**Social Prescribing Link Worker**

**Job Description**

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| **Job title** | **Social Prescribing Link Worker** |
| **Salary:** | **£23,400.00 - £24,000.00 per year** |
| **Hours**  | Full Time 35 Hours per week – workers must be prepared to work flexibly |
| **Accountable to**  | Brent Mencap Team Manager and Named Locality Manager |
| **Responsible to** | Mencap Director  |
| **Location**  | At one of the Primary Care Networks (PCN) in Brent. You will be based at different practices in your PCN. Brent Mencap – 379-381 High Road Willesden London NW10 2 JR - This is your employers main office and where the team meet on Fridays for team meetings. |

**Background to the role**

The Social Prescribing Link Worker (SPLW) role is working with front line general practices to support patients to achieve improved outcomes through engagement with community-based services and groups, through a personalised and structured plan. As the role develops the SPLW will engage with the local community to stimulate activities and collaboration based on local need.

The SPLW will be employed and managed by Brent Mencap but will work for a named Brent Primary Care Network with agreed supervision arrangements.

**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 will work with existing community activities and may help start new community activities, working collaboratively with patients and local partners.

Social prescribing can strengthen community resilience and personal resilience, and reduce 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 relationships:**

* Designated Primary Care Network
* General practices and their teams
* Brent Care Navigation service

**Key responsibilities**

1. To work as part of the social prescribing team within a designated Primary Care Network and its member general practices taking referrals to provide advice and support to registered patients and their families and carers who meet the local agreed criteria.

2. Once established to take referrals for registered patients who meet local agreed criteria from a wide range of agencies in agreement with GP practices and primary care networks e.g. 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 and voluntary sector organisations (list not exhaustive).

3. 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 to 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 individualson the caseload.

4) 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.

5. Develop a good knowledge of local community activities and local voluntary sector organisations and community groups to refer to. Check they 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.

6. To work closely with the Brent Care Navigation service to meet the identified needs of the patients and local communities in health creating activities.

7. To provide hands on support to patients in achieving their personalised plan and relevant application processes.

8. To run “surgeries” in general practices providing face to face appointments for referred patients who meet the agreed criteria using the EMIS clinical system for which training will be provided.

9. To attend practice and PCN meetings as requested and liaise with referring GPs and their teams, providing updates and reports promptly as necessary .

**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 between general practices and with local agencies to encourage referrals, recognising what they need to be confident in the service to make appropriate referrals.

• Work in partnership with 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 referring GP or 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 engagement with all local communities, particularly those communities that statutory agencies may find hard to reach.

•Work with practice teams to achieve the reduction in demand for GP appointments through proactive with patients to identify alternative and appropriate forms of support.

**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.

• 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.

•Form close links to member general practices and their teams. Support and encourage referral to and adoption of self-care and health creating activities and advice.

• 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.

**Work with community groups and voluntary sector organisations**

•Work with local voluntary sector organisations, community and neighbourhood level groups, and add to our existing knowledge of community groups and activities. Inform them about micro-commissioning or small grants if available.

• Make timely, appropriate and supported referrals for the person being introduced to group

•Check local community groups and voluntary sector 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, signpost groups to CVS Brent to work towards this standard before referrals are made to them.

• Check community groups and voluntary sector organisations meet in insured premises and health and safety requirements are in place. Where such policies and procedures are not in place, signpost groups to CVS Brent to work towards this standard before referrals are made to them.

• Ensure local groups act in accordance with information governance policies and procedures, ensuring compliance with the General Data Protection Regulations and Data Protection Act.

**Work collectively with local partners to improve access to community activities**

• Work with locality team 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, in order to build their skills and confidence, and strengthen community resilience.

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

**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 EMIS 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.

**PERSON SPECIFICATION**

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| **CRITERIA** | **ESSENTIAL**  | **DESIRABLE**  |
| **Personal Qualities & Attributes** | Ability to listen, empathise with people and provide person-centred support in a non-judgemental way | X |  |
|  | Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity  | X |  |
|  | Commitment to reducing health inequalities and proactively working to reach people from all communities | X |  |
|  | Understanding of the importance of confidentiality  | X |  |
|  | Understanding of information governance and GDPR | X |  |
|  | Able to support people in a way that inspires trust and confidence, motivating others to reach their potential | X |  |
|  | Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders | X |  |
|  | Ability to identify risk and assess/manage risk when working with individuals | X |  |
|  | Team player able and willing to support colleagues  | x |  |
|  | 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 | X |  |
|  | Able to work from an asset based approach, building on existing community and personal assets  | X |  |
|  | Able to provide leadership and to finish work tasks  | X |  |
|  | Able to effectively listen and translate into supportive goal setting and planning | X |  |
|  | Ability to maintain effective working relationships and to promote collaborative practice with all colleagues  | X |  |
|  | Ability to work and communicate with various teams including designatedgeneral practices | X |  |
|  | Commitment to collaborative working with all local agencies  | X |  |
|  | Able to communicate at all levels from patients to health professionals | X |  |
|  | Demonstrates personal accountability, emotional resilience and works well under pressure  | X |  |
|  | Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines  | X |  |
|  | High level of written and oral communication skills ,able to produce clear ,accurate written reports and referrals in English and be able to be able to be understood by patients on telephone and in person in English or a community language | X |  |
|  | Ability to work flexibly and enthusiastically within a team or on own initiative  | X |  |
|  | Understanding of the needs of small volunteer-led community groups and ability to signpost them for support  | X |  |
|  | Knowledge of and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety  | X |  |
| **Qualifications & Training** | NVQ Level 3, Advanced level or equivalent qualifications in health, social care, advice, wellbeing or related subjects | X |  |
|  | Demonstrable commitment to regular and ongoing professional and personal development  | X |  |
|  | Training in motivational coaching and interviewing or equivalent experience |  | X |
| **Experience** | Substantial Experience of working directly in a community development context, adult health and social care setting, learning support or public health/health improvement (including unpaid work) | X |  |
|  | Substantial Experience of supporting people, their families and carers in a related role (including unpaid work) | X |  |
|  | Experience of supporting people with their mental health, either in a paid or unpaid or informal capacity |  | X |
|  | Experience of working with the voluntary sector in paid or unpaid capacity including with volunteers or small community groups  | X |  |
|  | Experience of data collection and providing monitoring information to assess the impact of services  |  | X |
|  | Experience of partnership/ collaborative working and of building relationships across a variety of organisations | X |  |
| **Skills and knowledge** | Knowledge of personalised care approach, recent legislation and developments in health and social care, the Equality Act,  | X |  |
|  | Understanding of the wider determinants of health, including social, economic an environmental factors and their impact on communities  |  X |  |
|  | Knowledge of IT systems, including ability to use MS Word and Excel, emails and the internet to create simple plans and reports  | X |  |
|  | Knowledge of motivational coaching and interview skills  |  | x |
|  | Knowledge of voluntary sector and community services in the locality | X |  |
| **Other** | Enhanced DBS check must show no serious/ recent convictions cautions or arrests | X |  |
|  | Willingness to work flexible hours when required to meet work demands  | X |  |
|  | Ability to travel across the locality on a regular basis, including to visit people in their own homes  | X |  |

Candidates must complete an application form with a full work/education and volunteering timeline, explaining any gaps.

Candidates must explain in their statement **how they meet each of the essential criteria ie what experience and or knowledge they have. It's not enough to say “I can do this” if no evidence is provided”.**

Brent Mencap does not accept CVs alone. If you submit a CV it must cover all the essential criteria and you must still complete the other sections of the application form, sign it and ensure we have a full work/education and volunteering timeline

Interviews will take place at Brent Mencap 379-381 High Road, Willesden and take about 2 hours. Our interviews include practical research, report writing, telephone and presentation tasks along with an interview.