

**JOB DESCRIPTION**

|  |  |
| --- | --- |
| **Job Title:** | **Social Prescribing Link Worker** |
| **Salary:** | £30,050.00 per annum FTE |
| **Hours of Work:** | 18.75 -30 hours per week  Inclusive of 8 EAS (extended access hours) per week of evening and/ or weekend. |
| **Responsible to:** | Social Prescribing Manager |
| **Based at:** | Ann Owens Centre Barnet GP Practices PCN2  Oak Lane Health Centre, 280 Oakleigh Rd, N2 0DH  East Finchley  London N2 8LT  Hybrid Remote Working |
| **Website:** | www.ageukbarnet.org.uk |

**Purpose of the role.**

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 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. The Social Prescribing Link Worker will hold a case load of clients for the main service as well as support social prescribing related projects delivered across the Primary Care Network. The project support aspect of the role will vary throughout the year and the case work will be tailored to the capacity available in line with the demands of the various projects ongoing. This role will require the individual to work 8 hours per week within the extended access service. Therefore, some hours will be required to work in the evening and / or a weekend.

Age UK Barnet is the commissioned provider for Social Prescribing with Primary Care Network 2 in Barnet, for an all-age service working as part of a specialist multidisciplinary team including GPs and nurses supporting those with complex needs. The Link Workers will focus on providing support for patients’ non-medical needs. These needs are often complex, and many patients referred to the service are frequent visitors to primary care, in particular their GP. The service is for adults over the age of 18 whose needs meet referral criteria. Link Workers will be employed by Age UK Barnet as the contract holder but expected to develop strong relationships with a wide range of local providers whose services

**Key responsibilities**

1. Social Prescribers take referrals from the PCNs, and GP practice staff and provide personalised support to individuals, to take control of their health and wellbeing, live independently and improve their health outcomes.
2. The Social Prescriber will support the delivery of projects that fall within the remit of social prescribing delivered through the primary care network throughout the year. These projects will vary on duration, demand and themes to support specific cohorts of patients across the PCN. The social prescribing case load may be paused or expected to be continued alongside the projects depending on the demand of the project.
3. 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 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. 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**

**1.** **Promote social prescribing within Networks**

• 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.

• Support PCN efforts 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.

• Contribute to programmes and projects gaining regular feedback about the quality of service and impact of social prescribing on referral agencies.

**2. Provide personalised support**

• Provide one to one support to clients, giving them time to tell their stories and focus on ‘what matters to me’. Build a rapport with the person, providing non-judgmental support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on the person’s assets.

• Help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities.

• 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.

Follow up to ensure they are happy, able to engage, included and receiving good support.

**3**. **Support community groups and VCSE organisations to receive referrals**

• Work with the support of Age UK Barnet and the PCN to forge strong links with 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.

**4. Support collective work with local partners to ensure community groups are strong and sustainable**

• Contribute information to help PCN, commissioners and local partners identify unmet needs within the community and gaps in community provision.

**Miscellaneous**

• The post holder must always carry out duties and responsibilities with due regard to the organisations equal opportunity policies and procedures.

• Work as part of the PCN healthcare team to seek feedback, continually improve the service and contribute to service improvement and business development.

• 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.

• The post holder must always respect patient confidentiality and, in particular, the confidentiality of electronically stored personal data in line with the requirements of the General Data Protection Regulation (GDPR).

• The post holder will be expected to take responsibility for self-development on a continuous basis, undertaking on-the-job training as required.

• The post holder must be aware of individual responsibilities under the Health and Safety at Work Act and identify and report as necessary any untoward accident incident or potentially hazardous environment.

• The post holder will ensure they accurately represent the PCN and ensure the values of the PCN are always upheld in carrying out their work

• The post holder will work as part of a team and provide cover for absent colleagues.

• The post holder will be expected to be on a rota for weekend working (with full staffing levels this will be approximately once every 8 weeks)

• The post holder may be required to undertake duties at any location within the Borough of Barnet, in order to meet service needs.

• The post holder must always work in general accordance with the organisation’s policies and guidelines.

• The post holder must always adhere to the organisation’s information governance policy, in particular ensuring that there is no breach of confidentiality as a result of his/her actions.

**Equal Opportunities:**

The organisation operates an equal opportunities policy and expects staff to have a commitment to equal opportunities policies in relation to employment and service delivery.

**Performance Management**

Example numerical indicators include:

1. Numbers of patients benefiting from services

2. Service response times achieved

3. Number of users reporting improved outcomes

4. User perception of quality/usefulness/responsiveness of service

This job description is intended as a basic guide to the scope and responsibilities of the post and is not exhaustive. It will be subject to regular review and amendment as necessary in consultation with the post holder.