**JoB DESCRIPTION**

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| **Job Title:**  | Social Prescriber Link Worker   |
| **Accountable to:**  | **Proactive Nurse Lead**  |
| **Responsible to:**  | **PCN Clinical Lead**  |
| **Location:**  | This role will require movement around all of Clacton PCN’s Member practices   |
| **Pay Band:**  | 5 equates to £29,970 per annum  |
| **Hours:**  | 37.5 hours a week (with some weekend working involved)  |

**Purpose of The Job**

**Purpose of the role**

You will work with Practices within Clacton PCN as part of the Proactive care Team. The postholder will support the development of long-term sustainable communities that help and empower local residents to lead healthier, more independent, and more active lives.

Social prescribing empowers people to take control of their health and wellbeing through referral to non-clinical social prescribing link workers.

They give people time to focus on ‘what matters to me’ and take a holistic approach to an individual’s health and wellbeing.

**Social prescribing link workers:**

* Take a whole population approach, working with a range of people who may benefit from social prescribing, including people who are lonely, have complex social needs, low level mental health needs and long-term conditions
* Help people to identify issues that affect their health & wellbeing, and co-produce a simple personalised care and support plan
* Support people by connecting them to non-medical, community-based activities, groups and services that meet their practical, social and emotional needs, including specialist advice services and arts and culture, physical activity, and nature and green based activities
* Use coaching and motivational interviewing techniques to support people to take control of their own health and wellbeing
* Support development of accessible and sustainable community offers by working in partnership with VCSE organisations, local authorities and others to identify gaps in provision, and take a community development approach to enabling growth in community activities and groups.

In particular, the postholder will work towards achieving one or more of the following outcomes:

1. Those who are socially isolated will report reduced feelings of loneliness by being supported to access local services and activities.
2. People suffering from poor physical and/or mental health and/or long-term health conditions will report an improvement in their sense of health and well-being by increasing their physical activity and/or accessing volunteering opportunities and/or attending new clubs or activities and making new friends.
3. People supported will report that they are better able to manage their health and wellbeing.
4. People supported will report that they are more able to manage practical issues.

**Key Responsibilities**

Professional Duties

* Take referrals from the PCNs Core Network Practices 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.
* 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 approximately 6-12 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 utilise existing networks and build on existing provision
* Work collectively with all local partners to ensure community groups are accessible and sustainable
* Work 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.
* Work 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**

* Work with a supervisor and/or line manager to undertake continual personal and professional development in line with the social prescribing Workforce Development  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 behaviors
* 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 and 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.

Financial and Physical resources

* Responsibility for Information Resources within the PCN
* Use IT packages including Work, Excel, Outlook, Powerpoint, Publisher as needed for reports / programmes
* Advanced use of virtual meeting platforms – Teams and Zoom

Effort and Environment

Physical Effort

* Light physical effort
* Keyboard work for long periods

Mental Effort

* Ability to work flexibly and under pressure, to multi-task and to negotiate with team over priority of work
* Concentration for administrative duties
* Manage interruptions

Emotional Effort

* Ability to value and respect other team members

Working Conditions

* Normal working conditions for office based staff
* Able to work and travel across all practices within the Clacton PCN

Other duties

To provide cover for other members of the team as appropriate to ensure an effective service is provided at all times.

This job description is not a definitive or exhaustive list of responsibilities but identifies the key responsibilities and tasks of the post holder. The specific objectives of the post holder will be subject to review as part of the individual’s performance review/appraisal. There may be a requirement to undertake other duties as may reasonably be required to support Clacton PCN in accordance with your grade/level in the organisation.

CODES OF CONDUCT

The Clacton PCN requires the highest standards of personal and professional conduct from all of its employees.  All employees must comply with the Code of Professional Conduct appropriate to their professional governing body and to HR Code of Conduct.

EQUAL OPPORTUNITIES

The Clacton PCN is committed to equal opportunities that affirms that all staff should be afforded equality of treatment and opportunity in employment irrespective of sexuality, marital status, race, religion/belief, ethnic origin, age or disability.  All staff are required to observe this standard in their behaviour to fellow employees.

SAFEGUARDING CHILDREN, YOUNG PEOPLE AND ADULTS AT RISK

Safeguarding is a key priority for NHS. Staff must always be alert to the possibility of harm to children, young people and adults at risk through abuse and neglect. This includes being aware of the adults who may find parenting difficult. All staff should be able to recognise the indicators of abuse and know how to act on them, including the correct processes and decisions to be undertaken when sharing information. The depth of knowledge you work from must be commensurate with your role and responsibilities (As per the Intercollegiate Documents for Safeguarding Children, Adults and Looked After Children). All staff must follow the safeguarding policies, procedures and guidelines, know how to seek specialist advice and must make themselves available for training and supervision as required

CONFIDENTIALITY

All employees are required to observe the strictest confidence with regard to any patient/client information that they may have access to, or accidentally gain knowledge of, in the course of their duties.

All employees are required to observe the strictest confidence regarding any information relating to the work of the Clacton PCN and its employees.

You are required not to disclose any confidential information either during or after your employment with the Clacton PCN , other than in accordance with the relevant professional codes.

