JOB DESCRIPTION & PERSON SPECIFICATION

Job title:	Social Prescribing Link Worker
Hours:	37.5
Pay:	£24000
Location:	**Peterborough 1 PNC covering**: Ailsworth Medical Centre; Botolph Bridge Community Health centre; Dogsthorpe Medical Centre; Orton Bushfield Medical Practice; The Grange Medical Centre; Thorpe Road Surgery; Welland Medical Practice; Westwood Clinic **Practice you will be based:** Nightingale Medical Centre
Reports to:	PCN Clinical Director
Line manager for:	N/A
Contract Type:	1 Year fixed term with an opportunity to become permanent if successful.

Summary of main job purpose:	Purpose of the role Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'link workers' who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers 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 to strengthen community resilience and personal resilience and reduces health 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.

Key responsibilities

1. Take referrals from a wide range of agencies, working with GP practices within primary care networks, pharmacies, 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. Provide personalised support to individuals, their families and carers to take control of their 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 personalised 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 choose an item 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 needs is 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. Ensure they are supported, have basic safeguarding processes for vulnerable individuals and can provide opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence.
4. Work together with all local partners to collectively ensure that local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.

Key Tasks

Referrals

• Promoting social prescribing, its role in self-management, and the wider determinants of health.
• Build relationships with key staff in GP practices within the local Primary Care Network (PCN), attending relevant meetings, becoming part of the wider network team, 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 care.
• 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 wellbeing and prevention approaches. Choose an item.
• 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 – 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.

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 map or menu of community groups and assets. Use these opportunities to promote micro-commissioning or small grants if available.
• Develop supportive relationships with local VCSE organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.
• Ensure that local community groups and VCSE organisations being referred to have basic procedures in place for ensuring that vulnerable individuals are safe and, where there are safeguarding concerns, work with all partners to deal appropriately with issues. Where such policies and procedures are not in place, support groups to work towards this standard before referrals are made to them.
• Check that community groups and VCSE organisations meet in insured premises and that health and safety requirements are in place. Where such policies and procedures are not in place, support groups to work towards this standard before referrals are made to them.
• Support local groups to act in accordance with information governance policies and procedures, ensuring compliance with the Data Protection Act 2018.

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.
• Support local partners and commissioners to develop new groups and services where needed, through small grants for community groups, micro-commissioning and development support.
Choose an item.
• Encourage people who have been connected to community support through social prescribing to volunteer and give their time freely to others, in order to build their skills and confidence, and strengthen 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.

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. Use the case management system to track the person's progress. Provide appropriate feedback to referral agencies about the people they referred.
• Work closely with GP practices within the PCN to ensure that social prescribing referral codes are inputted to our clinical system and that the person's use of the NHS can be tracked, adhering to data protection legislation and data sharing agreements with the clinical commissioning group (CCG).

Professional development

• Work with your line manager 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 your line manager to access regular 'clinical supervision', to enable you to deal effectively with the difficult issues that people present.

Miscellaneous
• Work as part of the 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.
Choose an item.

Any special conditions

Hours: You will work a 37.5 hour week, Monday to Friday, using flexi-time (there is no overtime payment). You will arrange your hours to suit the workload, mostly during normal office hours, but occasionally evening or weekend work is required for activities such as meeting community groups or attending events.

DBS: A satisfactory enhanced level Disclosure & Barring Service check.

References: Two satisfactory references

Driving: You will be required to use your own car for work, and to be insured accordingly. A mileage allowance (45p per mile) will be paid for essential travel in connection with work from your main base

PERSON SPECIFICATION

Job title:	Social Prescribing Link Worker
Qualifications & Training	**Essential criteria** 1. NVQ Level 3, Advanced level or equivalent qualifications or working towards 2. Demonstrable commitment to professional and personal development
	Desirable criteria 1. Training in motivational coaching and interviewing, strength based questioning or equivalent experience
Experience	**Essential criteria** 1. Experience of working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work) 2. Experience of supporting people, their families and carers in a related role (including unpaid work) 3. Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups 4. Experience of partnership/collaborative working and of building relationships across a variety of organisations 5. Experience of volunteering or working with volunteers
	Desirable criteria 1. Experience of supervising volunteers. 2. Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity

	3. Experience of data collection and using tools to measure the impact of services
Knowledge	**Essential criteria** 1. Knowledge of the personalised care approach 2. Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities, individuals, their families and carers 3. Knowledge of community development approaches 4. Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports 5. Knowledge of how the NHS, voluntary and statutory sector works, including primary care
	Desirable criteria 1. Local knowledge of VCSE and community services in the locality 2. Work with groups or committees.
Skills	**Essential criteria** 1. Can organise and prioritise own work. 2. Good social skills in formal and informal settings, maintaining ethical and organisational norms. 3. Presents information effectively (informative, interesting and persuasive) to a range of audiences 4. Can solve practical problems and deal with a range of variables 5. Can influence and motivate people
	Desirable criteria 1. Use of System One, similar customer record management (CRM) software
Aptitude & characteristics	**Essential criteria** 1. Enthusiastic about supporting individuals and communities. Committed to equality and social inclusion. 2. Able to support people in a way that inspires trust and confidence, motivating others to reach their potential 3. Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders 4. Able to work from an asset-based approach, building on existing community and personal assets. 5. Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental way 6. Commitment to reducing health inequalities and proactively working to reach people from all communities 7. Ability to maintain effective working relationships and to promote collaborative practice with all colleagues 8. Ability to identify risk and assess/manage risk when working with individuals 9. Can demonstrate personal accountability, emotional resilience and ability to work well under pressure

	10. Accepts direction, but uses initiative and prioritises work effectively. 11. Dependable and a good time-keeper. 12. Able to prioritise competing activities. 13. 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 14. Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines 15. Knowledge of, and ability to work to, policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety