**Social Prescribing Link Worker and Carer’s Lead**

**Job Description and Person Specification**

**1. JOB DETAILS**

Job Title: Social Prescriber Link Worker

Responsible to: Assistant Practice Manager

Location: Cerne Abbas Surgery

Contract Type: Permanent

Hours: 10 hours/week

**2. JOB PURPOSE**

Link Workers empower people to take control of their health and wellbeing by giving time to people to focus on ‘what matters to me’. They take a holistic approach to an individual’s needs, connecting them to a diverse range of community groups and statutory services for practical and emotional support, via a ‘Social Prescription’.

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

The Link Worker will work as a key part of the multi-disciplinary team, helping PCNs to strengthen community and personal resilience and reduce health 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.

As part of your role, you will also be the Carer’s Lead for the Surgery. The Carer’s Lead is responsible for compiling and maintaining the list of registered carers and ensuring they receive the support, information and care they need. The Lead works very closely with our Integrated Nursing Team and will be a key resource for the Surgery.

**3 MAIN DUTIES AND RESPONSIBILITIES**

* Working under the guidance of the referring GP, take referrals from a wide range of agencies, including the GP practice and multi-disciplinary team as well as the wider system, and occasionally via self-referral.
* 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 surgery’s multi-disciplinary team.
* Develop trusting relationships by giving people time and focus on ‘what matters to me’ and taking 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, including introducing or reconnecting people to appropriate community groups and statutory services.
* Manage and prioritise own workload in accordance with the needs and priorities of individuals on the caseload.
* Maintain a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies.
* Work with a diverse range of people and their communities, to draw on and increase the strengths and capacity of local community groups, enabling local groups and organisations to receive social prescribing referrals.
* Educate non-clinical and clinical staff within the surgery on what services are available within the community and how to access them.
* Carry out searches and update clinical records to maintain an accurate list of carers
* Actively contact the registered carers to inform them of services and support available to them.
* Use various methods of communication to advertise services available, for example publishing information on our website, village magazines, and posters around the surgery.

**Education**

* Promote social prescribing within the practice and the wider system, including its role in self-management, addressing health inequalities and the wider determinants of health.
* 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.
* Raise awareness of the challenges faced by carers and how these challenges can be overcome

**Referrals**

* Receive and action referrals for social prescriptions via agreed systems.
* Manage and prioritise referrals appropriately.
* Redirect referrals, using the agreed protocols, to more appropriate agencies.
* Be proactive in developing strong links with all local agencies.
* Support referral agencies to provide appropriate information about the person they are referring.
* Adhere to data protection legislation and data sharing agreements.

**Personalised Support**

* Listen to and talk with people and their families about ‘what matters to me’.
* Be proactive in encouraging equality and inclusion, through connecting with local communities.
* 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 closely with the care co-ordinator to 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.
* Identify what individuals 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 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, signpost to the care co-ordinator to 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.

**Community Asset Development**

* Forge strong links with a wide range of local organisations, community and neighbourhood level groups, utilising their networks and building on what’s already available to create a menu of community groups and assets.
* Develop supportive relationships with local organisations to make timely, appropriate and supported referrals for the person being introduced.
* 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.
* Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.

**Collaborative working**

* As part of the multi-disciplinary team, build close working relationships with staff, attending relevant MDT meetings, giving information and feedback on social prescribing.
* Seek advice and support from the GP team 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.
* Explore ways of working and share good practice and learning with other social prescribing workers within the Primary Care Network.

**Data Collection**

* Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.
* 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.

**Professional Development**

* Work to undertake continual personal and professional development, taking an active part in reviewing and developing the role and responsibilities.
* Adhere to organisational policies and procedures, including but not restricted to confidentiality, safeguarding, information governance, equality, diversity and inclusion, training and health and safety.

**Service Development**

* Seek regular feedback about the quality of the service and impact of social prescribing to support continual improvement of the service and contribute to business planning.

**Other**

* Uphold the aims and values of the organisation.
* Maintain up to date knowledge of legislation, national and local policies and issues relevant to the role.
* All employees have a duty and responsibility for their own health and safety and the health and safety of colleagues, patients and the general public.
* 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** | **Essential or Desirable** |
| --- | --- |
| **Qualifications / Education / Training:**NVQ level 3 or equivalent relevant qualification and /or extensive experience Demonstrate commitment to professional and personal developmentTraining in motivational coaching and interviewing or equivalent | EssentialEssentialDesirable |
| **Experience:**Experience of working with people in a community development setting, adult health and social care, learning support or public health context Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity Experience of data collection and using tools to measure the impact of servicesExperience of individual needs assessmentExperience of building relationships across organisations | EssentialDesirableEssential DesirableDesirable |
| **Knowledge/Skills/Competencies:**Excellent written and oral communication skillsAbility to work flexibly within a team situation or on own initiative Ability to work from a strengths-based approachHaving a positive attitude to people from diverse backgroundsAbility to organise and prioritise workload Demonstrate ability to manage your own health and wellbeing Ability to research and identify appropriate community resources Knowledge of links between physical health and mental healthKnowledge of the personalised care approach Understanding of the wider determinants of health, including social, economic and environmental factorsKnowledge of community development approachesKnowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plansAwareness of GDPR and the Safeguarding Children & Adults Experience of using SystmOne | EssentialEssential EssentialEssentialEssentialEssential DesirableDesirableDesirableEssentialDesirableEssentialDesirableDesirable  |
| **Other:**Commitment to our organisational valuesCommitment to our Equal Opportunities and Diversity policies.Willingness to undergo a relevant DBS check if requiredAccess to own transport and willingness to travel locally if required. | EssentialEssentialEssentialDesirable |