Job Description

Job Title:	Social Prescribing Link Worker
Salary:	£24,000 per annum + organisational pension scheme/benefits
Hours:	Full time – 35 hours
Days and Times:	Monday to Friday, 9am - 5pm
Employed by:	Age UK Hillingdon, Harrow & Brent
Responsible to:	Social Prescribing Manager and Primary Care Network Lead
Responsible for:	Providing social prescribing interventions working with Harrow Collaborative Primary Care Network
Main Location:	GP practices in Harrow (currently home-based)
Status:	Permanent

Main Purpose of the Job

This is a new service designed in accordance with NHS England guidance released in 2019. This service is delivered through a voluntary sector consortium model whereby the Social Prescribing Link Workers are hosted by consortium member organisations. The model is supported be a new digital provider commissioned by Public Health Harrow. The service is over seen by Social Prescribing Board under the umbrella of the Harrow Integrated Care Partnership.

Social prescribing empowers people to take control of their health and wellbeing through referral to 'Link Workers' who give time, focus on 'What Matter to Me' and take a holistic approach 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 can help Primary Care Networks (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.

1.0 Key responsibilities

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: 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 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.

1.5 Social Prescribing Link Workers (SPLWs) 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.

1.6 Adhere to the HCA service quality assurance framework and guidance from the service manager

2.0 Key Tasks

Referrals

2.1 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 Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.

2.8 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

2.9 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.

2.10 Be a friendly source of information about health, wellbeing and prevention approaches.

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

2.12 Work with the person, their families and carers and consider how they can all be supported through social prescribing.

2.13 Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.

2.14 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.

2.15 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.

2.16 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.

2.17 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

2.18 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.

2.19 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

2.20 Work with commissioners and local partners to identify unmet needs within the community and gaps in community provision.

2.21 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.

2.22 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.

2.23 Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.

2.24 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.

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

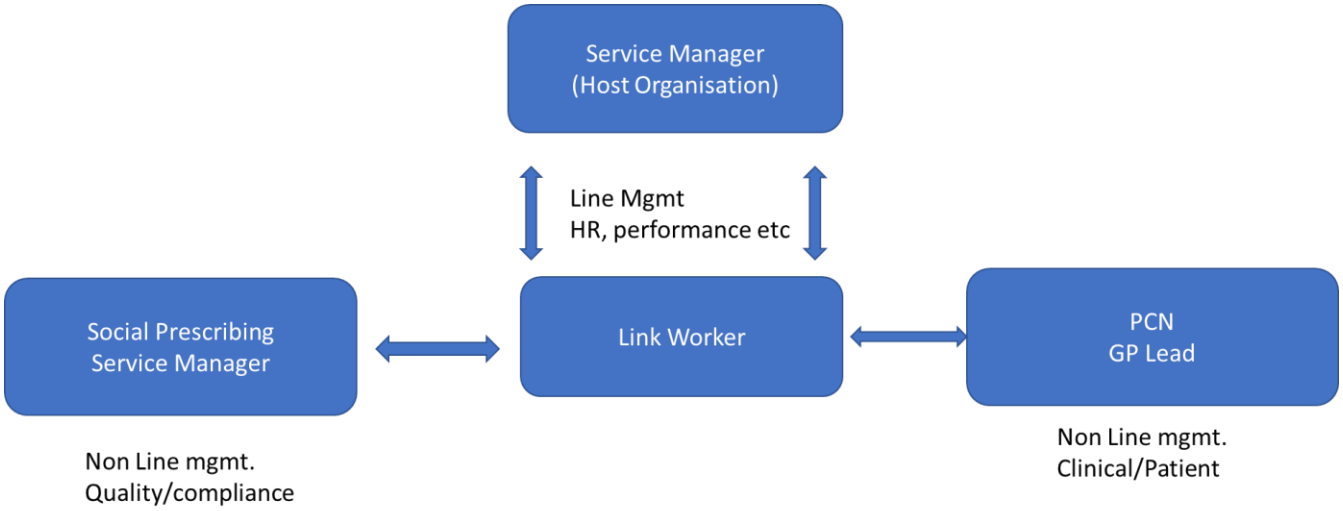
3.10 Work as part of the healthcare team to seek feedback, continually improve the service and contribute to business planning.

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.

4.0 Accountability structure



Age UK HHB is hosting the recruitment process on behalf of Harrow Community Action. It should be noted that successful candidate will be part of a multidisciplinary team and will be hosted/employed by Age UK HHB.