

Social Prescribing Link Worker (SPLW)

This pack contains an example job description, person specification and job advert for a Pharmacy Technician. These resources align to the requirements set out in the Network Contract DES and are intended to be helpful for PCNs as they recruit to the Additional Roles Reimbursement Scheme. They are based on the role outline included in section B of the Network Contract DES, which can be found [here](#) and incorporate wider responsibilities that Pharmacy Technicians may undertake.

However, they are intended as helpful resources only: **they are not mandatory for use and PCNs should create their own versions of each resource to align to their individual needs.**

EXAMPLE Job Description

Job Title: Social Prescribing Link Worker (SPLW)

Responsible to: To be determined by the PCN

Accountable to: To be determined by the PCN

Hours of work: To be determined by the PCN

Salary: To be determined by the PCN [*note: the role outline and reimbursement is based on indicative AfC Band 5*]

Job Scope

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 an 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.

Social prescribing can help to strengthen community resilience and personal resilience, and reduces 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. It particularly works for people with long-term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which affect their wellbeing.

Key duties and responsibilities

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 (list not exhaustive).

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 to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services.

The role will require managing and prioritising your own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. It is vital that you 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.

Draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. Ensure they are supported, have basic safeguarding processes for vulnerable individuals and can provide opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence.

Work together with all local partners to collectively ensure that local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.

KEY TASKS

Referrals

1. Promoting social prescribing, its role in self-management, and the wider determinants of health.
2. 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.
3. 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.
4. 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.
5. Provide referral agencies with regular updates about social prescribing, including training for their staff and how to access information to encourage appropriate referrals.
6. Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.
7. 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

1. Meet people on a one-to-one basis, making home visits where appropriate within organisations' policies and procedures. Give people time to tell their stories and focus on 'what matters to me'. 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.

2. Be a friendly source of information about wellbeing and prevention approaches.
3. Help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities.
4. Work with the person, their families and carers and consider how they can all be supported through social prescribing.
5. Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.
6. 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.
7. Where appropriate, physically introduce 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.
8. 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.
9. Support community groups and VCSE organisations to receive referrals
10. 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.
11. Develop supportive relationships with local VCSE organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.
12. 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.
13. 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.
14. Support local groups to act in accordance with information governance policies and procedures, ensuring compliance with the Data Protection Act.
15. Work collectively with all local partners to ensure community groups are strong and sustainable
16. Work with commissioners and local partners to identify unmet needs within the community and gaps in community provision.
17. Support local partners and commissioners to develop new groups and services where needed, through small grants for community groups, micro-commissioning and development support.

18. 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.
19. 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.
20. Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.
21. 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.

Data capture

1. 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.
2. Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.
3. 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.
4. Work closely with GP practices within the PCN to ensure that social prescribing referral codes are inputted to EMIS/SystmOne/Vision 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).

Clinical Governance

1. Identify risk issues that impact on peoples' health or social care needs.
2. Take appropriate action to the significance of the risk and consistent with protection procedures, applying protection procedures, following lone worker procedure.
3. Demonstrate effective team working inclusive of all relevant professionals.
4. Report all accidents / incidents, and all ill health, failings in equipment and / or environment to line managers.
5. Contribute towards audit and data collection as required.
6. Once assessed as competent will be accountable for their own practice within their area of responsibility when identified and agreed with the line manager.
7. Professional development
8. Work with your line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.
9. Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.

10. Work with the Clinical Director to access regular 'clinical supervision', to enable you to deal effectively with the difficult issues that people present.

Miscellaneous

1. Work as part of the team to seek feedback, continually improve the service and contribute to business planning.
2. 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.
3. Duties may vary from time to time, without changing the general character of the post or the level of responsibility.

Supervision

The postholder will have access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.

EXAMPLE Person Specification

Element	Essential	Desirable
Qualifications	<ul style="list-style-type: none"> • NVQ Level 3, Advanced level or equivalent qualifications or working towards this level. • Demonstrable commitment to professional and personal development 	<ul style="list-style-type: none"> • Training in motivational coaching and interviewing or equivalent experience
Skills & Knowledge	<ul style="list-style-type: none"> • Understanding of the wider determinants of health, including social, economic and environmental factors and their impact • Knowledge of community development approaches • Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans • Knowledge of motivational coaching and interview skills • Knowledge of VCSE and community services in the locality • Awareness of GDPR • Awareness of Safeguarding Children & Adults 	<ul style="list-style-type: none"> • Knowledge of the personalised care approach

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<p>Experience</p>	<ul style="list-style-type: none"> • Experience of working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work) • Experience of supporting people, their families and carers in a related role (including unpaid work) • Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups • Experience of partnership/collaborative working and of building relationships across a variety of organisations • 	<ul style="list-style-type: none"> • Experience of data collection and providing monitoring information to assess the impact of services • Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity
<p>Personal attributes & abilities</p>	<ul style="list-style-type: none"> • Ability to listen, empathise with people and provide person-centred support in a non-judgemental way • Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity • Commitment to reducing health inequalities and proactively working to reach people from all communities • Able to support people in a way that inspires trust and confidence, motivating others to reach their potential • Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders • Ability to identify risk and assess/manage risk when working with individuals • 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 • Able to work from an asset 	<ul style="list-style-type: none"> •

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	<p>based approach, building on existing community and personal assets</p> <ul style="list-style-type: none"> • Able to provide leadership and to finish work tasks • Ability to maintain effective working relationships and to promote collaborative practice with all colleagues • Commitment to collaborative working with all local agencies • Demonstrates personal accountability, emotional resilience and works well under pressure • Ability to organise, plan and prioritise on own initiative, including when under pressure • pressure and meeting deadlines • High level of written and oral communication skills • Ability to work flexibly and enthusiastically within a team or on own initiative • Understanding of the needs of small volunteer-led community groups and ability to support their development • Knowledge of and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, • information governance, and health and safety 	
<p>Other</p>	<ul style="list-style-type: none"> • Meets DBS reference standards and has a clear criminal record, in line with the law on spent • Willingness to work flexible hours when required to meet work demands • Current full driving licence and sole use of car. • Ability to travel across the locality on a regular basis, including to visit people in their own homes 	

EXAMPLE Job Advert

Job Title: Social Prescribing Link Worker (SPLW)
Working hours: 37.5 hours per week, full time
Rate of pay:
Contract:
Closing date:
Interview date:

We are looking to recruit to the post of social prescribing link worker, to work within our Primary Care Network multidisciplinary healthcare team.

FURTHER DETAIL TBC ONCE JD IS FINALISED

The post holder will work with a diverse range of people from different cultural and social backgrounds. The ability to work confidently and effectively in a varied, and sometimes challenging environment is essential.

The successful candidate will have excellent interpersonal and communication skills, and be organised, patient and empathetic. They will have experience of working in health, social care or other support roles including direct contact with people, families or carers.

For more information and a job pack:

Call us on:
Email:
Website: