Recruiting social prescribing link workers

NHS England and partners have created the following, as a helpful resource:

- sample job description
- sample person specification
- sample job advert
- sample interview questions

These resources will support the recruitment of link workers in a manner that aligns with the requirements set out in the Network Contract DES.

Sample job description – social prescribing link worker
Purpose of the role Social prescribing empowers people to take control of their health and wellbeing through referral to 'link workers' who give time, focus on 'what matters to me' and take a holistic approach to an individual's health and wellbeing, connecting people to diverse community groups and statutory services for practical and emotional support. Link workers also support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local diverse partners. Social prescribing link workers will work as a key part of the primary care network (PCN) multi-disciplinary team. Social prescribing can help PCNs to strengthen community and personal resilience, reduce health inequalities (in relation to timely access and outcomes) and wellbeing 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 diverse 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.
Salary: £24,907- £30,615
Key responsibilities 1. Working with direct supervision by a GP, take referrals from the PCN's Core Network Practices and from a wide range of agencies, including pharmacies, wider 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). 2. Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health access and outcomes, as a key member of the PCN multi-disciplinary team. 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 simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to appropriate 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 the person's needs are beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner.

3. Work with a diverse range of people and communities, to draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups (including faith groups) to receive social prescribing referrals.

4. Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local diverse partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities.

5. Social prescribing link workers will have a role in educating non-clinical and clinical staff within their PCN multi-disciplinary teams on what other services are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

Key Tasks

Referrals

- Promote social prescribing, its role in self-management, addressing health inequalities and the wider determinants of health.
- As part of the PCN multi-disciplinary team, build relationships with staff in GP practices within the local PCN, attending relevant MDT meetings, 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 access and 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 equality and inclusion, through self-referrals and connecting with all diverse local communities, particularly those communities that statutory agencies may find hard to reach.

Provide personalised support

- 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 and respect with the person, providing non-judgemental and non-discriminatory support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person's assets.
- Be a friendly and engaging source of information about health, 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 to address the person's health and wellbeing needs – based on the person's priorities, interests, values, cultural and religious/faith needs 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, physically introduce people to culturally appropriate community groups, activities and statutory services, ensuring they are comfortable, feel valued and respected. 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.
- Seek advice and support from the GP supervisor and/or identified individual(s) to discuss patient-related concerns (e.g. abuse, domestic violence and support with mental health), referring the patient back to the GP or other suitable health professional if required.

Support community groups and VCSE organisations to receive referrals

- Forge strong links with a wide range of local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what's already available to create a menu of diverse community groups and assets, who promote diversity and inclusion.
- Develop supportive relationships with local diverse VCSE organisations, culturally appropriate community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.

Work collectively with all local partners to ensure community groups are strong and sustainable

- Work with commissioners and local partners to identify unmet diverse needs within the community and gaps in community provision.
- Encourage people who have been connected to community support through social prescribing to volunteer and give their time freely to others, building their skills and confidence and strengthening 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

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. Provide appropriate feedback to referral agencies about the people they referred.
- Work closely within the MDT and with GP practices within the PCN to ensure that the social prescribing referral codes are inputted into clinical systems (as outlined in the Network Contract DES), adhering to data protection legislation and data sharing agreements.

Professional development

- Work with your supervising GP and/or line manager (if different) 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, equality, diversity and inclusion training and health and safety.
- Work with your supervising GP to access regular 'clinical supervision', to enable you to deal effectively with the difficult issues that people present.

Miscellaneous

- Work as part of the healthcare team to seek feedback, continually improve the service and contribute to business planning.
- Contribute to the development of policies and plans relating to equality, diversity and health inequalities.
- 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.

Person specification – social prescribing link worker

Criteria		**Essential**	**Desirable**
Personal qualities & attributes	Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental way	✓	
	Able to provide a culturally sensitive service, by supporting people from all backgrounds and communities, respecting lifestyles and diversity	✓	
	Commitment to reducing health inequalities and proactively working to reach people from diverse 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 the person's needs are beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner	✓	
	Able to work from an asset-based approach, building on existing community and personal assets	✓	
	Ability to maintain effective working relationships and to promote collaborative practice with all colleagues	✓	
	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	✓	
	Can demonstrate personal accountability, emotional resilience and ability to work 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	✓	
	Understanding of the needs of small volunteer-led community groups and ability to support their development	✓	
	Able to provide motivational coaching to support people's behaviour change	✓	
	Knowledge of, and ability to work to, policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety	✓	
Qualifications & training	NVQ Level 3, Advanced level or equivalent qualifications or working towards	✓	
	Demonstrable commitment to professional and personal development	✓	
	Training in motivational coaching and interviewing or equivalent experience		✓
Experience	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 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 using tools to measure the impact of services	✓	
	Experience of partnership/collaborative working and of building relationships across a variety of organisations	✓	

