**Job Description:**

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| **Job Title**: Social Prescribing Link Worker/Wellbeing Coordinator (Hand in Hand) |
| **Reporting to**: Head of Care Quality & Service Development | **Number of Direct Reports**: Nil |
| **Purpose of the Role**: 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. The Social Prescribing Link Worker/Wellbeing coordinator will work within with the Winchester City Primary Care Teams and alongside the Proactive care teams to provide social prescribing services for people aged 55 and over in their own home and in the GP practices through the delivery of clinics. This role will work with the wider Social prescribing team including a team of trained Volunteers.  |
| **Main Duties**:**Referrals** * Promoting 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.
* Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.
* To provide an advice, befriending and signposting service for scheme members (service users), residents, members, carers and professionals.
* To meet the requirements as set out in the St John’s Operational Guidance and Service Speciation.
* To co-ordinate and arrange meetings with older people within their homes or a suitable location with their carers to signpost them to support services to achieve their goals and encourage them to take the lead in managing their own care and well-being.
* To provide social prescribing clinics within the constituent practices of Winchester PCN.

**Provide personalised support** * Work from a strength-based approach focusing on a person’s assets to develop personalised Living Well /support plans.
* Be a friendly source of information about wellbeing and prevention approaches. Work with the person, their families and carers and consider how they can all be supported through social prescribing.
* To ensure that scheme users are able to access services available in the community – both free and where charges apply - based on the coordinator’s detailed knowledge of the relevant access arrangements, eligibility criteria and service content.
* To connect to the services that already exist locally – both statutory and voluntary, so that services ‘wrap-around’ the scheme user.
* To work with people with a range of needs, dealing with issues ranging from social isolation and keeping people engaged in their community, to prevent unnecessary admission to hospital or care homes.
* To work with members proactively to set up a Living Well Plan and signpost with a follow up process.
* To assist people to access an assessment for Adult Social Care where appropriate.
* To liaise with the Primary Care Team and hospitals.
* To maintain a database of appropriate support services, ensuring that it is regularly cleansed and updated.

**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.
* 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).
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**Person Specification:**

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| **Criteria**  | **Essential**  | **Desirable**  |
| **Personal Qualities & Attributes** page23image1660224page23image1660640page23image1663136page23image1663552page23image1663968page23image1664384 | Ability to listen, empathise with people and provide person- centered support in a non-judgemental way  | ✓  |  |
| Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity  | ✓  |  |
| Able to support people in a way that inspires trust and confidence, motivating others to reach their potential  | ✓  |  |
| Ability to identify risk and assess/manage risk when working with individuals and a clear 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 | ✓ page23image1677696 |  |
| Ability to maintain effective working relationships and to promote collaborative practice with all colleagues  | ✓  |  |
| Demonstrates personal accountability, emotional resilience and works well under pressure  | ✓  |  |
| Ability to organise, plan and prioritise on own initiative, including when under 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  | ✓  |  |
| Knowledge of and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety  | ✓  |  |
| **Qualifications & Training** page23image1699536 | Good general education especially in English and MathsA social work qualification/NVQ 3, Advanced level or equivalent health and social care qualification | ✓  |  |
| Demonstrable commitment to professional and personal development  | ✓  |  |
| **Experience**  |  |  |  |

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|  | Experience of supporting people, their families and carers in a related role (including unpaid work)  | ✓  |  |
| Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity  |   | ✓ |
| Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups  | ✓  |  |
| Experience of data collection and providing monitoring information to assess the impact of services  |   | ✓ |
| Experience of partnership/collaborative working and of building relationships across a variety of organisations  | ✓  |  |
| **Skills and knowledge** page24image3676672page24image3677712 | Knowledge of the personalised care approach  |   | ✓ |
| Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports  | ✓  |  |
| Knowledge of VCSE and community services in the locality  | page24image3690608  | ✓ |
| **Other**  | Meets DBS reference standards and has a clear criminal record, in line with the law on spent convictions  | ✓  |  |
| Willingness to work flexible hours when required to meet work demands  | ✓  |  |
| Access to own transport and ability to travel across the locality on a regular basis, including to visit people in their own homes  | ✓  |  |

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| I confirm receipt of this job description and person specification |
| NAME (print) |  |
| Signature |  |
| DATE |  |