PCN SAILors

Job Pack

SAIL in the Surgery

s.a.i.l. safe and independent living

Powered by... Lambeth age UK

Welcome from the CEO

PCN SAILor Project Worker

Thanks for your interest in this post.

It's a funny one because these are "new" jobs in a "new" setting with a whole bunch of "new" acronyms to learn. But, at heart, these roles are as old as frontline support work is itself.

Yes, they are going to be based in Primary Care Networks (that's groups of GP practices) around the Borough (there's 9 of them). Yes, it is using a relatively "new" term, social prescribing, but really it is about sitting with patients and helping them understand where they are at in their life and what they want their life to look like.

Then, and this is the good bit, you get the enormous privilege of walking alongside that person for a wee while in their lives, helping them work out places to go for support, care, enjoyment and improved health and wellbeing.

It will use your skills to get alongside people, listen and show care. It will use your knowledge of what services are out there that will work for them (don't worry, we can help with that bit!). Most of all it will depend on your ability to build trust and motivate people to try things that might be new for them.

The pay off is that you will get to see lives transformed by patients doing things for themselves: accessing good support services, trying out new things and meeting new people. All helping patients to get lives more like the ones they want. And... you get to be a part of an amazing service that is looking forward to supporting adults of all ages across Lambeth.

So... if you have experience of meeting people and helping them move forward in their lives by listening, pointing them to places to go or even offering support, then we want you to apply.

We look forward to seeing your application.

Graham

CEO

How to Apply

There is an online application process for this post.

Go to www.lambethsail.org.uk/jobs and click on the apply button for the job you are applying for. Just follow the instructions.

Make sure you attach your CV and Covering letter to your application.

You covering letter should set out how your experience, skills and abilities meet the selection criteria set out in the job description and person specification.

Closing Date: 4th October 2019

Good Luck!

Job Description

Post:	Primary Care Network (PCN) SAILor
Location:	Lambeth
Salary:	£25,600
Contract:	One year fixed term
Pension:	Contributory pension scheme; employee 5% & employer 7%
Annual leave:	26 days a year (plus bank holidays)
Reporting to:	Community and PCN SAIL Practitioner
Hours:	37 hours per week
Date:	August 2019

Job Purpose

The Safe and Independent Living (SAIL) service supports individuals access support, connect with local community groups and statutory services for practical support, to help maintain independence, safety and improve wellbeing. The SAIL team provide brief intervention, social prescribing support, allowing the individual to focus on 'what matters to me' and take a holistic approach to an individual's health and wellbeing, connecting people to community groups and statutory services for practical and emotional support. SAILors also support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners through linking in with Age UK Lambeth's Community Development team.

Primary Care Network (PCN) SAILors will work as a key part of the PCN multi-disciplinary team. Helping PCNs to strengthen community and personal resilience and reduces health and wellbeing 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.

Key Responsibilities

1. Working with direct supervision by a GP, take referrals from a wide range of agencies, including PCNs, GP practices and multi-disciplinary team in 2019/20 and from 2020/21: pharmacies, wider mult-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations, and voluntary, community and social enterprise (VCSE) organisations (list not exhaustive).

2. Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health outcomes,

as a key member of the PCN multi-disciplinary team. Develop trusting relationships by giving people time and focus on ‘what matters to me’. Take a holistic approach, based on the person’s priorities and the wider determinants of health. Co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services. The role will require managing and prioritising your own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. It is vital that you have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/ agencies, when the person’s needs are beyond the scope of the PCN SAILor role- e.g. when there is a mental health need requiring a qualified practitioner.

3. Draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals.

4. Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities.

5. Social prescribing link workers will have a role in educating non-clinical and clinical staff within their PCN multi-disciplinary teams on what other services are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

Specific Duties

Referrals

- Promote social prescribing, its role in self-management, and the wider determinants of health.
- As part of the PCN multi-disciplinary team, build relationships with staff in GP practices within the local PCN, attending relevant MDT meetings, giving information and feedback on social prescribing.
- Be proactive in developing strong links with all local agencies to encourage referrals, recognising what they need to be confident in the service to make appropriate referrals.
- Work in partnership with all local agencies 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.
- Provide referral agencies with regular updates about social prescribing, including training for their staff and how to access information to encourage appropriate referrals.
- Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.

