Solihull Healthcare Partnership	**Document ID:**	HR03-03
	Issue Date:	24th June 2026
	Revision:	1.2
Job Description & Person Specification	**Approved by:**	HR

Job Title:	PCN Social Prescribing Link Worker
Reporting To:	Head of Clinical Services
Direct Reports:	Clinical Director
Hour per week:	37.5
Salary:	Depending on Experience

1. Job Role / Purpose:

Join Solihull Healthcare Partnership — Where Your Work Truly Matters

Solihull Healthcare Partnership (SHP) is more than a GP organisation. We are a community of people driven by a shared purpose: to deliver exceptional, person-centred care to over **56,000 patients** across Solihull and Shirley. Working from seven local surgeries, we bring together the best of traditional general practice with the innovation, resilience, and opportunity of a modern, forward-thinking partnership.

Every member of our team ranging from clinical, operational, administrative, and managerial plays a vital role in shaping the future of primary care. Supported by a central team covering HR, IT, finance, governance and communications, our practice teams are empowered to focus on what matters most: delivering compassionate, high-quality care that changes lives.

We believe that General Practice is the heart of the NHS, and we are committed to evolving, improving, and transforming the way care is delivered in our neighbourhood. If you want to be part of an organisation that values your contribution, invests in your growth, and encourages you to make a meaningful impact, SHP is the place to build your career.

Purpose of the Role

Social prescribing is a vital and growing part of modern primary care. Within Primary Care Networks (PCNs), it offers a holistic, person-centred approach that recognises the powerful impact of social, emotional, and practical factors on health. By connecting people to meaningful community-based support, Social Prescribing Link Workers help individuals take control of their wellbeing while reducing pressure on GP services and strengthening the resilience of the wider health system.

Why Social Prescribing Matters at SHP

- **Tackles Wider Determinants of Health** — Addressing issues such as debt, housing, loneliness, and low-level mental health needs helps improve long-term wellbeing, not just symptoms.
- **Relieves GP Workload** — Link Workers provide dedicated time and continuity for patients with complex social needs, enabling clinicians to focus on medical care.
- **Delivers Strong Social Value** — Evidence shows significant Social Return on Investment through reduced A&E attendances, hospital admissions, and GP appointments.
- **Reduces Health Inequalities** — Social prescribing supports the NHS Core20PLUS5 approach by reaching vulnerable, marginalised, and underserved groups.

What Social Prescribing Link Workers Do

- **Take a whole-population approach** — Supporting people who may be lonely, have complex social needs, low-level mental health concerns, or long-term conditions.
- **Co-produce personalised care plans** — Helping individuals identify what matters to them and shaping simple, achievable wellbeing goals.
- **Connect people to community support** — Linking patients to practical, social, and emotional support including advice services, arts and culture, physical activity, nature-based activities and more.
- **Use coaching and motivational interviewing** — Empowering people to build confidence, take control and make sustainable changes.

- **Strengthen community capacity** — Working with VCSE partners, local authorities and community groups to identify gaps, develop new offers and support long-term sustainability.

2. Key Duties & Responsibilities:

Key responsibilities

- Take referrals from the PCN patients and from a wide range of agencies, including pharmacies, health and care multi-disciplinary teams (MDTs), the emergency services, legal and welfare advice services, VCSE organisations, and through self-referrals (list not exhaustive).
- Provide personalised support to individuals, their families and carers to access community-based activities and support that can help them to take control of their health and wellbeing through co-producing a simple personalised care and support plan and introducing people to appropriate activities, groups and services as described above.
- Work with appropriate supervision as part of the PCN to manage and prioritise your own caseload, in accordance with needs, priorities and support required by individuals. Refer people back to other health professionals/agencies, as appropriate or necessary.
- Build ongoing relationships with local infrastructure organisations, community activities, and support services to increase knowledge of the community support offer, and work collaboratively to develop effective partnership working to support the community offer to be sustainable, identifying gaps in provision, nurturing community assets and sharing intelligence on gaps or problems with commissioners and local authorities
- Increase the strength and capacity of the community, enabling local VCSE organisations and community groups to both receive social prescribing referrals and to make referrals to social prescribing link workers.
- Educate non-clinical and clinical staff within PCN MDTs on the community support offer, how and when patients can access it, and the value of non-medical community-based interventions.

This may include verbal or written advice and guidance.

- Promote social prescribing as an approach across the PCN and wider agencies, including its role in supported self-management, in addressing health inequalities and the wider determinants of health, reducing pressure on statutory services, improving access to healthcare and improving health outcomes, and in taking a holistic approach to care.

