned healthcare services in Buckinghamshire, and believe in continuous commitment to quality service delivery and positive patient outcomes.

Patients are at the heart of everything we do, and we pride ourselves in ensuring our patients feel safe, supported, communicated with and respected, at a time when they may be feeling vulnerable. Our vision is to provide high quality, seamless health care that enables people to lead healthier lives, whilst feeling supported and cared for.

|  |
| --- |
| **JOB TITLE: Social Prescribing Link Worker** **HOURS: 37.5 Monday to Friday**  **LOCATION: Phoenix Health Primary Care Network** **SALARY: £24,907- £27,416** |

**Role Summary**

An opportunity has arisen for a Social Prescriber to join our developing multidisciplinary team in Phoenix Health Primary Care Network.

Social prescribing is a term used for local GPs and other healthcare workers to refer patients to a link worker. In turn link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and other services for practical and emotional support.

We are looking for a compassionate, collaborative and motivated link worker to empower people to take control of their health and wellbeing through referral to non-medical ‘link workers’ who give time, focus on ‘what matters to me’ and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support.

This role will work as an integrated part of health and social care provision throughout the PCN to support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners.

Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical ‘social prescribers’ who give time, focus on ‘what matters to me’ and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Social prescribers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with local partners.

Social prescribing can help to strengthen community resilience and personal resilience and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing, and physical inactivity, by increasing people’s active involvement with their local communities. It particularly works for people with long-term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which affect their wellbeing.

**Primary Duties and Areas of Responsibility**

* As a key member of the PCN’s team of health professionals, ensure that referrals from the PCN’s Core Network Practices and from a wide range of agencies are dealt with appropriately and support is offered for the health and wellbeing of patients.
* Constantly assess how far a patient’s health and wellbeing needs can be met by services and other opportunities available in the community.
* Devise and validate the ongoing Directory of Services for patients within the community. Ensure this is accurate and up to date as a constantly evolving point of reference.
* Support Social Prescribers within your network to co-produce a simple personalised care and support plan to address the patient’s health and wellbeing needs by introducing or reconnecting people to community groups and statutory services, including weight management support and signposting where appropriate and it matters to the person.
* Evaluate how far the actions in the care and support plan are meeting the patient’s health and wellbeing needs.
* Provide personalised support to patients, their families, and carers to take control of their health and wellbeing, live independently, improve their health outcomes, and maintain a healthy lifestyle.
* Develop trusting relationships by giving people time and focus on ‘what matters to them’.
* Take a holistic approach, based on the patient’s priorities and the wider determinants of health.
* Explore and support access to a personal health budget where appropriate.
* manage and prioritise own caseload, in accordance with the health and wellbeing needs of their population.
* Where required and as appropriate, refer patients back to other health professionals within the PCN.
* Meet people on a one-to-one basis, making home visits where appropriate. Give people time to tell their stories and focus on ‘what matters to me’. Build trust with the person, providing non-judgmental support, respecting diversity, and lifestyle choices. Work from a strength-based approach focusing on a person’s assets.
* Be a friendly source of information about wellbeing and prevention approaches. Help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities.
* Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.
* Work with individuals to co-produce a simple personalised support plan – based on the person’s priorities, interests, values and motivations – including what they can expect from the groups, activities and services they are being connected to and what the person can do for themselves to improve their health and wellbeing.
* Where appropriate, physically introduce people to community groups, activities, and statutory services, ensuring they are comfortable. Follow up to ensure they are happy, able to engage, included and receiving good support.
* Where people may be eligible for a personal health budget, help them to explore this option as a way of providing funded, personalised support to be independent, including helping people to gain skills for meaningful employment, where appropriate.
* Must be able to travel by own car between all Primary Care Network locations and patient's homes.

**Key Wider Areas of Responsibility**

* Promote social prescribing, its role in self-management, and the wider determinants of health.
* Build relationships with key staff in GP practices within the local Primary Care Network (PCN), attending relevant meetings, becoming part of the wider network team, giving information and feedback on social prescribing.
* Work in partnership with all local agencies (examples include ACHT, hospitals, housing services, voluntary/community services, faith groups) to raise awareness of social prescribing and how partnership working can reduce pressure on statutory services, improve health outcomes and enable a holistic approach to care.
* Seek regular feedback about the quality of service and impact of social prescribing on patient health and well-being and their use of health and social care services.
* Be proactive in encouraging self-referrals and connecting with all local communities, particularly those communities that statutory agencies may find hard to reach.
* Provide personalised support to patients on the caseload referred by the GP practices within the Network.
* Forge strong links with local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what is already available to create a map or menu of community groups and assets. Use these opportunities to promote micro-commissioning or small grants if available.
* Ensure that local community groups and VCSE organisations being referred to have basic procedures in place for ensuring that vulnerable individuals are safe and, where there are safeguarding concerns, work with all partners to deal appropriately with issues. Where such policies and procedures are not in place, support groups to work towards this standard before referrals are made to them.
* Work sensitively with people, their families and carers to capture key information, enabling tracking of the impact of social prescribing on their health and wellbeing.
* Work closely with GP practices within the PCN to ensure that social prescribing referral codes are inputted to EMIS and that the person’s use of the NHS can be monitored
* Participate in clinical supervision, appraisal, and training to ensure continual personal and professional development, taking an active part in reviewing and developing the role and responsibilities.
* Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.
* Undertake any tasks consistent with the level of the post and the scope of the role, ensuring that work is delivered in a timely and effective manner.

The above is only an outline of the tasks, responsibilities and outcomes required of the role. The job holder will carry out any other duties as may reasonably be required by the organisation.

The job description and person specification may be reviewed on an ongoing basis in accordance with the changing needs of AVS PCN and FedBucks Limited.

**Person Specification**

|  |  |
| --- | --- |
| **Education / Qualifications / Experience** | * NVQ Level 3, Advanced level or equivalent qualifications or working towards
* Evidence of recent and relevant Continuing Professional Development
* Training in motivational coaching and interviewing or equivalent experience
* Experience of supporting people, their families, and carers in a related role (including unpaid work)
* Experience of setting up services within Primary Care Networks and their local communities.
* Experience of working directly in a community development context, adult health, and social care, learning support or public health/health improvement (including unpaid work)
* Experience of working with local VCSE organisations and community groups
 |
| **Skills and Knowledge**  | * Understanding of NHS long term plan and priorities relevant to primary care
* Local knowledge of community healthcare and social care is desirable
* Knowledge of the personalised care approach Understanding of the wider determinants of health, including social, economic, and environmental factors and their impact on Communities
* Knowledge of community development approaches
* Knowledge of motivational coaching and interview skills
* Capacity to be innovative and develop the role of a link worker
* Ability to work with a range of clinical and non-clinical personnel as part of a team
* Ability to work independently and effectively with a high degree of motivation
* Ability to prioritise and work to deadlines
* Ability to define, collate, analyse, and interpret data
* Understanding of the current issues facing primary care teams.
 |
| **Personal Attributes**  | * Able to demonstrate resilience
* Ability to listen, empathise with people and provide person centred support in a non-judgemental way
* Demonstrates personal accountability, emotional resilience
* Works well under pressure
* Able to get along with people from all backgrounds and communities, respecting lifestyles, and diversity
* Compassion to patients, relatives, carers, and professional colleagues
* Core values consistent with a patient and family centred approach to care
* Demonstrate professional, appropriate, effective, and tactful communication skills
* Able to support people in a way that inspires trust and confidence, motivating others to reach their potential
* Builds credibility (personal and organisational) and rapport quickly
* Ability to travel between sites in a timely manner if required
 |