

**JOB DESCRIPTION**

**Job Title:** Health Connector

**Accountable to:** Frome Medical Practice

**Reports to**: Area Lead

**The Service:**

Health Connections Mendip helps members of the community access support to better self-manage their health and wellbeing and long term health conditions. The service does this in a number of ways:

* Creating a database of support in the community
* Providing a phone service to signpost patients to support
* Identifying gaps in service provision
* Supporting individuals and groups to fill these gaps in service provision
* Supporting groups before they become self-sustaining.
* Supporting support organisations and services to network and work together
* Setting up information-giving events
* Supporting and training members of the community to become Community Connectors.
* Working with individuals in the most appropriate way for the individual; this might be one-to-one in GP practices, in hospitals, in the community, on the phone or in patients’ homes.
* Working with a multi-disciplinary team on care planning for complex patients and their carers.
* Working with groups to support people to better self-manage their health and wellbeing by providing self-management courses, group education sessions and peer support groups.

**Job Purpose:**

The Health Connector will be a member of the Health Connections Mendip service which operates across Mendip. It is part of an innovative primary care model that is changing the way that health services, social care and local communities work together to help people stay well, manage health conditions effectively, avoid hospital admissions, prevent loneliness and isolation and feel a sense of belonging within their local area.

The Health Connector will work across Mendip (including the villages) delivering person centred care. They will support people to better self-manage their long term conditions in the community through a combination of individual and group work. At present, the majority of the Health Connectors’ work is one-to-one.

The post holder will work with a multi-disciplinary team to plan care and support for local patients, who often have complex needs, as well as providing support to their carers.

The post holder will also work with the Area Leads to utilise untapped community resources, support the facilitation of self- help groups and other innovative approaches to enable people to better manage their own care.

In addition the post holder will work collaboratively with the wider team across Mendip, contributing to audit activity and review of progress.

Health Connectors, Senior Health Connectors and Area Leads work with a team of ‘Community Connectors’ – local people who help friends, family, colleagues and neighbours find support in their own communities, such as information on groups, counselling, education or debt advice.

Both Health Connectors and Area Leads will help support the Community Connectors to signpost local people to voluntary and community groups that might support their health and wellbeing. The Community Connectors are a practical resource to help connect people into services at a local level.

Health Connectors will need to be in charge of their own administration tasks for their role, so need to be well-organised and self-motivated.

**MAIN DUTIES AND RESPONSIBILITIES**

**Direct person centred care**:

* Support people to better self-manage their long term health conditions through a combination of individual or group work.
* Individual work will involve listening to the patient to find out what is most important to them, working with patients to who are not yet ready to change and helping them move to a stage where they feel more empowered to look at making changes, supporting them to identify needs and changes that they can self-manage, network mapping and network enhancement, linking to suitable support structures in the community and helping them to achieve goals that are important to the patient. This may be on the phone or face to face. This will take place in the place most appropriate for the patient; this might be in a GP practice, in hospital, care homes or at the patient’s home.
* The post holder will work with a multi-disciplinary team on care planning for complex patients and their carers.
* Group work will include setting up or running pre-existing groups/education sessions to provide appropriate support to patients.
* Evaluate the patients’ responses to health care provision and the effectiveness of care through agreed processes.
* Enter information in a timely manner into the electronic EMIS patient record system as agreed with the Area Lead.
* Prepare reports on progress of their work and recommend future development of the service and service improvements to the Senior Health Connector and Area Lead.

**Mapping & Promotion**

* Have strong links with the voluntary sector, supporting the voluntary and statutory sector to network and improve partnership working.
* Keep the website information up to date for their allocated area as directed by the Senior Health Connector and Area Lead.
* Promote the directory and the peer support service within the locality, both for users and clinicians.
* Take part in awareness raising events for services that help support people to improve their health and wellbeing, and those services that support people to self-manage.
* Take part in networking events for service providers.
* Disseminate marketing materials to a wide range of audiences.
* Promote the service via social media, newsletters, and bulletins and through thewebsite.

**Needs assessment**

* Listen to patients and be aware of areas where there are gaps in service provision.
* Work with partners, the GP practices in their areas and with the community to see if there is a need to fill the gaps and identify the best way to do this.
* Work with the area team to consider if an area wide or Mendip solution is required.

**Increasing resources**

* Work with patients and other services to help fill gaps in service provision within current resources.
* Help the Senior Health Connector and Area Lead to develop and support peer support groups.

