JOB DESCRIPTION

TITLE:	Social Prescribing Link Worker
LOCATION:	Rochdale North Primary Care Network
HOURS:	Full Time
SALARY:	Dependent on experience.
RESPONSIBLE TO:	Business Support Manager/Clinical Director

JOB PURPOSE:

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, working collaboratively with all local partners, support existing groups to be accessible and sustainable and help people to start new community groups.

The GP Led Primary Care Networks within Heywood, Middleton and Rochdale focus on the population profile and the community needs. These networks comprise of a range of clinical and non-clinical roles working closely and in collaboration with the wider community assets and support networks. The Social Prescribing Link Worker is pivotal to supporting people through connection to and engagement with bespoke activities in relation to improving health and well-being, resulting in achievement of personalised goals and self-care.

Training and support available for the suitable candidate.

CORE DUTIES AND RESPONSIBILITIES:

The non-exclusive list of duties and responsibilities, which follows, represents the broad range of tasks, which may be required to be undertaken either routinely or periodically.

Social Prescribing Referral Management

- Act as the central point for the referral within the Primary Care Network managing the coordination and connection of people to the local community statutory and voluntary assets.

- Working autonomously take referrals and work 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.
- Triage and oversee the referral process to ensure the individual receives the most appropriate level of personalised support to meet their needs. This may be with the Social Prescribing Link Worker, or may be more suitably placed with partners e.g. Community Connectors, Health Trainers
- Establish relationships with referred people to determine personalised support to individuals, family and carers in pursuit of holistic independent control of choice and support of 'what matters to me'
- Utilising the Our Rochdale Directory of Services, together with community and voluntary service networks and build on what's already available to create a map or menu of community groups and assets
- Build a robust relationship and pathways with the statutory services and community groups to ensure effective connection of individuals, family and carers

Communication

- Promoting social prescribing, its role in self-management, and the wider determinants of health such as housing, finance management and employment.
- 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.

Service Quality

- Seek regular feedback about the quality of service and impact of social prescribing referral agencies.
- Be proactive in encouraging self-referrals and connecting with all local communities particularly the hard-to-reach groups.
- Meet people on a one-to-one basis, making home visits where appropriate within

organisations' policies and procedures.

- 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.
- Help people maintain or regain independence through signposting to resources that support 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.
- Conduct reviews of the plan at set intervals to determine the impact of social prescribing
- Ensure that local community groups and voluntary 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. • Support local groups to act in accordance with information governance policies and procedures, ensuring compliance with the Data Protection Act.

Service Impact

- Work with the network lead; employer and local partners to identify unmet needs within the community and gaps in community provision.
- 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 between GP Practices.

Professional Development

- Work with your line manager to undertake mandatory training and continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.
- Participate in role development programmes delivered and coordinated by the Primary Care Academy
- 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.

SAFEGUARDING:

All staff are responsible for ensuring that they are familiar with and adhere to RHA's and the CCG's safeguarding procedures and guidelines in conjunctions with the safeguarding Children's and Adult Board Policies, Procedures and Guidelines.

EQUALITY AND DIVERSITY:

We are all responsible for applying the principles of RHA'S equality and diversity standards within the application of our duties and ensuring that our actions are non- discriminatory to colleagues and patients.

HEALTH AND SAFETY:

RHA has a statutory responsibility to provide and maintain a healthy and safe environment for workers, patients and visitors. Workers equally have a responsibility to ensure that they promote and maintain a safe working environment, reporting appropriately any risks. RHA's Health and Safety policy within the Staff Handbook outlines staff responsibilities.

INFORMATION GOVERNANCE

To comply with Company policies and procedures relating to Information Governance. This will include, but not be limited to, Confidentiality policies, record management protocols, the Information Security Policy, The Data Protection Act, The Freedom of Information Act etc.

The post holder shall not, during or after working at RHA, disclose confidential information belonging to the company. You have a responsibility to protect and maintain confidentiality of all information. You must not, except as authorised or required by law or your duties, reveal any confidential information.

This obligation will continue after the termination of this work unless and until any such information enters the public domain.

This job description is not intended to be exhaustive, and it is likely that duties will be altered from time to time in the light of changing circumstances and after consultation with the post holder.

Social Prescribing Link Worker

Person Specification

Criteria	Essential	Desirable
Qualifications		
NVQ Level 3, Advanced level, or equivalent qualifications or willing to do so.	X	
Demonstrable commitment to professional and personal development.	X	
Training in motivational coaching and interviewing or equivalent experience.		X
Experience		
At least 2 years' experience working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work).		X
At least 2 years' 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, unpaid, or informal capacity.		X
Experience of working with volunteers and small community groups either in a paid, unpaid, or informal capacity.		X
Experience of clinical systems such as EMIS.		X
Experience of data collection and providing monitoring information assess the impact of services.		X

	Essential	Desirable
Skills		
Knowledge of the personalised care approach.	X	
Understanding of the wider determinants of health, including social economic and environment factors and their impact on communities.	X	
Knowledge of IT systems, including ability to use word processing skills, email and the internet to create simple plans and reports.	X	
Knowledge of motivational coaching and interview skills.	X	
Knowledge of statutory, voluntary and community services in the locality.	X	
Able to listen, empathise with people and provide person-centred support without judgement.	X	
Able to build relationships with people from all backgrounds and communities, respecting lifestyles and diversity.	X	
Able to communicate effectively, both verbally and in writing with people, their families, careers, community groups, partner agencies and stakeholders.	X	
Commitment to collaborative working with all local agencies and able to work with other to reduce hierarchies and find creative solutions to community issues.	X	