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 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 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 and reduces health and wellbeing inequalities by addressing the wider determinants of health, such as debt, poor housing, physical inactivity and isolation, 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.

Key responsibilities

Please note that some of the duties and responsibilities will be amended due to the impact of COVID-19; particularly around the way we engage with clients and colleagues.

1. Working with direct supervision by a GP, 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. As a key member of the PCN multi-disciplinary team; provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health outcomes. 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, and where appropriate, introducing or reconnecting people to community groups and statutory services. Manage and prioritise a caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. It is vital to have a strong awareness and understanding of when it is appropriate or necessary to refer people 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.

3. Draw on, and increase the strengths and capacities of, local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals, supporting them to use the Cornwall Link as a resource.

4. Alongside other members of the PCN multi-disciplinary team, work collaboratively with local partners and colleagues delivering other services on behalf of Age UK Cornwall, to contribute towards supporting the local VCSE organisations and community groups to become sustainable and nurture community assets. 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, guidance and reference to Cornwall Link.

Key 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 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 outcomes and enable a holistic approach to wellbeing.
- 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 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 life 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, utilising the Cornwall Link.
- 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 the 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 the 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 the supervising GP to access regular 'clinical supervision', to be able to deal effectively with the difficult issues that people present.

Miscellaneous

- Provide management support for Age UK Cornwall volunteers and staff involved in the delivery of social prescribing in the area, as this work develops.
- 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.

Job context

This post is subject to a satisfactory Enhanced Disclosure and Barring Service (DBS) check with Adult Barred list check.

Travel is an essential part of the role; the post-holder will therefore be required to travel independently to various day service venues in order to fulfil the requirements of the role.

The postholder will be required to adhere to the organisations Code of Conduct and demonstrate commitment to our organisational values.

Our goal is inspiring individuals and communities to age well. We recognise that each person is an individual and we put them and their lifestyle needs at the forefront of all that we do. We believe that, by enabling a person to live the life they want, to the best of their abilities, using their own motivation to achieve their chosen lifestyle, they will attain a greater sense of well-being. This, in turn, is shown to have a positive impact on their health, reducing their dependency on formal health and social care, and helping them feel more connected to the people and activities in their local community.

Every volunteer and staff member within Age UK Cornwall & The Isles of Scilly is expected to uphold and promote these values in every aspect of their role, positively influencing and challenging attitudes and practice to enable others to adopt the same values.

Hours of work
As advertised. The post-holder is required to demonstrate reasonable flexibility potentially, with notice, working out of hours, weekend or evenings.

Salary £25,969 pro rata per annum

Office base
As advertised, with the requirement to work at different locations and venues in Cornwall and The Isles of Scilly.

Duration Fixed term contract for 1 year from start date

The above description is correct as of May 2022. The post-holder is expected to undertake duties relevant to the role, some of which may develop and change over time. Therefore, this job description will periodically be reviewed and amended in consultation with the post holder.

Signed ..... Date .....

Competencies, skills and experience

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 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 to other health professionals/agencies, when the persons needs are beyond the scope of the link worker role	✓	
	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 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		✓
	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 & 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	✓	
	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 own homes	✓	