Bournemouth East Collaborative

Bournemouth East Collaborative, Primary Care Network

SOCIAL PRESCRIBER

BEC PCN ENHANCED CARE TEAM

Job Title: Social Prescriber PCN Enhanced Care Team

Contract Type: Part Time | Permanent

Working Days/Hours: 20 Hours per week

- Wednesday 12.00-17.00
- Thursday and Friday: 08:00-16:00

Salary: £15.00 per hour

Location: Based in our Mental Health Team Office at Southbourne Surgery, Beaufort Road, BH6 5BF

About us!
Bournemouth East Collaborative Primary Care Network (PCN), situated on the stunning Dorset South Coast, comprises four like-minded practices working together in East Bournemouth, with a strong reputation on quality improvement and investing in its employees. The PCN serves a population of approximately 53,000 patients with a diverse demographic.

Practices part of the PCN are:

- Beaufort Road Surgery
- Littledown Surgery
- Shelley Manor and Holdenhurst Medical Centre
- Southbourne Surgery

The PCN is committed to developing, supporting, and sustaining a diverse workforce, representative of the community it serves. By working together with our different Network teams, we use our combined skills to provide a service that is joined-up, holistic, proactive, and personal for the patient.

We are lucky that all our practices are located close to the sea and open green spaces.

Our Network teams include:

- Enhanced Care Visiting team for frail housebound patients and those in care homes. The team includes visiting GPs, ANPs, Frailty Nurses, Nurse Associates, Healthcare Assistants, Care Coordinators and a Clinical Pharmacist.
- BEC Treatment Centre working out of the Private Suite at Shelley Manor Medical Centre.
- Pharmacy Team made up of a number of experienced Clinical Pharmacists and Pharmacy Technicians supporting our practices and patients
- First Contact Physiotherapy Practitioner service.
- Digital Care Coordinator, Digital Champions.
- Mental Health practitioners.
- Health & Wellbeing Coaches within Help & Care team.

Bournemouth East Collaborative

Main duties of the job:

The Social Prescribing Link Worker will work as part of the Primary Care Network's multidisciplinary team to support patients with non-medical needs that impact their health and wellbeing. The post holder will have a particular focus on supporting specialist population groups, including unpaid carers, care leavers, veterans, people experiencing or at risk of homelessness, and other vulnerable communities.

The role will involve providing personalised support, reducing health inequalities, strengthening community connections, and improving access to local services. The post holder will also work proactively within the community by developing partnerships, facilitating focus groups, engaging with community organisations, and supporting projects that improve health and wellbeing across the Primary Care Network population.

This role will require an Enhanced DBS Clearance. Should you have this certificate as part of the DBS subscription service, we would be happy to accept this, providing the original is shown. Otherwise, you will be expected to complete a new application

Job Description and responsibilities

Patient Support:

- Receive referrals from GPs, nurses, allied health professionals, care coordinators, and other members of the multidisciplinary team.
- Undertake person-centred assessments to identify social, emotional, practical, and wellbeing needs.
- Develop personalised care and support plans based on each individual's goals and priorities.
- Empower individuals to improve their confidence, resilience, independence, and self-management**.**

Specialist Population Groups:

- Provide dedicated support to specialist population groups, including
    - Unpaid carers
    - Care leavers
    - Veterans
    - People experiencing or at risk of homelessness
    - Individuals experiencing social exclusion or health inequalities
- Build strong relationships with local organisations supporting these communities.
- Promote equitable access to healthcare, community resources, welfare advice, education, employment, housing, and wellbeing services.
- Identify barriers to accessing healthcare and work collaboratively to reduce inequalities**.**

Social Prescribing:

- Connect individuals with community groups, voluntary organisations, statutory services, and local resources.
- Support referrals to services including:
    - Carers' support organisations
    - Veterans' services

- Housing and homelessness support
- Welfare benefits and financial advice
- Mental health and wellbeing services, PCN Mental Health team
- Employment, education, and training opportunities
- Peer support groups
- Community activities
- Volunteering opportunities
- Physical activity and healthy lifestyle programmes

