Role Profile

Job Title: Social Prescribing Link Worker	**Role Profile Number:** OPN76
Grade: M	**Date Prepared**: 25 September 2019
Directorate/Group: Community Health and Wellbeing, Public Health	**Reporting to:** Healthy Communities Manager
Structure Chart attached:	No

Job Purpose

Social prescribing empowers people to take control of their health and wellbeing through referral to 'link workers' who give time, focus on 'what matters to me' and take a holistic approach to an individual's health and wellbeing, connecting people to diverse community groups and statutory services for practical and emotional support. Link workers also support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local diverse partners.

Social Prescribing link workers will work as a key part of the primary care network (PCN) multi-disciplinary team. Social Prescribing can help PCN's to strengthen community and personal resilience, reduce health inequalities (in relation to timely access and outcomes) and wellbeing inequalities by addressing the wider determinants of health such as debt, poor housing and physical inactivity by increasing peoples 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. In Swindon, the Great Western Hospital PCN Social Prescribing Link worker will work alongside the Community Navigator team, utilizing their experience, networks and relationships for the best outcomes for the Great Western Hospital PCN patients.

Key Accountabilities

- Work with direct supervision by a GP, taking referrals from a wide range of agencies, including PCN's GP Practices and multi-disciplinary teams in 2019/2020 and from 2020/2021: Pharmacies, wider multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise organisations (list not exhaustive)

- Provide personalized support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health access and outcomes, as a key member of the PCN multi-disciplinary team. Take a holistic approach, based on the person's priorities and the wider determinants of health.
- You will co-produce a simple personalized care and support plan to improve health and wellbeing, introducing or reconnecting people to appropriate community groups and statutory services.
- Promote Social Prescribing, its role in self-management, addressing health inequalities and the wider determinants of health.
- Build relationships with staff in GP practices within the local PCN, attending regular MDT (Multi-Disciplinary Team) meetings, giving feedback and information on Social Prescribing.

Supplementary Accountabilities

- Manage and prioritise 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 strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals and agencies, when the person's needs are beyond the scope of the link worker role, for example when there is a mental health need requiring a qualified practitioner.
- Work with a diverse range of people and communities, to draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups (including faith groups) to receive social prescribing referrals.
- Alongside other members of the PCN multidisciplinary team, work collaboratively with all local diverse partners to contribute towards supporting the local VSCE 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.
- Social Prescribers will have a role in educating non clinical staff and clinical staff within their PCN multidisciplinary teams on what services are available within the community and how and when patients can access them. This may include verbal or written guidance.

Knowledge & Experience

- Experience of supporting people, their families and their families in a related role (including unpaid work).
- Experience of supporting people, their families and carers with their mental health either in a paid, unpaid or informal capacity.
- Experience of working one to one with people, of actively listening, empathising and providing person-centred, non-judgemental and non-discriminatory support, respecting diversity and lifestyle choices.
- Experience of working with the Voluntary and community sector (in a paid or unpaid capacity) including with volunteers and small community groups.
- Knowledge of strengths based approaches focussing on a person's assets
- Experience of being a source of friendly and engaging information about health, wellbeing and prevention approaches.
- Understanding of health inequalities and proactively working to reach people from diverse communities.
- Experience of providing a culturally sensitive service by supporting people from all backgrounds and communities, respecting lifestyles and diversity.
- Experience of supporting people in a way that inspires trust and confidence, motivating others to reach their potential.
- Knowledge of a personalised care approach
- Knowledge of Community Development approaches
- Knowledge of IT systems, including the ability to use word processing skills, emails and the internet to create simple plans and reports
- Knowledge of how the NHS works, including primary care
- Knowledge of and ability to work to policies procedures including confidentiality, safeguarding, lone working, information governance and health and safety.

Qualifications

- NVQ level 3, relevant advanced level or equivalent qualifications or working towards
- Demonstrable commitment to professional and personal development
- Preferred: Training in motivational coaching and interviewing or equivalent experience

- Access to own transport and ability to travel across the locality on a regular basis, including to visit people in their own homes

Decision Making

- Ability to maintain effective working relationships and to promote collaborative practice with all colleagues.
- Understanding of the needs of small volunteer lead community groups and the ability to support their development.
- Ability to organise, plan and plan on own initiative including when under pressure and meeting deadlines.

