**JOB DESCRIPTION**

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| **Job Title:** | Primary Care Network (PCN) Social Prescribing Link Worker |
| **Location:** | North Uttlesford |
| **Contract Type:** | Permanent |
| **Salary:** | £21892 - £24,157 |
| **Hours of Work:** | Full or part-time, to be agreed |
| **Position Accountable To:** | Clinical Director, North Uttlesford PCN |
| **Position Line Managed By:** | To be confirmed |

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| **Job Context:** |
| This post will operate within the North Uttlesford Primary Care Network supporting four local GP practices. As part of the PCN’s ambitious plans for transforming and developing primary care locally, the post holder will be expected to operate flexibly and collaboratively with all stakeholders. The role will be part of a multi-disciplinary team and will be central to the delivery of key network objectives. The post will be employed by Uttlesford Health Limited, which is working in partnership with North Uttlesford PCN and Uttlesford CVS to deliver high quality patient care at all times. This role is critical to supporting the PCN’s ambition to optimise individual health and wellbeing, reduce health inequalities and address the wider determinants of health and wellbeing. The postholder will be expected to have a commitment to excellence, partnership working, continued personal and service development. |

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| **Job Summary:** |
| The post holder will empower 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. The aim of the role will be to help to strengthen both community and personal resilience, and reduce health 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 communities. The post holder will work with all patient groups, but particularly with patients that have long-term conditions (including support for mental health) and those with complex social care needs which affect their health and wellbeing. |

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| **Key Duties and Responsibilities:** |
| Referrals* Promote social prescribing, its role in self-management, and the wider determinants of health.
* 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.
* Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.
* Be proactive in encouraging self-referrals and connecting with all local communities, particularly those communities that statutory agencies may find hard to reach.

Provide personalised support* Give people time to tell their stories and focus on ‘what matters to me’. Build trust with the person, providing non-judgmental 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 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.
* Where appropriate, facilitate the introduction of people to community groups, activities and statutory services, ensuring they are comfortable. 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, 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.

Support community groups and VCSE organisations to receive referrals:* Forge strong links with local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what’s already available to create a map or menu of community groups and assets. Use these opportunities to promote micro-commissioning or small grants if available.
* Develop supportive relationships with local VCSE organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.
* Ensure that local community groups and VCSE 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. Where such policies and procedures are not in place, support groups to work towards this standard before referrals are made to them.
* Check that community groups and VCSE organisations meet in insured premises and that health and safety requirements are in place. Where such policies and procedures are not in place, support groups to work towards this standard before referrals are made to them.
* Support local groups to act in accordance with information governance policies and procedures, ensuring compliance with the Data Protection Act.

Work collectively with all local partners to ensure community groups are strong and sustainable* Work with commissioners and local partners to identify unmet needs within the community and gaps in community provision.
* Support local partners and commissioners to develop new groups and services where needed, through small grants for community groups, micro-commissioning and development support.
* Encourage people who have been connected to community support through social prescribing to volunteer and give their time freely to others, in order to build their skills and confidence, and strengthen community resilience.
* Develop a team of volunteers within your service to provide ‘buddying support’ for people, starting new groups and finding creative community solutions to local issues.
* Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.
* Provide a regular ‘confidence survey’ to community groups receiving referrals, to ensure that they are strong, sustained and have the support they need to be part of social prescribing.

General tasks, including data capture* 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 into EMIS and SystmOne and that the person’s use of the NHS can be tracked, adhering to data protection legislation and data sharing agreements with the clinical commissioning group (CCG).
* Work with practices to promote and support the use of digital technologies to aid health and wellbeing.
* Actively support health and wellbeing campaigns, facilitating the promotion of support to key patients within general practice.

Professional development* Work with your line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.
* 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.

