Recruitment Pack

Team Lead – Social Prescribing & Care Coordinator

37.5 hours

Permanent

Closing date for applications: 3rd December, 2021

Dear Candidate

I am delighted that you have shown interest in joining our team.

The health and well-being of our patients is at the heart of everything we do. Our goal is to provide an accessible, friendly, evidence based and compassionate service and you will have a vital role to play as our Team Lead for Social Prescribing and Care Coordinators

You will be an experienced Social Prescribing Link Worker and hold your own case load. Alongside this you will oversee and lead the Social Prescribers, Care Coordinators and Safeguarding Administrator. You will coach and support the team to meet their set objectives and KPIs as well as providing effective support and the best possible care for patients.

You will engage with the leadership of other providers (health, social care and third sector) supporting the Partnerships' patients to deliver collaborative solutions that improve patient outcomes and sustainability of PCN / GP services. You will work with the clinical team and senior management team to identify new solutions for improving patient health and wellbeing.

This is a great development opportunity for an experienced and exceptional social prescriber who already is working within a Primary Care Network to influence the design of the service.

You will enjoy membership of the coveted NHS pension scheme, as well as 25 days annual leave (pro rata), generous NHS employee discounts, free parking and more.

If this is you, we would really like to meet.

To apply

- Provide an up to date CV and a supporting cover letter, detailing how you meet the requirements of the role. candidate for this post
- Indicate your availability for the interview date
- Please specify what part time hours you are interested in
- Applications are to be e-mailed to soccg.livingwell-recruitment@nhs.net
- Applications must be received by 18:00 on the 3rd December

Thank you for your interest, we look forward to hearing from you.

Dave Barclay

Dave Barclay

Managing Partner (Non-clinical)

About Living Well

Our foundations

Living Well Partnership was formed in 2017 following the merger of four GP surgeries and three smaller branch sites. The GP partners, many of whom continue to lead LWP, were brought together by a growing awareness that we could deliver more streamlined medical care by sharing resources rather than operating on a smaller scale as individual practices.

We are delighted that our patients have benefited from faster access to a larger range of services while achieving operational efficiencies behind the scenes.

Our reach

We care for 38,000 adults and children across the eastern Southampton region. Our seven different sites ensure everyone has local GP access, from the inner city to the rural outskirts.

Our clinical team is made up of 10 GP Partners, as well as 18 Non-Principal GPs including 4 retainers, employed directly by LWP. Our GPs work alongside Advanced Nurse Practitioners, Practice Nurses, Health Care Assistants, Social Prescribers, Care Coordinators and our own in-house Pharmacy team.

Our vision

The health and well-being of our patients is at the heart of everything we do. Our goal is to provide an accessible, friendly, evidence based and compassionate service. By taking into account an individual's holistic needs we will utilise the correct professionals from our large multi-disciplinary team to address the problem presented. We pride ourselves that we are able to address medical, physical, psychological and social aspects of care.

Next generation

As a practice that strives for continuing clinical excellence we are passionate about helping to train the next generation of competent clinicians. We are a thriving and progressive training hub supporting physician associates, nurses, HCA's, pharmacy technicians, independent prescribers, medical students, newly qualified doctors and GP registrars through their academic and clinical education.

Come and join us

We are looking for an exceptional team leader and social prescriber who wants to embrace the changes in general practice and values providing excellent service.

Come and talk to us, come and see what we are doing, come and join us.