Skills and knowledge	Knowledge of the personalised care approach	✓	
	Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities, individuals, their families and carers	✓	
	Understanding of, and commitment to, equality, diversity and inclusion.	✓	
	Knowledge of community development approaches	✓	
	Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports	✓	
	Local knowledge of VCSE and community services in the locality		✓
	Knowledge of how the NHS works, including primary care		✓
Other	Meets DBS reference standards and criminal record checks	✓	
	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	✓	

Sample job advert

Job Title: Social Prescribing Link Worker
Working hours: 37.5 hours per week, full time
Rate of pay: £24,907- £30,615
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 multi-disciplinary healthcare team, providing 1:1 personalised support to people who are referred to them by team members and local agencies.

This post empowers people to take control of their health and wellbeing by giving time to focus on 'what matters to me'. The social prescribing link worker will build trusting relationships with people, create a shared personalised care and support plan and connect them to local, diverse and culturally appropriate community groups, VCSE organisations and services. They will also work with a diverse range of partners to provide support to community groups and VCSE organisations involved in social prescribing.

This role helps people to work on their wider health and wellbeing, specifically addressing health access and outcomes and wider determinants of their health, such as debt, poor housing and physical inactivity, as well as other lifestyle issues and low-level mental health concerns by increasing people's active involvement with their local communities. This approach particularly helps people with long term conditions (including support for mental health), people who are lonely or isolated, or who have complex social needs which affect their wellbeing.

You must be a good listener, have time for people and be committed to supporting local communities to care for each other. You should have experience of working positively with people facing complex social and emotional challenges. You will have great interpersonal skills in supporting people, community groups and local organisations.

The postholder will work with a diverse range of people from different cultural and social backgrounds. The ability to work confidently and effectively in a diverse, and sometimes challenging environment is essential. We are committed to having a workforce in which people from diverse backgrounds are supported and empowered to work with local communities to improve health access and outcomes for all and provide culturally appropriate and responsive public services.

For more information and a job pack

Call us on
Email
Website

Sample interview questions

Example scenario (or substitute a real-life example from your practice)

Please ask all candidates to arrive 15 minutes early, give them this scenario and ask them to prepare some points to discuss at interview:

An older woman (Malia) has been attending GP consultations at least every week for anxiety and insomnia over the past few months. Her daughter (Asha) needs support with her mental health and has two autistic sons, aged 7 and 5, who Malia helps to care for. Malia is worried that Asha cannot cope anymore and may carry out her threat of suicide.

How would you go about supporting this family and what would your approach be?

You have 10 minutes at the start of the interview to outline your approach.

Example Interview questions:

1. Why do you want this post and what do you bring to it?
2. What skills/qualities will you bring to the primary care network multi-disciplinary team?
3. Please tell us about a time when you have supported someone who is experiencing complex personal circumstances, such as long-term health conditions, anxiety or practical issues, such as debt and poor housing. How did you support them and what were the challenges in providing support?
4. Tell us about when you have led or participated in partnership working. Please explain your role, what you did to support the partnership, what you achieved together and what the challenges were?
5. The social prescribing link worker role aims to reduce health inequalities, by supporting people to overcome exclusion or disadvantage. Can you tell us why health inequalities are bad for people and give us an example of where you have practically helped someone to overcome exclusion, reduce disadvantage or discrimination?
6. How would you support someone who is distressed, angry and emotional? Please explain what you would do to support them now and how would you help them in the future to overcome their issues?
7. Local community groups and organisations change leaders frequently. How would you keep up to date with understanding the people and development needs of local community groups and organisations?
8. What would you need to do to ensure that local community groups are safe and inclusive, to enable you to connect people to them?
9. Please can you tell us about a piece of work where you have had to record information and monitor the impact of the work? How did you go about this, what did you learn from the process?
10. How would you support your PCN colleagues to strengthen links between the GP practices within the primary care network and local community?
11. If someone were to describe your approach to work in three words, what would the three words be?