Community Engagement and Development:

- Develop strong partnerships with voluntary, community, faith, and statutory organisations.
- Identify gaps in local provision and work collaboratively to develop new initiatives where appropriate.
- Organise, facilitate, and evaluate community focus groups to understand local health and wellbeing needs.
- Support the planning and delivery of community wellbeing projects and initiatives.
- Promote community engagement through outreach activities, local events, and partnership working**.**

Care Coordination:

- Work collaboratively within the multidisciplinary team.
- Attend multidisciplinary team meetings and contribute to personalised care planning.
- Liaise with external agencies to ensure coordinated support for individuals with complex social needs.
- Support continuity of care through effective communication with partner organisations**.**

Safeguarding:

- Recognise safeguarding concerns relating to adults and young people where appropriate.
- Follow local safeguarding policies and procedures.
- Escalate concerns promptly and participate in safeguarding processes when required.

Record Keeping:

- Maintain accurate records using the practice clinical system
- Record interventions, outcomes, and follow-up activity.

Health Promotion:

- Promote health and wellbeing through community engagement and personalised care.
- Encourage participation in preventative health initiatives and local wellbeing programmes.
- Support individuals to access health screening, vaccinations, and wider NHS services where appropriate.

PERSON SPECIFICATION: Skills, Abilities and Knowledge

Essential

- Excellent communication and relationship-building skills.
- Understanding of person-centred care and personalised care approaches.
- Knowledge of health inequalities and the wider determinants of health.
- Ability to engage effectively with diverse communities and partner organisations.
- Compassionate and inclusive approach.
- Excellent listening and motivational interviewing skills.
- Strong networking and partnership-building abilities.
- Skilled in facilitation, community engagement, and project support.
- Ability to identify community assets and opportunities.
- Good IT and clinical system skills.
- Ability to manage competing priorities and work flexibly.
- Strong organisational and time management skills.
- Ability to work independently and manage a varied caseload.

Desirable

- Knowledge of the needs of carers, veterans, care leavers, and people experiencing homelessness.
- Knowledge of safeguarding legislation.
- Awareness of the NHS Long Term Plan, Personalised Care agenda, and Core20PLUS5 approach.

Experience

Essential

- Experience working within health, social care, community, or voluntary sector services.
- Experience supporting vulnerable or marginalised individuals and communities.
- Experience facilitating groups, workshops, or community engagement activities.

Desirable

- Experience working within Primary Care or a Primary Care Network.
- Experience of community development or asset-based community approaches**.**

Equality & Diversity

Demonstrates knowledge and understanding of equality of opportunity and diversity, taking into account and being aware of how individual actions contribute to and make a difference to the equality agenda.

The PCN is a friendly, flexible, forward thinking and a supportive Network.

Bournemouth East Collaborative

What can we offer you in return?

- Our PCN reflects the NHS values of working together for our patients and the communities we serve; we will support you with a robust induction programme to help you achieve your full potential and highlight areas of training to ensure good progression.
- We highly value a teamworking ethos and strongly promote a culture of support and development for our staff.
- All our mandatory learning opportunities are free to all employees, and many can be used towards revalidation for those with a professional qualification.

Equal opportunity

Bournemouth East Collaborative PCN is committed to creating a diverse and inclusive environment and is proud to be an equal opportunity employer. All applicants meeting the minimum criteria for the role will receive consideration for employment without regard to age, marriage or civil partnership status, gender, gender expression or gender identity, disability, race or ethnicity, religion or belief, sexual orientation, or veteran status.

Immigration Act 2016

All applicants will be asked to provide the required documented evidence of eligibility to live and work in the UK, prior to the interview. In completing this application, you are giving Bournemouth East Collaborative PCN permission to contact the Home Office/UKBA to establish your immigration status and eligibility to work at Bournemouth East Collaborative PCN.

Bournemouth East Collaborative PCN is not a Licence Sponsor and can only consider applicants who have the right to live and work in the UK.

Bournemouth East Collaborative PCN reserves the right to close this vacancy early should we receive sufficient applications.

Application Deadline: 17 August 2026