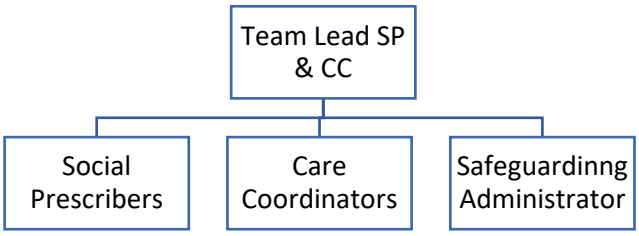
Job description & person specification

Job Title:	**Team Lead Social Prescribing / Care Coordination**
Status:	Permanent
FTE:	1.0 FTE / 37.5 hours
Location:	Practices of Living Well PCN Southampton
Accountable to:	Managerial – Non-Clinical Partner / Clinical – Allocated GP
Team / Function	Social Prescribing / Care Coordinators

Job summary

The Team Lead for Social Prescribing & Care Coordinators is responsible for the delivery of a professional, efficient and effective co-ordination service through effective management of the team of Social Prescribers and Care Coordinators. They will coach and support the team to meet their set objectives and KPIs as well as providing effective support and the best possible care for patients.

The post holder will engage with the leadership of other providers supporting the Partnerships' patients to deliver collaborative solutions that improve patient outcomes and sustainability of PCN / GP services.



Alongside managing the team, the team lead will also be a Social Prescriber Link Worker that will hold their own caseload of patients. Social prescribing empowers 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.

Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all 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.

The allocation of time is to Social Prescriber and team / service lead is approximately 60% - 70% and 30% - 40%.

Duties and responsibilities

- Proactively identify and work with vulnerable patients to support their personalised care requirements, using the available decision support aids.
- Holistically bring together all of a person's identified care and support needs, and explore options to meet these within a single personalised care and support plan (PCSP), in line with PCSP best practice, based on what matters to the person
- Help patients, carers and family members to manage their needs through answering queries, making and managing appointments, and ensuring that people have good quality written or verbal information to help them make choices about their care.
- Engage with and act as contact point on behalf of the Partnership with other service providers (including health, social, voluntary sector) who support LWP vulnerable patients.
- Provide coordination and delivery of Multi-Disciplinary Team meetings for vulnerable patients within the LWP PCN. Including, but not limited to the raising of complex cases or concerns to the MDT.
- Proactively find resolutions or escalate issues, concerns and monitoring regarding a vulnerable patient
- Liaising with all internal teams to support a vulnerable patient's needs.
- Provide signposting support to patients, carers and family members on information about a patient condition(s).
- Explore and assist people to access personal health budgets where appropriate.
- Provide coordination and navigation for people and their carers across health and care services, alongside working closely with social prescribing link workers and other care coordinators.
- Provide support and training to patients, carers and family members to make the best use of the PCN's IT systems e.g. for requests, prescriptions, consultations etc.
- Utilise population health intelligence to proactively identify and work with a cohort of patients to deliver personalised care.
- Support patients, carers and their family members to understand their level of knowledge, skills and confidence (their "Activation" level) when engaging with their health and wellbeing, including through the use of the Patient Activation Measure - https://www.england.nhs.uk/personalisedcare/supported-self-management/patient-activation/
- Assist patients, carers and their family members to access self-management education courses, peer support or interventions that support them in their health and wellbeing and increase their activation level.
- Liaise with the GP Partner responsible for vulnerable patients to agree strategy, implementation and monitoring of outcomes
- Provide monitoring, oversight and reporting against set objectives and Key Performance Indicators to the Partners and wider LWP team.
- Proactively utilise protocols and guidance available to ensure patients, carers and family members are provided with accurate and up to date information.
- Develop a sound understanding of significant events and how to report them.
- Undertake and participate in any training required including mandatory updates/refresher training.
- Support the Partnership in preparing for CQC or other external inspections or audits.
- Manage team to deliver PCN targets, improve patient outcomes, promote service achievements and work collaboratively with other providers
- Responsible for the co-ordination and delivery of specific projects associated with the role.

Communication and working relationships

- Establish and maintain effective communication pathways with all practice staff and external teams appropriate to role.
- Proactively participate in learning and development activities and opportunities.
- Lead and engage with regular team meetings, 1:1s and appraisals; providing, listening and responding to constructive performance feedback.
- Contribute to the effectiveness of the role by reflecting on own and team activities and making suggestions on ways to improve and enhance performance.
- Manage own time, workload and resources to ensure priorities are met and quality is not compromised.
- Promote and help to enhance the reputation of Living Well Partnership in accordance with policies and procedures, promoting good relations with patients and other health care professionals through effective communication skills.

