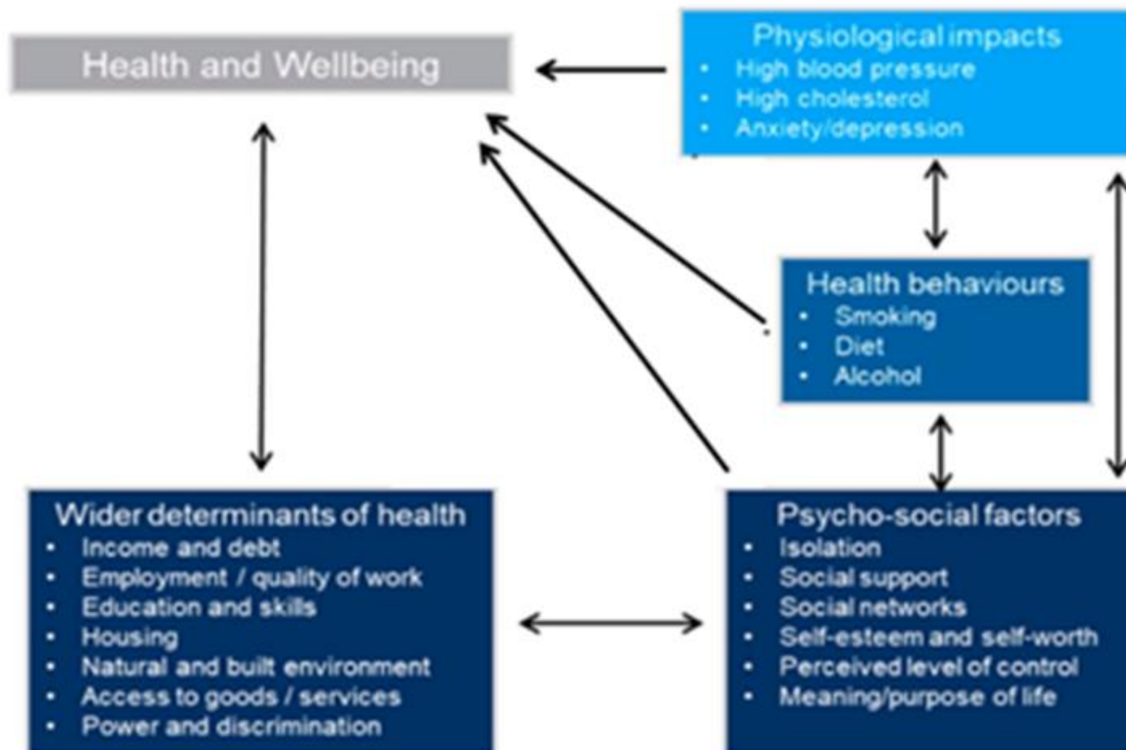
FIRST CONTACT CLINICAL
ENABLING HEALTHY BEHAVIOUR CHANGE

The purpose of Social Prescribing



Social prescribing empowers people to take control of their health and wellbeing through referral to non-clinical social prescribing link workers. They give people time to focus on what matters most and take a holistic approach to an individual's health and wellbeing. Working within a biopsychosocial framework, we coach people around what matters to them and support them to set goals they can work towards and achieve. We provide personalised behaviour change interventions to build on people's knowledge, skills and confidence.

Link Workers in the Primary Care Network Teams:

- Take a whole population approach, working with a range of people who may benefit from social prescribing, including people who are lonely, have complex social needs, low level mental health needs and long-term conditions
- Help people to identify issues that affect their health & wellbeing, and co-produce a simple personalised care and support plan
- Support people by connecting them to non-medical, community-based activities, groups and services that meet their practical, social and emotional needs, including specialist advice services and arts and culture, physical activity, and nature and green based activities
- Use coaching and motivational interviewing techniques to support people to take control of their own health and wellbeing
- Support development of accessible and sustainable community offers by working in partnership with VCSE organisations, local authorities and others to identify gaps in provision, and take a community development approach to enabling growth in community activities and groups.

Link Workers in our non-PCN team also:

- Promote the service and identify new opportunities to expand
- Identify new opportunities to respond to population-level needs
- Build access to social prescribing in under-served communities
- Work across the locality, and with internal and external colleagues, on innovative projects to test new interventions

Health and Wellbeing Coaches:

- Work as part of a multi-disciplinary team, across a variety of health and social care settings, providing holistic care to a case load of people. This may include those who have physical and/or mental health conditions, people with long term conditions and those at risk of developing them
- Help people to identify issues that affect their health & wellbeing, and co-produce a simple personalised care and support plan
- Focus goal setting to improve health related outcomes where lifestyle modification and self-management have a significant impact on outcomes and prognosis
- Support people by connecting them to non-medical, community-based activities, groups and services that meet their practical, social and emotional needs, including specialist advice services and arts and culture, physical activity, and nature and green based activities
- Use coaching skills and motivational interviewing techniques to support people to manage their condition and/or situation
- Support groups of people through group coaching and structured self-management education

Care Coordinators:

- Work as a part of a multi-disciplinary team, to build trusting relationships with clients and taking a holistic approach to support.
- Take a personalised approach and bring together all the information about a person's care and support needs.
- Work with a range of clients, particularly those who are living with long-term conditions and frailty, supporting people to coordinate and navigate their care across the health and care system so that they might become more active in their own health and care.
- Facilitate referrals and conversations to support a joined-up wat of working, including with specialists, GPs and community services. This may include setting up an MDT and advocating for what matters most to your client.
- Use your conversation skills to assess needs, facilitate joined working, ensure the effective flow of information, monitor needs and respond to change.

All roles:

Work unsupervised in a professional manner that promotes excellent person care and experience, while recognising professional and organisational requirements and boundaries. Regularly review risks, as an individual worker and as a team, and issues that could impact on individual care and wider service delivery. Actively engage in supervision and training with a commitment to personal development.

Build relationships with our partners who introduce people to us and to those we introduce people to. Ensure accurate reporting and data collection and contribute to the promotion of our work. Adopt our quality improvement methodology and seek to continuously improve our processes and systems to increase the experience and outcomes of our stakeholders.

Undertake any reasonable duties/responsibilities required to meet the needs of the developing service with a flexibility to work weekends and evenings if required. Contribute to the development and delivery of our high-quality behaviour change training programmes.

This list is not intended as an exhaustive list of duties and responsibilities. The post holder will be asked to carry out other duties which are appropriate to the skills of the post holder and grade of the post as the priorities of the service change.

Deliver our quality standards (full-time equivalent):

- Engage 200 to 250 people within any 12-month rolling period.
- Attend a personalised care and support plan conversation (PCSP) (new or review) with at least 25 people each complete working week.
- Complete an initial PCSP assessment within 15 working days of the referral date with at least 95% of people who engage.
- Complete and record an initial PAM with at least 90% of people who engage.
- Complete an attended appointment with at least 98% of the people on their caseload within any 8-week rolling period.
- Close at least 95% of the people they work with within 12 months of the referral date.
- Deliver an increasing number of conversations face to face. A % of overall contacts will be follow.
- Review each case after 6 PCSP sessions, and every multiple of 6 sessions thereafter. Best practice would see this performed with a peer or in supervision.