Failure to comply with these regulations whilst in the employment of the Clacton PCN ould result in action being taken.

DATA PROTECTION

All employees must adhere to appropriate NHS standards/policies in respect of the use of Personal Information, including guidance on the use and disclosure of information.

HEALTH AND SAFETY

The NHS expect all staff to have a commitment to promoting and maintaining a safe and healthy environment and be responsible for their own and others welfare.

RISK MANAGEMENT

You will be responsible for adopting the Risk Management Culture and ensuring that you identify and assess all risks to your systems, processes and environment and report such risks for inclusion within your organisation’s Risk Register.  You will also attend mandatory and statutory training, report all incidents/accidents including near misses and report unsafe occurrences as laid down within the policies.

GOVERNANCE

All staff have a responsibility to be aware of governance arrangements and ensure that the reporting requirements, systems and duties of action put into place by the NHS are complied with.

INFECTION CONTROL

All staff must observe the Code of practice for the prevention and control of infections (updated 2015), and ensure that they understand and implement their responsibilities in the prevention and control of infection.

DISCLOSURE & BARRING SERVICE (DBS) CHECK

If your post is one that requires a disclosure (at whatever level) from the DBS, the organisation retains the right to request that a further disclosure is sought at any time as deemed to be appropriate.  If you have been appointed and are awaiting the outcome of a DBS check and it proves to be unsatisfactory, your employment will be terminated.

CRIMINAL CONVICTIONS

If during the course of your employment you are convicted of or charged with a criminal offence (with the exception of a traffic offence) whether it arises from your employment or otherwise, you are required to report the matter to the PCN Operations Manager who will decide on the appropriate course of action. Should you be convicted of an offence and receive a custodial sentence the organisation reserves the right to terminate the contract of employment, after careful consideration of the facts. Failure to report a conviction may itself lead to disciplinary action being taken.  Any information will be treated confidentiality except insofar as it is necessary to inform other relevant members of management.  Additionally, if driving is part of your duties and you are convicted of any traffic offence, you must report it to PCN Business Manager who will decide on the appropriate course of action.

Person Specification

**POST TITLE: PCN Social Prescriber Link Worker**

**BAND: 5**

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| **Person specification – social prescribing link worker**  |
| **Criteria**  | **Essential**  | **Desirable**  |
| **Personal qualities & attributes**  | Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental way  | ✓  |   |
| Able to provide a culturally sensitive service, by supporting people from all backgrounds and communities, respecting lifestyles and diversity  | ✓  |   |
| Commitment to reducing health inequalities and proactively working to reach people from diverse communities  | ✓  |   |
| Able to support people in a way that inspires trust and confidence, motivating others to reach their potential, adapting to individual levels of activation and health literacy  | ✓  |   |
| Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders, adapting communication styles accordingly  | ✓  |   |
| 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  | ✓  |   |
| Can demonstrate personal accountability, emotional resilience and ability to work well under pressure  | ✓  |   |
| **Qualifications & training**  | NVQ Level 3, Advanced level or equivalent qualifications or working towards  | ✓  |   |
| Demonstrable commitment to professional and personal development  | ✓  |   |
| Training in motivational coaching and interviewing or equivalent experience  |   | ✓  |
| **Experience**  | 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 supporting people, their families and carers in a related role (including unpaid work)  | ✓  |   |
| Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity  | ✓  |   |
| Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups  | ✓  |   |
| Experience of data collection and using tools to measure the impact of services  | ✓  |   |
| Experience of partnership/collaborative working and of building relationships across a variety of organisations  | ✓  |   |
| Ability to maintain effective working relationships and to promote collaborative practice with all colleagues  | ✓  |   |
| Ability to work flexibly and enthusiastically within a team or on own initiative  | ✓  |   |
|   | Knowledge of, and ability to work to, policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety  | ✓  |   |
| Have awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when the person’s needs are beyond the scope of the role – for example, when there is a mental health need requiring a qualified practitioner  | ✓  |   |
| **Skills and knowledge**  | Knowledge of the personalised care approach. Utilises the evidence base for social prescribing interventions and activities.  | ✓  |   |
| Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities, individuals, their families and carers  | ✓  |   |
| Understanding of, and commitment to, equality, diversity and inclusion.  | ✓  |   |
| Knowledge of community development approaches including asset-based community development and community resilience  | ✓  |   |
| Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports  | ✓  |   |
| Local knowledge of VCSE and community services    |   | ✓  |
| Knowledge of how the NHS works, including primary care and MDT working  |   | ✓  |
| Able to work from an asset-based approach, building on existing community and personal assets  | ✓  |   |
| Understanding of the needs of small volunteer-led community groups and ability to contribute to supporting their development  | ✓  |   |
| Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines  | ✓  |   |
| High level of written and oral communication skills  | ✓  |   |
| Confidently approaches difficult conversations  | ✓  |   |
| Able to provide motivational coaching to support people’s behaviour change  | ✓  |   |
| **Other**  | Meets DBS reference standards and criminal record checks  | ✓  |   |
| Willingness to work flexible hours when required to meet work demands  | ✓  |   |
| Access to transport and ability to travel across the locality on a regular basis, including to visit people in their own homes and support people to attend activities as appropriate.   | ✓  |   |