**Job Description**

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| **Job Title:** | **Social Prescribing Link Worker** |
| **Salary:** | £24,000 per annum + organisational pension scheme/benefits |
| **Hours:** | Full time – 35 hours (part time also considered). |
| **Days and Times:** | Monday to Friday, 9am - 5pm |
| **Employed by:** | A member of Harrow Community Action (to be confirmed) |
| **Responsible to:** | Employing organisation, Social Prescribing Manager and Primary Care Network Lead |
| **Responsible for:** | Providing social prescribing interventions working with a specific Primary Care Network in Harrow |
| **Main Location:** | To be confirmed, within the London borough of Harrow |
| **Status:** | Permanent |

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|  | **Main Purpose of the Job** |



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| **1.0** | **Key responsibilities** |

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| 1.1 | | Working with direct supervision from the host charity service manager, take referrals from a wide range of agencies, including PCNs’ GP practices and multi-disciplinary team in 2019/20 and from 2020/21: pharmacies, wider multi-disciplinary teams, hospital discharge teams, social care services. | | |
| 1.2 | | 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. Co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services. 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. | | |
| 1.3 | | Draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. | | |
| 1.4  1.5  1.6 | | Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local 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.  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.  Adhere to the HCA service quality assurance framework and guidance from the service manager | | |
| **2.0** | | **Key Tasks** | | |
| 2.1 | | **Referrals**  Promote social prescribing, its role in self-management, and the wider determinants of health. |
| 2.2 | | Contribute to the single point of access (SPA) rota to triage assess clients in accordance with service guidelines |
| 2.3 | | 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. |
| 2.4 | | 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. |
| 2.5 | | 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 care. |
| 2.6 | | Provide referral agencies with regular updates about social prescribing, including training for their staff and how to access information to encourage appropriate referrals. |
| 2.7  2.8  2.9  2.10  2.11  2.12  2.13  2.14  2.15  2.16  2.17  2.18  2.19  2.20  2.21  2.22  2.23  2.24 | | 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 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 motivation – 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 social prescribing manager or health colleagues 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. |

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| **3.0** | **General Tasks** |

**Data Capture**

3.1 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.

3.2 To undertake client assessments, including visiting clients in their home environment and using the PAM (Patient Activation Measure) assessment tool for which full training will be given

3.3 To ensure data is captured to populate and update the local directory of resources in accordance with service protocols, undertaking external service engagement and mapping within your assigned service area to establish new referral partners.

3.4 Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.

3.5 Support referral agencies to provide appropriate information about the person they are referring. Provide appropriate feedback to referral agencies about the people they referred.

3.6 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**

3.7 Work with your line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities attending 1-1 non line mgmt. supervision meetings with service manager and PCN social prescribing lead as required

3.8 Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.

3.9 Work with your line manager and PCN to access regular ‘clinical supervision’, to enable you to deal effectively with the difficult issues that people present.

**Miscellaneous**

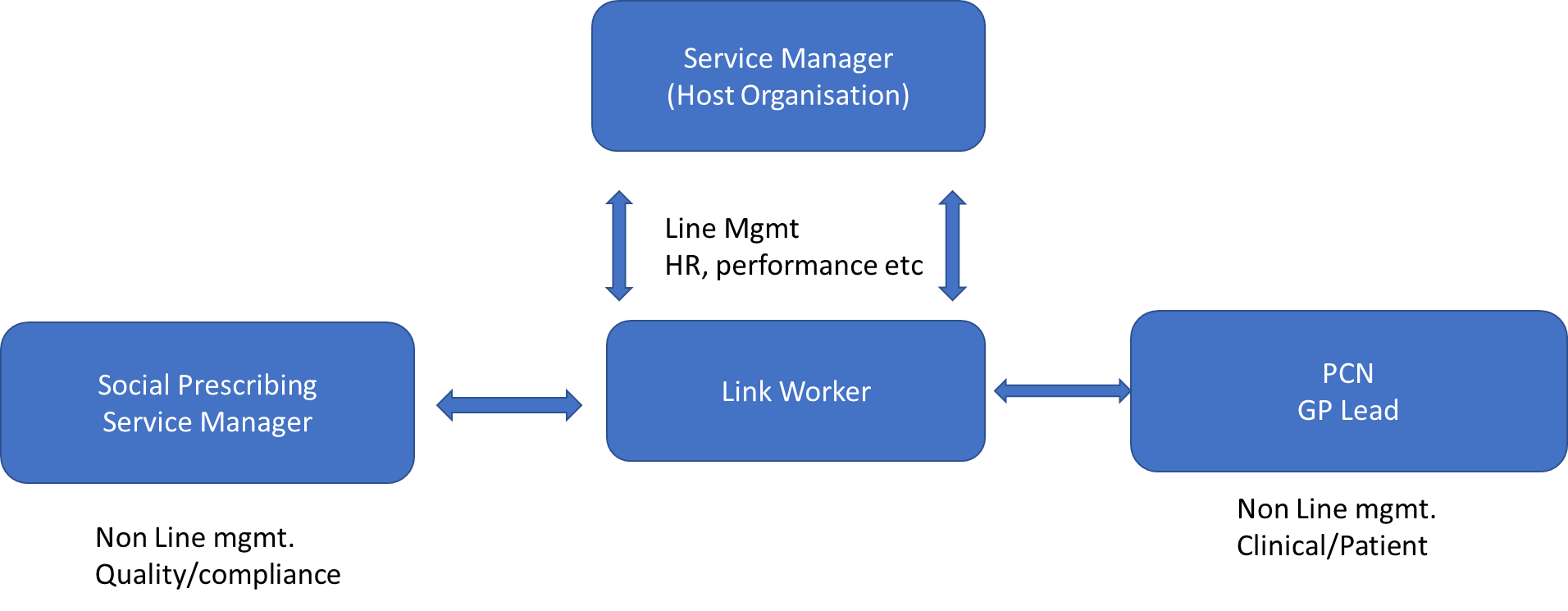
3.10 Work as part of the healthcare team to seek feedback, continually improve the service and contribute to business planning.

3.11 Undertake any tasks consistent with the level of the post and the scope of the role, including mutual cover arrangements for leave, ensuring that work is delivered in a timely and effective manner.

3.12 Duties may vary from time to time, without changing the general character of the post or the level of responsibility.

3.13 To ensure all activities are carried out in harmony with Harrow Community Actions vision and within the spirit of its equal opportunities policy and to abide by the employing organisations policies on Safeguarding, Equality & Diversity, Health & Safety and Confidentiality.

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| **4.0** | **Accountability structure** |



**Age UK HHB is hosting the recruitment process on behalf of Harrow Community Action. It should be noted that successful candidates will be part of a multidisciplinary team and could be hosted/employed by one of a number of Harrow based organisations who are collaborating to deliver this service.**

**Person Specification**

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| **Personal qualities & attributes** | |
| **Essential Criteria** | **Desirable Criteria** |
| 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 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 |  |
| 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 |  |

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| **Qualifications & training** | |
| **Essential Criteria** | **Desirable Criteria** |
| 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 |

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| **Experience** | |
| **Essential Criteria** | **Desirable Criteria** |
| 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 |  |

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| **Skills and Knowledge** | |
| **Essential Criteria** | **Desirable Criteria** |
| 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 Harrow |
|  | Knowledge of how the NHS works, including primary care |

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| **Other** | |
| **Essential Criteria** | **Desirable Criteria** |
| 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 |  |