Other duties

- General practice is fast moving and therefore changes in 'employees' duties may be necessary from time to time.
- The post holder will be required to undertake other appropriate duties according to the needs of the service, requested by a manager.

Travel

- The post holder may be required to travel to other practices within the Primary Care Network during their working day although this will be kept to a minimum where possible.

It is a requirement of all staff that they are aware of and follow the Partnership's policies and procedures, with attention to patient confidentiality, health and safety, infection. Control, equality and diversity and customer service excellence. To further your development and knowledge you will be expected to attend training as necessary.

The Partnership reserves the right to amend this role profile as necessary, after consultation with the post holder, to reflect changes in or to the job.

Key results

1. Measurable positive outcomes and feedback from patients, carers and family members
2. Monthly publication of an achievements, stories and impacts to promote the service
3. Reduction in attendance of high frequency users, repeat non-attenders, non-responders
4. Development and implementation of collaborative solutions with other providers across Southampton and Eastleigh Southern Parishes.

Person specification

		Essential/ Desirable
Qualifications	• Education to at least GCSE level, including English and Maths, or equivalent	E
Experience/ Achievements	• Is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute	E
	• Evidenced experience of working for at least 3 years in a Social Prescriber Role	E
	• Evidenced experience of leading a small team and associated people management processes	E
	• Evidenced experience of working in General Practice	D
	• Evidenced experience of working with social care	D
	• Evidenced experience of working with safeguarding, palliative care or end-of-life patients.	D
	• Evidenced experience of working collaboratively with multiple providers	E
	• Knowledge of services in Primary Care	E
	• Knowledge of Palliative Care, end-of-life or safeguarding services	E
	• Knowledge of General Practice processes and systems (e.g. EMIS, Docman, AccuRx).	D
	• Knowledge of healthcare signposting / care pathway options available to patients.	D
Aptitudes Teaching and training	• Ability to communicate effectively and sensitively with patients, carers and family members who may be emotional, upset, distressed or unwell, in a calm and compassionate manner.	E
	• Excellent listening skills and ability to ask open questions to understand patients' needs.	E
	• Excellent written communication skills and the ability to document information clearly and accurately.	E
	• Excellent attention to detail especially when following processes.	E
	• Highly organised and methodical, ensuring tasks are completed in full	E
	• Able to prioritise workload (of team and self) and ensure that urgent requests are completed promptly.	E
	• Ability to work on own initiative whilst recognising when to ask for help and support in making decisions.	E
	• Able to interpret information and data and provide analytical analysis to present to the Partners	E
Attitude/ Commitment	• Personal commitment to the values, vision and objectives of the Partnership	E
	• Ability to work under pressure to progress multiple work streams concurrently	E
	• Able to work for the benefit of the team	E
	• Reliable & Flexible	E
	• Treats others with respect and dignity.	E
	• Helpful and friendly manner ensuring that everyone feels they have been acknowledged, heard and understood.	E
	• Takes accountability for the quality of work delivered and appropriately resolves or escalates issues.	E
	• Demonstrates a willingness to learn and develop within the role	E
	• Contributes to building a positive culture.	E
Practical and personal qualities	• Evidence of continual learning and development	E
	• UK Driving Licence	E

Salary & remuneration

Position	Safeguarding Administrator
Normal Work location	The practices of Living Well PCN Southampton
Remuneration	£31,000pa
Hours of work	37.5 hours across 5 days per week
Annual Leave	25 days per annum plus bank holidays, pro rata.
Pension	NHS pension scheme

Salary & remuneration

Closing date for completed applications	3rd December
First Interview	Tuesday 14th & Thursday 16th December

If you have any queries please contact the recruitment team on soccg.livingwell-recruitment@nhs.net