Job Description
Social Prescribing Team Lead

Hours of work: 37.5 hours

Annual Leave: 25 days FTE

Salary: £25,500

Contract: Permanent

Employed by: Involve Kent

Responsible to: Head of Services (initially then TBC)

Based: Turkey Mill Maidstone, GP Primary Care Networks throughout Kent (mileage paid to PCNs @45p per mile) dependant on home location

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' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners.

As a motivational team lead you will be providing daily support, supervision and cover to Social Prescribing link workers, Health Coaches and Care Coordinators in designated PCNs. (GP primary care networks) in Kent. Ensuring staff are embedded within the PCN's and liaising with practice staff to ensure the service is a success and that smooth pathways for patients to access the service are implemented.

Key tasks and responsibilities

- Proactively manage your own health, wellbeing, and resilience as a positive role model to staff and to ensure you can provide consistent, quality support to your staff and our clients.
- Daily line management of link workers, including supervision, support, and training.
- Responsibility for induction of new link workers including accessing appropriate training, supporting link workers in the surgeries until confident to lone work with people.
- Support link workers in induction and ongoing to work from the GP surgeries, introduce them to practice staff, assist the link worker to embed social prescribing within the surgeries, ensuring referrals of people are received by the link workers.
- Attend training, meetings and supervision and lead group supervisions and link worker team meetings.
- Work with the Senior Management team, Managers and other team lead colleagues to ensure best practice, quality and continuous improvement across Involve Kent social prescribing and navigation services, including data collection.
- Provide cover for other team leads' annual leave and sickness.
- Cover link workers in surgery and on home visits when they are on annual leave or sick.
- Ensure all necessary data and information about Clients is recorded accurately and entered confidentially on Involve's database or other collection methods, with awareness of information governance best practice. Support staff where issues are identified in data collection or recording.

- Support staff daily with any complex people or issues, answering queries swiftly and competently and raising complex issues with management for advice and guidance swiftly to ensure staff and people are supported appropriately. Build expertise, resilience and confidence in the link workers.
- Liaise with link workers daily ensuring staff are supported, safe when visiting in the community and not at risk of isolation in their roles.
- Work with Link workers to manage their caseloads, ensure people are reviewed and supported appropriately and avoiding ongoing dependency on the link worker.
- 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.
- 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 link workers to:

- 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.
- 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.
- Using the 'Connect Well West Kent' social prescribing software and directory, 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. Ensure appropriate

services and charities which meet the requirements of the directory are directed to the Information Officer for addition to the site.
- Seek opportunities and activities in the local area which people could benefit from, such as local community groups, make contact, engage them in the service and register them on the "Connect Well" directory (with support from colleagues).
- 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, advise potential volunteers and recruit.
- 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 Heath and Social Care Coordinators 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.

Person Specification	**Essential**	**Desirable**
Experience of providing advice, guidance, information and working holistically with a person-centred approach	x	
Experience of daily supervision of a team, including providing supervision one to one or in a group setting		x
Experience of motivating, empowering and supporting staff to achieve targets, KPI's and continuous improvement in quality of work	x	
Background in health/social care or working with vulnerable / isolated people		x
Able to follow processes and systems, assessing people, developing action/support plans and following up in an outcome focussed way using a motivation interview approach	x	
Excellent communication skills, able to negotiate, build relationships, advocate for people and inspire others	x	
Driven, target focused, highly motivated. Resilient and confident, able to work and support a team to work in a busy environment (GP practice) with colleagues under pressure and champion the service to health professionals	x	
Outgoing, energetic, and passionate about improving the wellbeing of others	x	
Ability to learn and implement systems, policies and processes	x	
Good IT skills and experience of using a database or CRM system accurately and ability to train staff	x	
Able to take decisions and use professional expertise, but within a structured framework and existing systems and policies	x	
Experience of recruiting and working with volunteers. Setting up community Groups and activities		x
Driving licence and a car	x	