Public Voice

service improvement
through user engagement

Link Worker - Social Prescribing Applicant Pack

Dear Applicant,

Thank you for expressing an interest in the role of Link Worker / Social Prescriber working with GP Practices in one of the eight Primary Care Networks (PCNs) in Haringey. This is an exciting new opportunity and I hope you will find the details in this application pack both interesting and useful in making your application. I do suggest you have a look at our two websites, details below, which will give you a better understanding of Public Voice and the scope of our current activities.

Please send us a CV and a separate Personal Statement of no more than two sides of A4 explaining how you meet the person specification for the role, see below. We will be evaluating all applications against the Person Specification. Applications must also include a completed Monitoring Form.

Applications should be sent to info@publicvoice.london by 5.00pm Wednesday 21st August and should include the names and contact details of two referees. Postal applications can be sent to: Public Voice, Tottenham Town Hall, Town Hall Approach Road, London, N15 4RX.

If you require the recruitment pack in an alternative format, please call 020 3196 1900.

I look forward to hearing from you

Mike Wilson

Director

ADVERT

Social Prescribing Link Worker

Hours of work: 37.5 or Part time

Annual Leave: 25 days (plus bank holidays)

Salary: £26k (+3%pension contribution)

Period: July 2020, with possibility of extension.

Based: London Borough of Haringey, local 'Primary Care Networks'

Purpose of the job

These are innovative new roles to develop 'social prescribing' in the local NHS. Based in one of the eight Primary Care Networks (PCNs) you will work in different GP practices in that Network to deliver their specific priorities. You will be part of a wider community based Borough team which offers information, signposting and short term support across the eight localities in Haringey.

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.

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.

For more information about how to apply please email info@publicvoice.london

Closing date: Wednesday 21st August 5.00pm.

PUBLIC VOICE – WHO ARE WE?

Public Voice is a Community Interest Company (CIC) which started trading in April 2015 and has a mission to improve services through user engagement. Our main long term contracts in Haringey include delivering the statutory Healthwatch programme and the Information, Advice and Guidance service, as a member of the Haringey Advice Partnership. We also undertake public health related research projects and support an Expert by Experience board engage with the North Central London STP Mental Health workstream. Find out more about us on our two websites www.publicvoice.london and www.healthwatchharingey.org.uk

We recently won a substantial contract in Haringey to deliver a "Community Navigation Service" which provides support to those residents 50+ through signposting and brief interventions where additional support is required. The Link Workers / Social Prescribers will be part of this team but based in GP Practices and offering a service to all adults over eighteen years of age.

LINK WORKER / SOCIAL PRESCRIBER

NHS England (NHSE) has made funding available to Primary Care Networks (PCNs) from 1st July 2019 to provide a "social prescribing" service to patients who will benefit from a more holistic approach to their wellbeing. The NHSE Guidance states that "social prescribing and community-based support is part of the NHS Long-Term Plan's commitment to make personalised care business as usual across the health and care system".

The term 'social prescribing' refers to an arrangement where health professionals link up patients to activities and support in the community that may benefit them – a non-medical prescription. It can be particularly effective in helping individuals to manage long-term conditions, mental health problems and social isolation. Activities that make up a social prescribing service are extremely varied and can be tailored to meet the needs of a particular community, demographic or patient group. For example, they can include support groups, exercise classes, advice services, cookery and outdoor activities.

Purpose of the job

At the centre of the social prescribing process is a "link worker", working with GP Practices in a Primary Care Network, who connects patients who are referred to a range of activities and services in the local area depending on their needs, interests and capacity for engagement. This is a complex role as the link worker will need to have good interpersonal skills to engage with the patient and have a comprehensive knowledge of the services and activities available in the local area.

Accountability

The Link Worker will be employed by Public Voice, reporting to the Director of Public Voice for their line management and performance reporting. Link Workers will be based in a GP Practice in one of the eight Primary Care Networks (PCNs) and be accountable to the PCN for delivering the GP's specific social prescribing objectives. They will be part of the Borough Wide Community Navigator Service which is community based and operates in eight localities across Haringey. The eight localities are similar to the eight PCN areas and each Link Worker will be a member of, and supported by, their local Community Navigator team which is led by a Community Connector.

Key tasks and responsibilities

Working with GP practices within one of the primary care networks, taking referrals from GPs, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals and other agencies. 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.

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 individual.

Work in partnership with key staff in GP practices within the local Primary Care Network (PCN) to deliver their priorities, attending relevant meetings, becoming part of the wider network team, giving information and feedback on social prescribing. As a member of the local Community Navigator team you will attend regular team meetings to give feedback on the service, raise issues and receive briefings and updates from team members.

- 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, engage and inspire people to take part, assessing their needs and offering a personalised approach to include face to face meetings, home visits, telephone support as required
- 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. Set goals and develop plans with people to help them take control of their health and wellbeing.
- Work with people in a supportive, holistic way (using a Motivational Interview approach) to address practical and psychological barriers, such as lack of transport, low confidence and social isolation, to co-produce a solution.
- Using the Charity Log CRM system 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 Haringey Circle.
- Maintain regular, supportive contact to address issues as they arise and ensure people progress and achieve their goals.
- Ensure all necessary data and information about patients, users and volunteers is recorded accurately and confidentially on the CRM database with awareness of information governance best practice.
- Use recognised tools with patients to track improvements in their health and wellbeing, such as Warwick Edinburgh scale and Work with GP practices to review data on GP appointments and hospital admissions to track statistical improvements at practices.

- Engage with Patient Participation Groups, existing community groups, patients and staff to promote volunteer opportunities
- Work closely with the locality Community Navigator team to benefit from the co-ordination of activities and link in with the wider service offer.
- Help to identify 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 CRM directory (with support from colleagues).
- Achieve demanding targets for numbers of people engaged and supported and produce monthly monitoring reports as required.

Person Specification

Essential:

- Background in health / social care or working with vulnerable / isolated people
- Experience of working in an urban multi-cultural area
- To be non-judgmental and to take a positive approach to all people.
- Able to follow processes and systems when accepting referrals, assessing people, developing action plans and following up
- Excellent communication skills, able to negotiate, build relationships, advocate for people and inspire others
- To be sensitive to the needs of individuals and communities that are perceived as hard-to-reach
- The ability to effectively communicate with a wide range of stakeholders, including good social interaction and listening skills
- Driven, target focused and highly motivated
- Resilient and confident, able to work in a busy environment (GP practice) with colleagues under pressure and champion the service to health professionals
- Outgoing, energetic and passionate about improving the health and wellbeing of others
- Good IT skills and experience of using a database or CRM system
- Good knowledge of information governance and ability to maintain confidentiality at all times, within any statutory guidance on safeguarding.
- Able to work autonomously and be a self-starter.
- Able to take decisions and use professional expertise, but within a structured framework and existing systems and policies.
- Effective team player who contributes to the success of others.

Desirable

- Experience of motivating, empowering and supporting people to achieve goals
- Experience of working with volunteers
- Fluent in a second language

END