

## **Job Description**

### ***Social Prescribing Link Worker***

**Hours of work: 37.5 hours or job share considered for the right candidates**

**Annual Leave: 25 days FTE**

**Salary: £22,440**

**Contract: Permanent**

**Employed by: Involve Kent**

**Responsible to: Social Prescribing Team Lead**

**Based: Various GP Primary Care Networks**

### **Purpose of the job**

**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' with the person and take a holistic approach, connecting people to 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 partners and volunteers**

### **Key tasks and responsibilities**

- Proactively manage your own health, wellbeing and resilience as a positive role model to patients and to ensure you are able to provide consistent, quality support to our clients
- Take referrals from a wide range of agencies, working 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 on the caseload
- Ensure all necessary data and information about Clients is recorded accurately and entered confidentially on Involve's database or other NHS collection methods, with awareness of information governance best practice.
- Work in partnership 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 to ensure promotion of the service
- 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 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 personalised support plan (action plan) to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services. Manage and prioritise your own caseload, in accordance with the needs, priorities and any urgent support required by individual.

- Accept referrals for people with health conditions (including common mental health conditions, obesity, diabetes, respiratory conditions, mobility issues and sensory impairment) who wish to benefit from community support, focusing on people who are isolated. This includes self-referrals and online enquiries.
- Proactively contact and engage with the local agencies to encourage referrals and to promote self-referrals.
- Motivate, empower and encourage people to take positive action to improve their health and wellbeing, by connecting with others, attending groups, promoting self-care, volunteering, accessing advice and information and support services.
- Work with people in a supportive, holistic way focussing on strength-based assessment to address practical and psychological barriers, such as lack of transport, low confidence, and social isolation, to co-produce a solution
- Refer people back to other health professionals/agencies, when the person has needs beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner
- Support people to choose appropriate community activities to support their wellbeing, such as exercise groups, self-help groups, debt advice, community gardening; and many other opportunities.
- Seek opportunities and activities in the local area which people could benefit from, such as local community groups, make contact and engage them in the service
- Confirm that the appropriate SNOMED codes are used on EMIS/Vision/System One with awareness of information governance best practice.
- Use recognised tools with patients to track improvements in their health and wellbeing using ONS scales of Wellbeing. Work with GP practices to review data on GP appointments and hospital admissions to track statistical improvements at practices.
- Recruit volunteers to support the service locally. Engage with Patient Participation Groups, existing community groups, patients and staff to promote volunteer opportunities
- With Involve colleagues, provide volunteer training and induction.
- Coordinate volunteers to help deliver the service and match them with patients, to provide support such as driving isolated patients to activities, administration and communication with patients, mentoring and befriending and addressing minor issues or problems.
- Work closely with partners particularly Community Navigators and One You advisors, to ensure support for patients is complementary and people access the right service for their needs.
- Any other tasks and responsibilities that may be identified as necessary as the service evolves and develops

| <b><u>Person Specification</u></b>  | <b><u>Essential</u></b> | <b><u>Desirable</u></b> |
|---|-------------------------|-------------------------|
| Experience of supporting people one to one  | x                       |                         |
| Driven, target focused, highly motivated  | x                       |                         |
| Experience of motivating, empowering and supporting people to achieve their goals   | x                       |                         |
| Background working with vulnerable/ isolated people   |                         | x                       |
| Able to follow processes and systems, and with training develop action/support plans and outcome focused reviews.   | x                       |                         |
| Excellent communication skills, able to negotiate, build relationships, advocate for people and inspire others  | x                       |                         |
| Resilient and confident, able to work in a busy environment (GP practice) with colleagues under pressure and champion the service to health professionals | x                       |                         |
| Outgoing, energetic, and positive about improving the wellbeing of others and their community   | x                       |                         |
| Ability to learn and implement systems, policies and processes  | x                       |                         |
| Good IT skills and experience of using a database or CRM system and accurately able to enter sensitive data   | x                       |                         |
| Adaptable, flexible with a can-do attitude  | x                       |                         |
| Experience of recruiting and working with volunteers. Experience of working in the community to set up groups and activities                              |                         | x                       |
| Driving licence and a car   | x                       |                         |