Creativity and Innovation

- Able to work from an asset based approach, building on existing community and personal assets.
- Commitment to collaborative working with all local agencies (including VCSE organisations and community groups).
- Able to work with others to reduce hierarchies and find collaborative solutions to community issues.
- Ability to identify risk and assess/manage risk when working with individuals

Job Scope **Number and types of jobs managed**	**Budget Holder** **Responsibility** **Asset Responsibility**:	No .

Contacts and Relationships

- Ability to communicate effectively, both verbally and in writing with people, their families, carers, community groups, partner agencies and stakeholders
- Able to provide motivational coaching to support people's behaviour change
- Ability to maintain effective working relationships and to promote collaborative practice with all colleagues

Values and Behaviours

We strive to underpin our culture of being 'At our Best' through strong management and authentic leadership. This means getting the management basics right. We own and demonstrate accountability, both individually and collectively, and aim to get things right first time. Building on this we also expect everyone at SBC to demonstrate and live our organisational values and behaviours, by displaying:

- Accountability at all levels
- Customer care and pride in what we do
- Continuous learning and evaluation
- Valuing one another and the contribution each of us makes

Other Key Features of the role

This role profile is based on the national template for Social Prescribing Link workers. The full version is attached below.

Employee Signature:	Print Name:
Date:	
Line Managers Signature:	Print Name::
Date:	

Social prescribing link workers:

Recruiting social prescribing link workers

These resources will support the recruitment of link workers in a manner that aligns with the requirements set out in the Network Contract DES.

Job description – social prescribing link worker
Purpose of the role Social prescribing empowers people to take control of their health and wellbeing through referral to 'link workers' who give time, focus on 'what matters to me' and take a holistic approach to an individual's health and wellbeing, connecting people to diverse community groups and statutory services for practical and emotional support. Link workers also support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local diverse partners. Social prescribing link workers will work as a key part of the primary care network (PCN) multi- disciplinary team. Social prescribing can help PCNs to strengthen community and personal resilience, reduce health inequalities (in relation to timely access and outcomes) 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 diverse 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.
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 multi-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 access and 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 appropriate communitygroups 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 what the person's needs are beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner.

3. Work with a diverse range of people and communities, to draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups (including faith groups) to receive social prescribing referrals.

4. Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local diverse 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.

Key Tasks

Referrals

- Promote social prescribing, its role in self-management, addressing health inequalities 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 access and 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 equality and inclusion, through self-referrals and connecting with all diverse 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 and respect with the person, providing non-judgemental and non-discriminatory support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person's assets.
- Be a friendly and engaging 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.
- 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, cultural and religious/faith needs 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 culturally appropriate community groups, activities and statutory services, ensuring they are comfortable, feel valued and respected. 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.
- 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 a wide range of local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what's already available to create a menu of diverse community groups and assets, who promote diversity and inclusion.
- Develop supportive relationships with local diverse VCSE organisations, culturally appropriate 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

- Work with commissioners and local partners to identify unmet diverse needs within the community and gaps in community provision.
- 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.
- Develop a team of volunteers within your 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 or 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 tasks

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.
- Support referral agencies to provide appropriate information about the person they are referring. Provide appropriate feedback to referral agencies about the people they referred.
- 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 (as outlined in the Network Contract DES), 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 roles and responsibilities.
- Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, equality, diversity and inclusion training and health and safety.
- Work with your supervising GP to access regular 'clinical 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.
- Contribute to the development of policies and plans relating to equality, diversity and health inequalities.
- 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

Person specification – social prescribing link worker

Criteria		Es	D
Personal qualities & attributes	Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental	✓	
	Able to provide a culturally sensitive service, by supporting people from all backgrounds and communities, respecting lifestyles and diversity	✓	
	Commitment to reducing health inequalities and proactively working to reach people from diverse communities	✓	
	Able to support people in a way that inspires trust and confidence, motivating others to reach their potential	✓	
	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 is beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner	✓	
		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 prioritise 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	✓	
		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 & 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, their families and carers in a related role (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 the 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	✓	
	Understanding of, and commitment to, equality, diversity and inclusion.	✓	
	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	Meets 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 to visit people in their	✓	