Key Tasks

Referrals

- Promote social prescribing as an approach across the PCN by attending relevant MDT meetings to build relationships and developing links with local agencies.
- Proactively develop strong links with local agencies to encourage appropriate referrals
- 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.
- Proactively encourage equitable participation in social prescribing through taking self-referrals and connecting with diverse local communities through a range of methods, particularly communities that statutory agencies may find hard to reach and where health inequalities are most prevalent.

Provide personalised support.

- Meet people on a one-to-one basis, making home visits and visits to community organisation where appropriate and within organisations' policies and procedures.
- Use appropriate judgement to ascertain the number and length of sessions required, responding to the needs of the individual and their circumstances, for 6-10 contacts over 3 months.
- Give people time to tell their stories and focus on the question, 'what matters to me'?
- Build trust and respect with the person, providing non-judgemental and non-discriminatory support, taking a strength-based approach that focuses on a person's assets.
- Work with the person, their families and carers and consider how they can all be supported through social prescribing.
- 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 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, cultural and religious/faith needs, and motivations.

- Provide information on what people can from the groups, activities, and services they are being connected to
- Provide information on what the person can do for themselves to improve their health and wellbeing.
- Physically introduce people to appropriate community groups and activities, peer support groups, or statutory services, ensuring they are comfortable, feel valued and respected.
- Provide follow up support to the person to ensure they are happy, able to engage, feel included and that they are receiving good support.
- Help people maintain or regain independence through living skills, adaptations, enablement approaches, and simple safeguards.
- 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 safeguarding concerns and follow PCN safeguarding policies around reporting and/or escalating concerns.
- Seek advice and support from the GP supervisor and/or identified individual(s) to discuss concerns outside the scope of the social prescribing link worker's practice and make appropriate onward referrals.

Supporting the community offer

- Develop supportive relationships with local VCSE organisations, community groups, and statutory services, to understand their offer and make timely, appropriate, and supported referrals.
- Create strong links with local agencies to use existing networks and build on existing provision.
- Collaborate collectively with all local partners to ensure community groups are accessible and sustainable.
- Collaborate with commissioners and local partners to identify and share information on unmet

diverse needs within the community and gaps in community provision.

- Support development of community groups and assets who promote diversity and inclusion.
- Encourage people who have been connected to community support through social prescribing to volunteer or to start their own activities and groups.
- Support existing local volunteering schemes to strengthen community resilience and explore potential to develop a team of volunteers to provide 'buddying support,' peer support or to start new community-based groups or activities.

Data capture

- Support referral agencies to provide appropriate information about the person they are referring, including demographic data and data on wider determinants, for example, caring status.
- Provide appropriate and timely feedback to referral agencies about the people they referred.
- Collaborate sensitively with people, their families, and carers to capture key information to measure impact of social prescribing on their health and wellbeing, using validated tools determined locally such as the ONS4 wellbeing scale to assess need and measure outcomes.
- Encourage people, their families, and carers to provide feedback on their experience, for example, through patient satisfaction surveys, and to share their stories about the impact of social prescribing on their lives.
- Ensure that social prescribing referral SNOMED codes are coded appropriately into clinical systems (as outlined in the Network Contract DES)
- Adhere to PCN policies around data protection legislation and data sharing agreements, ensuring people give appropriate consent.

Continuing professional development

- Collaborate with a supervisor and/or line manager to undertake continual personal and professional development in line with the social prescribing Workforce Development Framework Competency Framework
- Work with your supervising GP and/or line manager to access regular 'clinical'/non-managerial supervision.
- Take an active role in reflecting, reviewing, and developing professional knowledge, skills, and behaviours.

- Attend appropriate mandatory training before working with people and be aware of own competence, maintaining boundaries around scope of practice and referring onwards for people whose needs fall outside of these boundaries.
- Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, equality, diversity and inclusion training, health, and safety.

Miscellaneous

- Work as part of the MDT to seek feedback, continually improve the service,and contribute to service planning.
- Contribute to the development of policies and plans relating to equality, diversity and inclusion, accessibility, and health inequalities.
- 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.

3. Other Responsibilities

Health and Safety

- To comply with the Health and Safety at Work etc. Act 1974.
- To take responsibility for their own health and safety and that of other persons who may be affected by their own acts or omissions.

Equality and Diversity

- To carry out at all times their responsibilities in line with Equal Opportunities Policy and Procedure.

