



Social Prescribing Link Worker (Primary Care Network role)

Salary: starting at £24,336, potential to rise to £27,596 per annum (dependent on role and competencies)

Purpose

Social prescribing empowers people to take control of their health and wellbeing through referral to non-clinical social prescribing link workers. They give people time to focus on what matters most and take a holistic approach to an individual's health and wellbeing.

Social prescribing link workers in the primary care network teams:

- Take a whole population approach, working with a range of people who may benefit from social prescribing, including people who are lonely, have complex social needs, low level mental health needs and long-term conditions
- Help people to identify issues that affect their health & wellbeing, and co-produce a simple personalised care and support plan
- Support people by connecting them to non-medical, community-based activities, groups and services that meet their practical, social and emotional needs, including specialist advice services and arts and culture, physical activity, and nature and green based activities
- Use coaching and motivational interviewing techniques to support people to take control of their own health and wellbeing
- Support development of accessible and sustainable community offers by working in partnership with VCSE organisations, local authorities and others to identify gaps in provision, and take a community development approach to enabling growth in community activities and groups.

Key Responsibilities

- Take referrals from the PCNs Core Network Practices and from a wide range of agencies, including pharmacies, health and care multi-disciplinary teams (MDTs), the emergency services, legal and welfare advice services, VCSE organisations, and through self-referrals (list not exhaustive).
- Provide personalised support to individuals, their families and carers to access community-based activities and support that can help them to take control of their health and wellbeing through co-producing a simple personalised care and support plan and introducing people to appropriate activities, groups and services as described above
- Work with appropriate supervision as part of the PCN to manage and prioritise your own caseload, in accordance with needs, priorities and support required by individuals. Refer people back to other health professionals/agencies, as appropriate or necessary.
- Build ongoing relationships with local infrastructure organisations, community activities and support services to increase knowledge of the community support offer, and work collaboratively to develop effective partnership working to support the community offer to be sustainable, identifying gaps in provision, nurturing community assets and sharing intelligence on gaps or problems with commissioners and local authorities

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- Increase the strength and capacity of the community, enabling local VCSE organisations and community groups to both receive social prescribing referrals and to make referrals to social prescribing link workers.
- Educate non-clinical and clinical staff within PCN MDTs on the community support offer, how and when patients can access it, and the value of non-medical community-based interventions. This may include verbal or written advice and guidance.
- Promote social prescribing as an approach across the PCN and wider agencies, including its role in supported self-management, in addressing health inequalities and the wider determinants of health, reducing pressure on statutory services, improving access to healthcare and improving health outcomes, and in taking a holistic approach to care.

Key Tasks

- Promote social prescribing as an approach across the PCN by attending relevant MDT meetings to build relationships and developing links with local agencies
- Proactively develop strong links with local agencies to encourage appropriate referrals
- 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.
- Proactively encourage equitable participation in social prescribing through taking self-referrals and connecting with diverse local communities through a range of methods, particularly communities that statutory agencies may find hard to reach and where health inequalities are most prevalent.
- Meet people on a one-to-one basis, making home visits and visits to community organisation where appropriate and within organisations' policies and procedures.
- Use appropriate judgement to ascertain the number and length of sessions required, responding to the needs of the individual and their circumstances, for approximately 6-12 contacts over 3 months.
- Give people time to tell their stories and focus on the question, 'what matters to me'?
- Build trust and respect with the person, providing non-judgemental and non-discriminatory support, taking a strength-based approach that focuses on a person's assets.
- Work with the person, their families and carers and consider how they can all be supported through social prescribing.
- 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 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
- Provide information on what people can do from the groups, activities and services they are being connected to
- Provide information on what the person can do for themselves to improve their health and wellbeing

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- Physically introduce people to appropriate community groups and activities, peer support groups, or statutory services, ensuring they are comfortable, feel valued and respected.
- Provide follow up support to the person to ensure they are happy, able to engage, feel included and that they are receiving good support.
- Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards
- 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 safeguarding concerns and follow PCN safeguarding policies around reporting and/or escalating concerns
- Seek advice and support from the GP supervisor and/or identified individual(s) to discuss concerns outside the scope of the social prescribing link worker's practice and make appropriate onward referrals
- Develop supportive relationships with local VCSE organisations, community groups and statutory services, to understand their offer and make timely, appropriate and supported referrals
- Create strong links with local agencies to utilise existing networks and build on existing provision
- Work collectively with all local partners to ensure community groups are accessible and sustainable
- Work with commissioners and local partners to identify and share information on unmet diverse needs within the community and gaps in community provision
- Support development of community groups and assets who promote diversity and inclusion
- Encourage people who have been connected to community support through social prescribing to volunteer or to start their own activities and groups
- Support existing local volunteering schemes to strengthen community resilience and explore potential to develop a team of volunteers to provide 'buddying support', peer support or to start new community-based groups or activities.
- Support referral agencies to provide appropriate information about the person they are referring, including demographic data and data on wider determinants, for example, caring status.
- Provide appropriate and timely feedback to referral agencies about the people they referred.
- Work sensitively with people, their families and carers to capture key information to measure impact of social prescribing on their health and wellbeing, using validated tools determined locally such as the ONS4 wellbeing scale to assess need and measure outcomes.
- Encourage people, their families and carers to provide feedback on their experience, for

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example, through patient satisfaction surveys, and to share their stories about the impact of social prescribing on their lives.

- Ensure that social prescribing referral SNOMED codes are coded appropriately into clinical systems (as outlined in the Network Contract DES)
- Adhere to PCN policies around data protection legislation and data sharing agreements, ensuring people give appropriate consent.
- Work with a supervisor and/or line manager to undertake continual personal and professional development in line with the social prescribing Workforce Development Framework Competency Framework
- Work with your supervising GP and/or line manager to access regular 'clinical'/non-managerial supervision
- Take an active role in reflecting, reviewing and developing professional knowledge, skills and behaviours
- Attend appropriate mandatory training before working with people and be aware of own competence, maintaining boundaries around scope of practice and referring onwards for people whose needs fall outside of these boundaries
- Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, equality, diversity and inclusion training and health and safety.
- Work as part of the MDT to seek feedback, continually improve the service, and contribute to service planning.
- Contribute to the development of policies and plans relating to equality, diversity and inclusion, accessibility, 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
Personal qualities & attributes	Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental 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, adapting to individual levels of activation and health literacy	✓	

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	Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders, adapting communication styles accordingly	✓	
	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	✓	
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	✓	
	Ability to maintain effective working relationships and to promote collaborative practice with all colleagues	✓	
	Ability to work flexibly and enthusiastically within a team or on own initiative	✓	
		Knowledge of, and ability to work to, policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety	✓
	Have 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 role – for example, when there is a mental health need requiring a qualified practitioner	✓	
Skills and knowledge	Knowledge of the personalised care approach. Utilises the evidence base for social prescribing interventions and activities.	✓	

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	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 including asset-based community development and community resilience	✓	
	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		✓
	Knowledge of how the NHS works, including primary care and MDT working		✓
	Able to work from an asset-based approach, building on existing community and personal assets	✓	
	Understanding of the needs of small volunteer-led community groups and ability to contribute to supporting their development	✓	
	Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines	✓	
	High level of written and oral communication skills	✓	
	Confidently approaches difficult conversations	✓	
	Able to provide motivational coaching to support people's behaviour change	✓	
Other	Meets DBS reference standards and criminal record checks	✓	
	Willingness to work flexible hours when required to meet work demands	✓	
	Access to transport and ability to travel across the locality on a regular basis, including to visit people in their own homes and support people to attend activities as appropriate.	✓	

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