Miscellaneous* Work as part of the team to seek feedback, continually improve the service and contribute to business planning.
* 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.
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| **General Duties:** |
| Health and Safety/Risk Management The post holder will take all reasonable care not to endanger themselves or anybody else by any act or omission as stated by the Health and Safety at Work Act 1974.The post-holder must comply at all times with the Health and Safety policies, in particular by following agreed safe working procedures and reporting incidents using the organisations and practices Incident Reporting System. Equality and Diversity The post-holder must co-operate with all policies and procedures designed to ensure equality of employment. Co-workers, patients and visitors must be treated equally irrespective of gender, ethnic origin, age, disability, sexual orientation, religion etc. Special Working Conditions The post-holder is required to travel independently between practice sites (where applicable), and to attend meetings etc. hosted by other agencies. ConfidentialityThe post holder must at all times maintain complete confidentiality of the material and information that they handle. Any matters of a confidential nature, or in particular, information relating to diagnosis and treatment of patients and individual staff records must, under no circumstances be divulged or passed onto any unauthorised person or persons. The post holder must respect patient named confidentiality in keeping with ‘*Caldicott principles’*. Data ProtectionThe postholder is required to ensure that any personal information obtained, processed or held (on a computer or otherwise), is done so in a fair and lawful way and that the data held and processed is only for the specified registered purposes, in particular personal data relating to patients. Business Conduct, Governance and StandardsUttlesford Health, North Uttlesford PCN and the constituent practices aim to maintain the goodwill and confidence of its own staff and of the general public. To assist in achieving this objective it is essential that, at all times, the postholder carries out their duties in a courteous, sympathetic manner. The postholder is required to comply with all policies and procedures in force and ensuring that the reporting requirements, systems and duties of action put into place by Uttlesford Health are complied with.In upholding the good governance and standards, Uttlesford Health has a clinical and corporate framework, which the postholder is expected to comply with and failure in this regard may lead to disciplinary action. Equal OpportunitiesThe Company has an Equal Opportunities Policy. The aim is to ensure that no individual receives less favourable treatment on the grounds of disability, age, sex, sexual orientation, marital status, race, colour, creed, ethic/national origin. Whilst the Company recognises specific responsibilities fall upon Management, it is also the duty of all employees to accept personal responsibility for the practical application of the Policy.Training & DevelopmentThe successful post holder will be expected to be responsible for his/her continuing professional development and to take a proactive approach to maintaining personal and professional effectiveness in an evolving role.Rehabilitation of Offenders ActThis post is subject to the Rehabilitation of Offenders Act (Exceptions Order) 1975 and as such it will be necessary for a submission for Disclosure to be made to the Disclosure and Barring Service (formerly known as CRB) to check for any previous criminal convictions. **This job description is not a definite 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 performance review process.** |

**PERSON SPECIFICATION**

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| **Criteria** | **Essential** | **Desirable** |
| **Personal Qualities & Attributes** | Ability to listen, empathise with people and provide person centred support in a non-judgemental way | E |  |
| Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity | E |  |
| Commitment to reducing health inequalities and proactively working to reach people from all communities | E |  |
| Able to support people in a way that inspires trust and confidence, motivating others to reach their potential | E |  |
| Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders | E |  |
| Ability to identify risk and assess/manage risk when working with individuals | E |  |
| Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when what the person needs is beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner | E |  |
| Able to work from an asset-based approach, building on existing community and personal assets | E |  |
| Able to provide leadership and to finish work tasks | E |  |
| Ability to maintain effective working relationships and to promote collaborative practice with all colleagues | E |  |
| 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 | E |  |
| Demonstrates personal accountability, emotional resilience and works well under pressure | E |  |
| Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines | E |  |
| High level of written and oral communication skills | E |  |
| Ability to work flexibly and enthusiastically within a team or on own initiative | E |  |
| Understanding of the needs of small volunteer-led community groups and ability to support their development | E |  |
| Knowledge of and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety | E |  |
| **Qualifications, Training & Experience** | NVQ Level 3, Advanced level or equivalent qualifications or working towards |  | D |
| Demonstrable commitment to professional and personal development | E |  |
| Training in motivational coaching and interviewing or equivalent experience |  | D |
| Experience of working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work) |  | D |
| Experience of supporting people, their families and carers in a related role (including unpaid work) | E |  |
| Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity |  | D |
| Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups |  | D |
| Experience of data collection and providing monitoring information to assess the impact of services |  | D |
| Experience of partnership/collaborative working and of building relationships across a variety of organisations | E |  |
| **Skills & Knowledge** | Knowledge of the personalised care approach |  | D |
| Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities | E |  |
| Knowledge of community development approaches |  | D |
| Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports | E |  |
| Knowledge of motivational coaching and interview skills |  | D |
| Knowledge of VCSE and community services in the locality |  | D |
| **Other** | Meets DBS reference standards and has a clear criminal record, in line with the law on spent convictions | E |  |
| Full driving licence and ability to travel between practices and attend various community-based meetings. | E |  |
| Willingness to work flexible hours when required to meet work demands | E |  |

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| **JOB DESCRIPTION AGREEMENT/ACCEPTANCE: To be finalized and completed on appointment** |
| This job description is intended to provide an outline of the key tasks and responsibilities only. There may be other duties required of the post-holder commensurate with the position. It will be subject to regular review and amendment as necessary in consultation with the post holder. As part of the regular appraisal process the post holder will be set annual objectives. |
| **Signed (job holder):** |
| **Please print name:** |
| **Date:** |

**Please return signed version to the HR Department, Uttlesford Health Limited,**

**5 Ferguson Close, Saffron Walden Community Hospital, CB11 3HY**