Risk Management and Clinical Governance

- To work within the Clinical Governance Framework of the practice, incorporating Risk Management and all other quality initiatives and all aspects of CQC implementation.

Confidentiality

- To maintain confidentiality of information relating to patients, clients, staff and other users of the services in accordance with the General Data Protection Regulations 2018 including outside of the work environment. Any breach of confidentiality may render an individual liable for dismissal and/or prosecution.

Safeguarding

- Whilst in post, staff are expected to acquire and update their knowledge on safeguarding as per the intercollegiate document requirements and SHP policies.

Professional development

- The post holder will participate in any training programme implemented by the practice as part of this employment
- To participate in an annual individual performance review, including taking responsibility for maintaining a record of own personal and/or professional development

General

- To undertake any other duties commensurate with the role, within the bounds of their own competence as guided by the attached management framework.
- To work across the various SHP sites as required.
- In light of national policy and due to the needs of the business it may be necessary for the Partnership to alter the opening hours of the surgeries. This could incorporate different opening hours and weekend working which may affect when you are required to work. The post holder is expected to be flexible and accommodating, following consultation, in terms of any changes to operating times in the future.

SHP Vision Statement: To be the most respected Primary Care provider in the Birmingham and Solihull Region.

Mission Statement:
Sustainable Primary Care services that meet the needs of our patients and commissioners.
Have a united, strong and financially viable organisation.
Practice of choice for our patients and the employer of choice for our people.

Solihull Healthcare Partnership	**Document ID:**	HR03-03
	Issue Date:	24th June 2026
	Revision:	1.2
Job Description & Person Specification	**Approved by:**	HR

PERSON SPECIFICATION

Qualifications	**Essential**	**Desirable**
Qualifications	**Essential**	**Desirable**
To have a Level 3 qualification (e.g., A level or other equivalent post-16 education). Or, when the SPLW does not have a Level 3 qualification, they are to be enrolled in or undertaking appropriate training or an apprenticeship to obtain a Level 3 occupational standard, accredited by the Personalized Care Institute for SPLW with consideration given to the Workforce Development Framework for SPLW	✓	
Has completed the NHS England SPLW eLFH online learning programme	✓	
Demonstrable commitment to professional and personal development	✓	
Attends the peer support networks run by NHS England and NHS Improvement at ICS and/or STP level	✓	
Training in motivational coaching and interviewing or equivalent experience		✓
Experience	**Essential**	**Desirable**
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 working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups	✓	
Experience of partnership/collaborative working and of building relationships across a variety of organisations	✓	
Experience of supporting people with their mental health, either in a paid, unpaid, or informal capacity		✓
Experience of data collection and providing monitoring information to assess the impact of services		✓
Experience of working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work)		✓
Knowledge and skills	**Essential**	**Desirable**
Understanding of the wider determinants of health, including social, economic, and environmental factors and their impact on communities	✓	
Knowledge of community development approaches	✓	
Clear, polite telephone manner	✓	
Knowledge of IT systems, including the ability to use word processing skills, emails, and the internet to create simple plans and reports	✓	

Knowledge of motivational coaching and interview skills	✓	
Ability to work as a team member and autonomously. Additionally, the ability to work under pressure and to meet deadlines	✓	
Clinical system (EMIS) IT user skills and the ability to record accurate notes		✓
Knowledge of VCSE and community services in the locality		✓
Knowledge of the personalised care approach		✓
Ability to listen, empathise with people and provide person centered support in a non-judgmental 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 use own initiative, discretion and sensitivity	✓	
Ability to communicate complex and sensitive information effectively with people at all levels by telephone, email, and face to face	✓	
Understanding of safeguarding adults and children	✓	
Ability to identify risk and assess/manage risk when working with individuals	✓	
High levels of integrity and loyalty	✓	
Polite and confident	✓	
Able to work from an asset-based approach, building on existing communities and personal assets	✓	
Able to provide leadership and to finish work tasks	✓	
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	✓	
Demonstrate personal accountability, emotional resilience, and 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	✓	
Understanding of the needs of small volunteer-led community groups and ability to support their development	✓	
Other requirements	**Essential**	**Desirable**
Flexibility to work outside of core office hours	✓	
Disclosure Barring Service (DBS) check	✓	
Occupational health clearance	✓	

Access to own transport and ability to travel across the locality on a regular basis, including visiting people in their own home	✓	

This document may be amended following consultation with the post-holder to facilitate the development of the role, the organisation, and the individual.

All personnel should be prepared to accept additional, or surrender existing duties, to enable the efficient running of the organisation.