**JOB DESCRIPTION**

**JOB TITLE:** Social Prescribing Link Worker

**LOCATION:** St Austell Healthcare Sites

(CRHH, Wheal Northey, Park, Mevagissey and Foxhole)

**REPORTS TO:**  Head of Social Prescribing

**HOURS:** Full time / Part time

**SALARY:** Band 4

**JOB SUMMARY:**

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 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 local partners.

The post holder 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 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. 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.

**MAIN DUTIES AND RESPONSIBILITIES:**

1. Working with direct supervision by a GP and the Head of Social Prescribing, take referrals from a wide range of agencies, including PCNs’ GP practices and multi-disciplinary team 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 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.
3. Co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services.
4. 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.
5. Draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals.
6. Alongside other members of the PCN multi-disciplinary team, work collaboratively with local partners to contribute towards supporting local VCSE organisations and community groups to become sustainable, and ensure that community assets are nurtured, by sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities.
7. 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.
8. To play a key role in updating our community directory Help at Hand and leading on a certain area of the app as per instructed by the Head of Social Prescribing.
9. Assist in the delivery of lifestyle education sessions, peer support group facilitation and walking group co-ordination if the need arises.

**Key Tasks:**

The following are key tasks of the social prescribing link worker. There may be on occasions a requirement to carry out other tasks:

**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, attending relevant MDT meetings to give information and feedback on social prescribing.
* Be proactive in developing strong links with local agencies to encourage referrals, recognising what they need to be confident in the service to make appropriate referrals.
* Work in partnership with 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 the 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.
* 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, physically introduce people to community groups, activities and statutory services, ensuring they are comfortable. 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 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**

* Work with commissioners and local partners to identify unmet 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.

**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, 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.
* 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.

**Clinical Governance**

Contribute to the development and maintenance of sound clinical governance and risk management.

* Support the development/implementation on any new ways of working/policies that need to be introduced across the SAH.
* Support SAHC in operating a quality assurance but no blame culture that adheres to best practice around incident reporting and whistle blowing.

**Engagement with Patients, Internal and External Stakeholders**

* Initiate, develop and maintain excellent third party relationships e.g. with CCGs, NHSE Area Teams, sub-contractor providers, patient groups, local community health teams and other stakeholders to grow, maintain and support service and performance delivery.
* To ensure patient surveys are undertaken, analysed and action plans are developed and acted upon

**Confidentiality**

* In the course of seeking treatment, patients entrust us with, or allow us to gather, sensitive information in relation to their health and other matters. They do so in confidence and have the right to expect that staff will respect their privacy and act appropriately.
* In the performance of the duties outlined in this job description, the post-holder may have access to confidential information relating to patients and their carers, practice staff and other healthcare workers. They may also have access to information relating to the practice as a business organisation.  All such information from any source is to be regarded as strictly confidential.
* Information relating to patients, carers, colleagues, other healthcare workers or the business of the practice may only be divulged to authorised persons in accordance with the practice policies and procedures relating to confidentiality and the protection of personal and sensitive data. **All such information from any source is to be regarded as strictly confidential.**

**Equality and Diversity**

* The postholder will support the equality, diversity and rights of patients, carers and colleagues to include:
* Acting in a way that recognises the importance of people’s rights, interpreting them in a way that is consistent with practice procedures and policies and current legislation.
* Respecting the privacy, dignity, needs and beliefs of patients, carers and colleagues.
* Behaving in a manner which is welcoming to and of the individual, is non-judgemental and respects their circumstances, feelings priorities and rights.

**Personal/Professional Development**

* The postholder will participate in any training programme implemented by the practice as part of this employment, such training to include:
* Participation in an annual individual performance review, including taking responsibility for maintaining a record of own personal and/or professional development.
* Taking responsibility for own development, learning and performance and demonstrating skills and activities to others who are undertaking similar work.

**Health and Safety**

The postholder will assist in promoting and maintaining their own and others’ health, safety and security as defined in the practice health & safety policy, the practice health & safety manual and the practice infection control policy and published procedures.

**Appraisal/ Objective setting**

The post holder will participate in an annual review of their performance during the previous year and agree objectives to be met in the next year. These will be reviewed at agreed points during the year. The annual appraisal will be undertaken by the Head of Social Prescribing (line manager) and a designated GP Partner may be present.

**Communication**

The postholder should recognise the importance of effective communication within the team and will strive to:

* Communicate effectively with other team members
* Communicate effectively with patients and carers
* Recognise people’s needs for alternative methods of communication and respond accordingly.

**Quality**

The postholder will strive to maintain quality within the practice, and will:

* Alert other team members to issues of quality and risk.
* Assess own performance and take accountability for own actions, either directly or under supervision.
* Contribute to the effectiveness of the team by reflecting on own and team activities and making suggestions on ways to improve and enhance the team’s performance.
* Work effectively with individuals in other agencies to meet patients’ needs.
* Effectively manage own time, workload and resources.

**Contribution to the implementation of services**

The postholder will:

* Apply practice policies, standards and guidance.
* Discuss with other members of the team how the policies, standards and guidelines will affect own work.
* Participate in audit where appropriate

Social Media and designated other websites cannot be accessed on SAH Computers. Personal mobile phones should not be accessed during working hours.

The details contained in this Job Description are not exhaustive and may change as the post develops.

**Working hours will be for 37.5 hours/week. Set patterns can be discussed and agreed with the Head of Social Prescribing and can includes 8am-8pm Mon – Sat.**

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| **Postholder’s Signature:** |  |
| **Date:** |  |
| **Signed on behalf of St Austell Healthcare:** |  |
| **Date:** |  |

**Person Specification**

This form lists the essential and desirable requirements in order to do the job. Applicants will be shortlisted solely on the extent to which they meet these requirements.

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| **Job Title:** | **Social Prescribing Link Worker** | **Accountable To:** | **Head of Social Prescribing** | | |
| **Criteria** | | | | **Essential** | **Desirable** |
| **Personal Qualities & Attributes** | | | |  |  |
| Ability to 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 | | | | ✓ |  |
| 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 | | | | ✓ |  |
| Demonstrates personal accountability, emotional resilience and works 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 development | | | | ✓ |  |
| 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 | | | |  | ✓ |
| Coaching/counselling qualification/ experience or other relevant qualification/experience involving reflective listening skills. | | | |  | ✓ |
| 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 working for a voluntary or statutory organisation that has supported people with one or more of the following: money and welfare, housing, mental health, isolation, physical activity, bereavement, carers needs or support for elderly. | | | |  | ✓ |
| Experience of using coaching approaches/frameworks and models or other helping strategies e.g. Motivational Interviewing. | | | |  | ✓ |
| 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 providing monitoring information to assess 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 | | | | ✓ |  |
| 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 | | | | ✓ |  |
| Knowledge of motivational coaching and interview skills | | | | ✓ |  |
| Local knowledge of VCSE and community services in the locality | | | |  | ✓ |
| **Other** | | | |  |  |
| Meets DBS reference standards and has a clear criminal record, in line with the law on spent convictions | | | | ✓ |  |
| 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 own homes | | | |  | ✓ |
| Understanding of and a commitment to equality, diversity and inclusion. | | | | ✓ |  |