PRIMARY CARE
WORKFORCE & TRAINING HUB

Social Prescribing Link Workers
Description of role/core responsibilities
Up to indicative Agenda for Change Band 5

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. 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 impact on wellbeing.
Social prescribing link workers will have a key role in supporting delivery of the Comprehensive Model of Personalised Care.

The following sets out the key role responsibilities for SP links workers:

a. They will in 2019/20 take referrals from the network's members, expanding from 2020/21 to take referrals from a wide range of agencies8. Primary Care Networks that already have social prescribing link workers in place, or who have access to social prescribing services may take referrals from other agencies prior to 2020/21

b. They will:

- 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 them';
- 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 community groups and statutory services; and
- evaluate the individual impact of a person's wellness progress.

b. The role will require social prescribing link workers to manage and prioritise their own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. Where required and as appropriate, the social prescribing link workers will refer people back to other health professionals within the network.

c. Social prescribing link workers will draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. They will ensure those organisations and groups 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.

d. Social prescribing link workers will 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.

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