**Mendip wide area/team responsibilities**

* Ensure that all audit and reports are undertaken as requested by the Area Lead.
* Ensure any databases are accurately updated and maintained.
* Ensure changes in the website directory are checked and then fed back to the Administration Lead.
* Contribute to quarterly monitoring reports to the CCG and other interested parties as required.
* Feedback any identified unmet community needs to the Senior Health Connector and Area Lead.
* Feedback any identified training needs to the Senior Health Connector and Area Lead.
* Act as a resource/support for other team members.
* Contribute to the dissemination of learning gained and sharing good practice.
* Be willing to cover other areas of Mendip as requested by the Senior Health Connector and Area Lead.

**All post holders are expected to:**

* Have a caseload of patients in-line with the service needs and developments.
* Demonstrate excellent organisational skills and keen attention to detail.
* Be flexible and solution focused when change is required in all aspects of the service.
* Be aware that the service changes and adapts according to needs and this requires a high degree of flexibility and a can-do attitude.
* The role requires the post holder to be resilient and deal well with situations that might be challenging.
* Attend training, external meetings and team meetings.
* Assist patients from marginalised groups to access quality care.
* Work within the operating hours of their base and the service. Some evening and weekend work may be required.
* Adhere to a strict code of confidentiality in all aspects of work.

**Health & Safety**

It is the responsibility of all employees to ensure that the requirements of the Health and Safety at Work Act are complied with, safe working practices are adhered to and that any hazards are reported to the appropriate officer immediately.

**All post holders are expected to:**

• Adhere to practice policies and procedures

• Promote Equality and Diversity in a non-discriminatory way.

• Adhere to the Data Protection Regulations, respecting confidentiality of patients and colleagues and the practice as a whole.

• Maintain personal and professional development in order to maintain their skill levels, participate in the appraisal process and any training and development that is recognised and agreed with Lead Practice Nurse.

• Respect and adhere to corporate and clinical governance principles

• Undertake a Disclosure and Barring Service (DBS) – criminal records and barring list checks

• Adapt to any changes made to the organisation structure/delivery of service

• Work as an integral part of the whole practice team

• Be committed to safeguarding and promoting the welfare of children, young people and vulnerable adults.

This job description is neither definitive nor exhaustive, and may be reviewed in the light of changing circumstances at a personal or organisational level. Any changes will be made in consultation with the post holder through the appraisal and review process.

Because of the nature of the work, this post is exempt from the provisions of Section 4 (2) of the Rehabilitation of Offenders Act 1994 (Exceptions) Order 1995. Applicants for posts are not entitled to withhold information about convictions which for other purposes are “spent” under the provisions of the Act and in the event of employment any failure to disclose such convictions could result in disciplinary action or dismissal by the Practice. Any information given will be completely confidential and will be considered only in relation to an applicant of a position to which the order applies.

**Person Specification:** Health Connector

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| **Attributes** | **Essential** | **Desirable** |
| Knowledge and experience | Knowledge of needs of patients with long-term health conditions  Knowledge of health promotion strategies  Knowledge and experience of working with people one-to-one using behaviour change, motivational interviewing and goal setting  Experience of working with people from a wide range of backgrounds | Ability to identify wider determinants of health in the local area  Knowledge of public health issues in the local area  Awareness of local and national health policy  Awareness of issues within the wider heath economy |
| Skills | Excellent communication skills both verbal and non-verbal, 1:1 and with groups  Excellent organisation and time management skills, with the ability to manage own workload  Ability to juggle competing priorities, in order to complete work to a high standard, and plan ahead to achieve targets  Ability to work flexibly with different teams and alone  Ability to communicate with other team members in a positive and constructive manner.  Ability to be resilient and to work well with different patients’ needs and an evolving service.  Ability to support patients to change their lifestyle and to support those with long term health conditions to move towards self-management  Ability to use your own initiative  Gets on well with people at all levels  Negotiation and conflict  management skills  Excellent literacy and numeracy skills  Computer literacy, including developed skills in using Microsoft Office applications.  Flexibility  Enthusiasm  Team Player  A good eye for detail | Group facilitation skills |
| Qualifications | 5 GCSEs at A-C or equivalent including English and Maths | Degree qualification in relevant area (or equivalent work experience). |
| Other | Ability to travel across Mendip in a timely manner  The start of the working day will be the practice that you are due to start in that day. This may not be your main office base.  Positive role model |  |