**Knowle West Health Park Company**

# Job Description

**Job title:** **Social Prescribing Link Worker**

**Salary:** **£28,624 (full-time equivalent, per annum)**

**Contract:** **Permanent**

**Hours:** **22.5 hours a week -** (to include Tuesdays)

**Reporting to:** **Operations Manager**

**Location:** **The Link Worker will work primarily from GP practice, with additional hot-desk space at the Knowle West Healthy Living Centre in Knowle West.**

## Purpose of the role

Social Prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'Link Workers' who are able to spend time, focus on 'what matters to me' and take a holistic approach, connecting people to community-based and community-led social, practical and emotional support, as well as statutory services. 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 aims to increase people's active involvement in their local communities. It can strengthen resilience at both a personal and community level, and it reduces health inequalities by supporting people to address the wider determinants of health, such as debt, poor housing and physical inactivity. It works particularly well for people with long-term conditions (including support for mental health), for people who are lonely or isolated, and those with complex social needs which affect their wellbeing.

## Key responsibilities

1. Take referrals for patients within the SWIFT PCN catchment area from GP practices, allied health and community professionals.
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 community groups and statutory services. The role will require you to manage and prioritise your own caseload, in accordance with the needs, priorities and any urgent support required by individuals. 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 link worker role, eg, when there is a mental health need requiring a qualified practitioner

3. Be creative in finding loneliness-busting solutions that harness assets and resources which are already available and are low cost/non funding-dependent.
4. Work with a diverse range of people and communities to draw on and increase the strengths and capacities of local communities, enabling local voluntary organisations and community groups (including faith groups) to receive social prescribing referrals.
5. 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.
6. 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.
7. Work together with local partners to collectively ensure local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.

## 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 key 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.
- Using motivational interviewing and other techniques, provide personalised information, advice and support to primary care patients and signpost or refer (with consent) individuals to appropriate activities, services and support which will help meet their needs, circumstances and preferences.

**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.
- Promote volunteering as a pathway for individuals, local opportunities and supporting the 5 ways of wellbeing.

## 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 of responsibility.

## Person Specification – Social Prescribing Link Worker

| Criteria | | Essential | Desirable |
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| **Personal qualities & attributes** | Ability to actively listen, empathise with people and provide person-centred support in a nonjudgemental way | ✓ | |
| | 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 indiiduals | ✓ | |
| | 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 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 | ✓<br>✓ | |

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| | 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 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 & 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 | ✓ | |

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| | 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 | ✓ | |
| | 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. Ability to manage all aspects of own caseload. | ✓ | |
| | 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 (including by foot, public transport and bicycle) and ability to travel across the locality on a regular basis | ✓ | |