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| **Job title:** | **Social Prescribing Link Worker** |
| **Responsible to:** |  |
| **Accountable to:** |  |
| **1. Job Role / Purpose:** |
| 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 diverse 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 diverse 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, reduce health inequalities (in relation to timely access and outcomes) 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 diverse 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. |
| **2. Key Duties & Responsibilities:** |
| **Key responsibilities*** Working with direct supervision by a GP, 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, allied health professionals, fire service, police, job centres, social care services, housing associations, and voluntary, community and social enterprise (VCSE) organisations (list not exhaustive).
* Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health access and 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 appropriate 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.
* Work with a diverse range of people and communities, to draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups (including faith groups) to receive social prescribing referrals.
* Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local diverse 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.

**Key Tasks** Referrals * Promote social prescribing, its role in self-management, addressing health inequalities 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 access and 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 equality and inclusion, through self-referrals and connecting with all diverse 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 and respect with the person, providing non-judgemental and non-discriminatory support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person’s assets.
* Be a friendly and engaging 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, cultural and religious/faith needs 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 culturally appropriate community groups, activities and statutory services, ensuring they are comfortable, feel valued and respected. 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 a wide range of local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what’s already available to create a menu of diverse community groups and assets, who promote diversity and inclusion.
* Develop supportive relationships with local diverse VCSE organisations, culturally appropriate 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 diverse 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.

**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 your 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, equality, diversity and inclusion training and health and safety.
* Work with your supervising GP to access regular ‘clinical supervision’, to enable you to deal effectively with the difficult issues that people present.

Miscellaneous * Work as part of the healthcare team to seek feedback, continually improve the service and contribute to business planning.
* Contribute to the development of policies and plans relating to equality, diversity 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.
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| **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 his/her 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.

**Vision Statement:** To be the most respected Primary Care provider in the Birmingham and Solihull Region.**Mission Statement:****S**ustainable Primary Care services that meet the needs of our patients and commissioners.**H**ave a united, strong and financially viable organisation.**P**ractice of choice for our patients and the employer of choice for our people. |