- 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

- Meet people on a one-to-one basis, making home visits where appropriate within organisations' policies and procedures. Give people time to tell their stories and focus on 'what matters to me'. Build trust with the person, providing non-judgemental 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 health, 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.
- Where appropriate work with the person, their families and carers and consider how they can all be supported through social prescribing.
- 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 to address the person's health and wellbeing needs- 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, refer individuals to a SAIL volunteer to physically introduce people to community groups, activities and statutory services, ensuring they are comfortable.
- Follow up referrals and signposts to community groups, activities and statutory services to ensure the person is happy, able to engage, included and receiving good support.
- Seek advice and support from the GP supervisor and/or identified individual(s) to discuss patient-related concerns (e.g. abuse, domestic violence and support with mental health), referring the patient back to the GP or other suitable health professional if required.

Support Community Groups and VCSE Organisations to Receive Referrals

- Forge strong links with local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what's already available to create a menu of community groups and assets.
- Develop supportive relationships with local VCSE organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.

Work Collectively with all Local Partners to ensure Community Groups are Strong and Sustainable

- Encourage people who have been connected to community support through social prescribing to volunteer and give their time freely to others, building their skills and confidence and strengthening community resilience.

- Signpost interested individuals to volunteer with the SAIL service to provide ‘buddying support’ for people, starting new groups and finding creative community solutions to local issues.
- Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups and volunteering.
- Provide a regular ‘confidence survey’ to community groups receiving referrals, to ensure that they are strong, sustained and have the support they need to be part of social prescribing.

General Duties

Data Capture

- 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.
- Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.
- Work closely within the MDT and with GP practices within the PCN to ensure that the social prescribing referral codes are inputted into clinical systems, adhering to data protection legislation and data sharing agreements.

Professional Development

- Work with your supervising GP and/ or line manager (if different) to undertake 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.
- Work with your supervising GP to access regular supervision, to enable you to deal effectively with the difficult issues that people present.

Miscellaneous

- Work as part of the healthcare team to seek feedback, continually improve the service and contribute to business planning.
- 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.
- Duties may vary from time to time, without changing the general character of the post or the level of responsibility.

Person Specification

Personal qualities and attributes	Essential	Desirable
Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental way	√	
Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity	√	
Commitment to reducing health inequalities and proactively working to reach people from all communities	√	
Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders	√	
Ability to identify risk and assess/manage risk when working with individuals	√	
Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/ agencies, when what the person needs goes beyond the scope of the PCN SAILor role	√	
Able to work from an asset-based approach, building on existing community and personal assets	√	
Ability to maintain effective working relationships and to promote collaborative practice with all colleagues	√	
Commitment to collaborative working with all local agencies (including VCSE organisations and community groups). Able to work with others to reduce hierarchies and find creative solutions to community issues.	√	
Can demonstrate personal accountability, emotional resilience and ability to work well under pressure	√	
Ability to organise, plan and priorities on own initiative, including when under pressure and meeting deadlines	√	
High level of written and oral communication skills	√	
Ability to work flexibly and enthusiastically within a team or on own initiative	√	
Understanding of the needs of small volunteer-led community groups and ability to support their development		√
Able to provide motivational coaching to support people's behaviour change		√
Knowledge of, and ability to work to, policies and procedures, including confidentiality, safeguarding, lone working, information governance and health and safety.	√	
Qualifications and training		
NVQ Level 3, Advanced level or equivalent qualifications or working towards	√	

Demonstrable commitment to professional and personal development	√	
Training in motivational coaching and interviewing or equivalent experience		√
Experience		
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 supporting people with their mental health, either in a paid, unpaid or informal capacity		√
Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups		√
Experience of data collection and using tools to measure impact of services	√	
Experience of partnership/ collaborative working and of building relationships across a variety of organisations	√	
Skills and knowledge		
Knowledge of the personalised care approach	√	
Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities, individuals, their families and carers	√	
Knowledge of community development approaches	√	
Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports	√	
Local knowledge of VCSE and community services in the locality		√
Knowledge of how the NHS works, including primary care		√
Other		
Meet DBS reference standards and criminal record checks	√	
Willingness to work flexible hours when required to meet work demands	√	
Access to own transport and ability to travel across the locality on a regular basis, including visit people in their own homes	√	

How to Apply

To apply for this position, click on the “apply” button for this vacancy at the bottom of the page and follow the instructions. You will be required to upload your curriculum vitae and a letter of application setting out how your experience, skills and abilities meet the selection criteria set out in the job description and person specification.

Closing Date: 11th September 2019