NHS
Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

Social Prescribing Link Workers Handbook

GUIDANCE TO SUPPORT THE SUCCESSFUL IMPLEMENTATION OF THE NEW ROLES WITHIN THE NETWORKED PRACTICES

Developed by NHS Hampshire Southampton and Isle of Wight CCG (South East Hampshire locality) in conjunction with the following Social Prescribing link workers:
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1. Key principles for delivering Social Prescribing within the Primary Care Networks

The NHS Long Term Plan ambition is that 2.5 million people will benefit from personalised care by 2023/24. SPLWs within primary care networks (PCNs) will work with people to develop tailored personalised care and support plans, and connect them to local groups and support services. More than 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by the end of 2023/24.

The Network Contract Direct Enhanced Service Specification 2021/22 sets out the requirements for PCNs to ensure that SPLWs undertake the following learning and development:

• Completion of the NHS England & NHS Improvement online learning programme, hosted by the Health Education England E-Learning for Health Platform

• Enrolment or completion of appropriate training as set out by the Personalised Care Institute

• Released for attendance at peer support sessions, co-ordinated by NHS England & NHS Improvement at Integrated Care System level.

As a valued member of the primary care network, we need to fully realise the value that the Social Prescribing workforce can bring to each of our practices.

By having an inclusive approach to sharing the caseload, we can work collaboratively to enhance the care we provide to our local population. This principle of working together has proven to have benefits for both staff and patients. Enhancing the oppourtunities for patients to be supported in their communities using a range of skilled individuals, each bringing their own skills and assets.

As a non-medical role, the skills of the Social Prescriber will complement and enhance the team of clinical practitioners to provide a holistic and personalised approach to the care delivery.

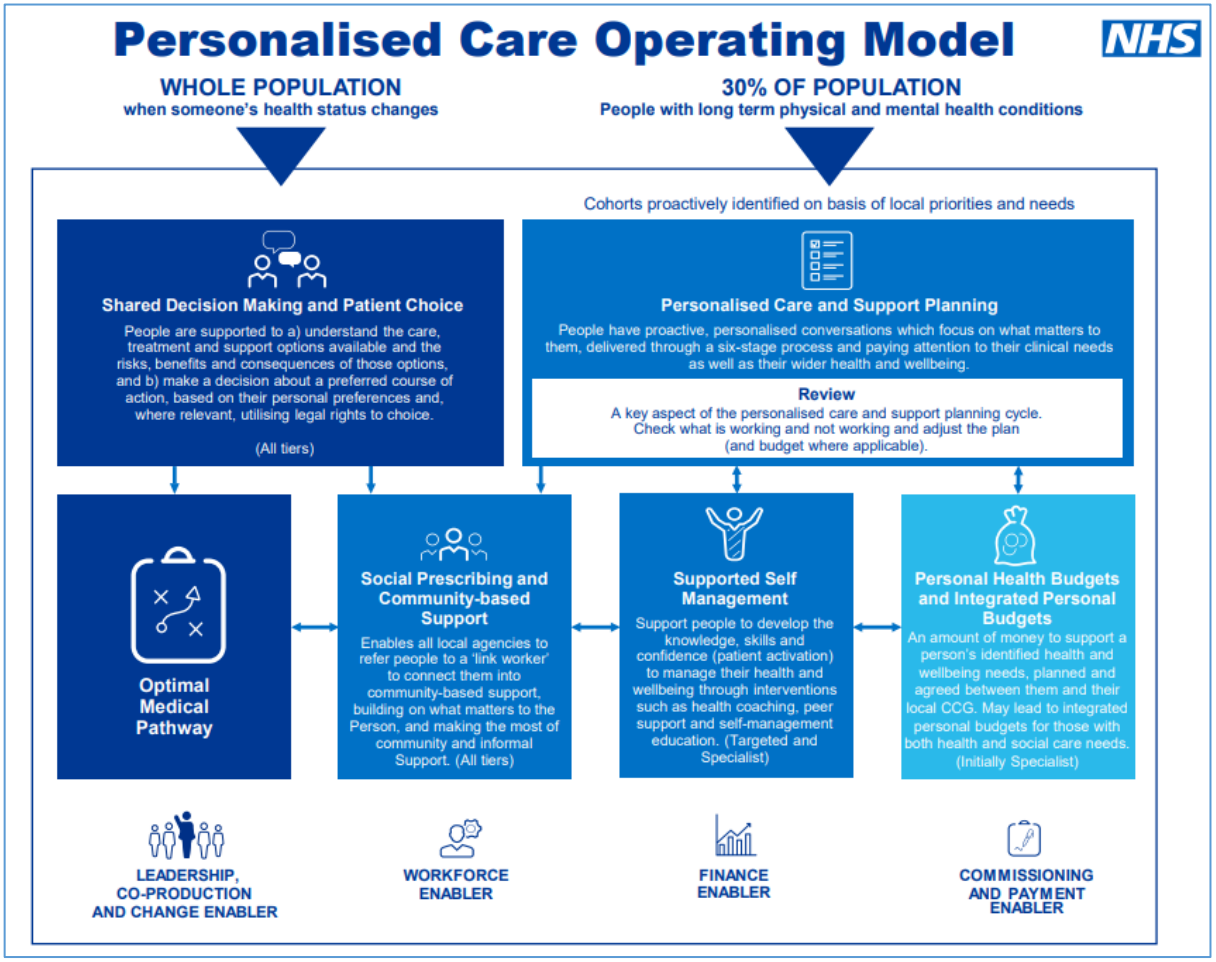
The comprehensive model of personalised care establishes:

"Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and making informed decisions and choices when their health changes. Building knowledge, skills and confidence and to help people live well with their health condition."

The personalised care model will helps us as a system to deliver this shift by bringing together six, evidence-based components or programmes, each of which is defined by a standard set of practices.

The six evidence-based components are:

1. Shared decision-making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets



Evidence has shown that to realise the full benefits of personalised care, these components and programmes should be delivered together and in full, alongside key enablers including strong leadership, co-production and workforce engagement across the health and care system, and in partnership with the voluntary and community sector.

NHS England and the Personalised Care Institute have developed a clear measurable model to assist in the delivery of personalised care at source; with Social Prescribing being a key enabler within our PCNs to help deliver these national standards in our daily practice.

2. Social Prescribing Link Worker

Primary Care Network (PCN) structure around the Social Prescribing Link Worker

The Social Prescribing principles, describe the expected professional conduct and actions of all Social Prescribers. By developing some local guidance, we aim to help promote role clarity for the benefit of the Social Prescriber and their managers.

2.1 Role Definition:

- Relationships and Communications
  - ✓ Develop relationships within the PCN clinical teams
  - ✓ Work with local community groups, VCSE organisations and other local partners to identify and utilise community assets. Staff can sign up to the Social Prescribing Collaboration Platform - Future NHS Collaboration Platform
  - ✓ To actively participate in peer-to-peer support and interconnectivity with the Social Prescribing Networks. Building links into National Academy for Social Prescribing - Thriving Communities | National Academy for Social Prescribing (socialprescribingacademy.org.uk)
  - ✓ To be aligned to the values of the PCN

- Confidentiality
  - ✓ Work with individuals to co-produce a personalised care and support plan that identifies outcomes that matter to the person. All documentation to be recorded in the GP clinical systems in line with local policy.
  - ✓ To adhere to the Caldicott principles around clinical record keeping.

- Training and Education
  - ✓ Access to statutory and mandatory training provided by the PCN to enable completion of a Social Prescriber competency framework.
  - ✓ Access to enhanced training via the Social Prescribing Network
  - ✓ Access to free online training via the Personalised Care Institute www.personalisedcareinstitute.org.uk
  - ✓ There is also an e-learning resource for Link Workers - Social Prescribing - e-Learning for Healthcare (e-lfh.org.uk)
  - ✓ Opportunities to attend accredited training add in the link from Home - National Association of Link Workers (nalw.org.uk)
  - ✓ To be allocated time for professional development and community integration work
  - ✓ Access and training on local IT systems
  - ✓ Understand the social/ wider determinants of health, health inequalities and population health
  - ✓ Engage in local health and wellbeing forum networks, to engage with and participate actively with local services
    - https://citahants.org/partners/home-and-well/
    - https://www.cfirst.org.uk/wellbeing/health-forums/

- Record Keeping
  - ✓ To maintain clinical records in line with PCN policies
  - ✓ Enable access to clinical records to upload information for the GPs
  - ✓ Complete national data set (in development – link to be added once published)

- Co-ordination and integration
  - ✓ To develop practice based relationships with the clinical staff and contribute to relevant MDT meetings.
  - ✓ To liaise with the patient to keep the patient informed
  - ✓ Working in coordination with voluntary sector organisations
  - ✓ To use standard IT systems to integrate notes for full transparency

- Enabling access to local services
  - ✓ Perform a link role between the PCN, the local GP practice, the patient and external agencies
  - ✓ To maintain an updated directory of local services e.g. Community directory search (connecttosupporthampshire.org.uk) / Home - Get Active
  - ✓ To work with other Social Prescribers to develop the directory
  - ✓ Develop the Social Prescribing referral criteria, identifying purpose for intervention.

Social Prescribing Link Worker role profile:

https://www.e-lfh.org.uk/wp-content/uploads/2020/10/Social-Prescribing-Link-Worker.pdf

Social prescribing Link Worker skills and competency framework:

Social_Prescribing_Link_Worker_Competency_framework_April_2021_DRAFT.pdf

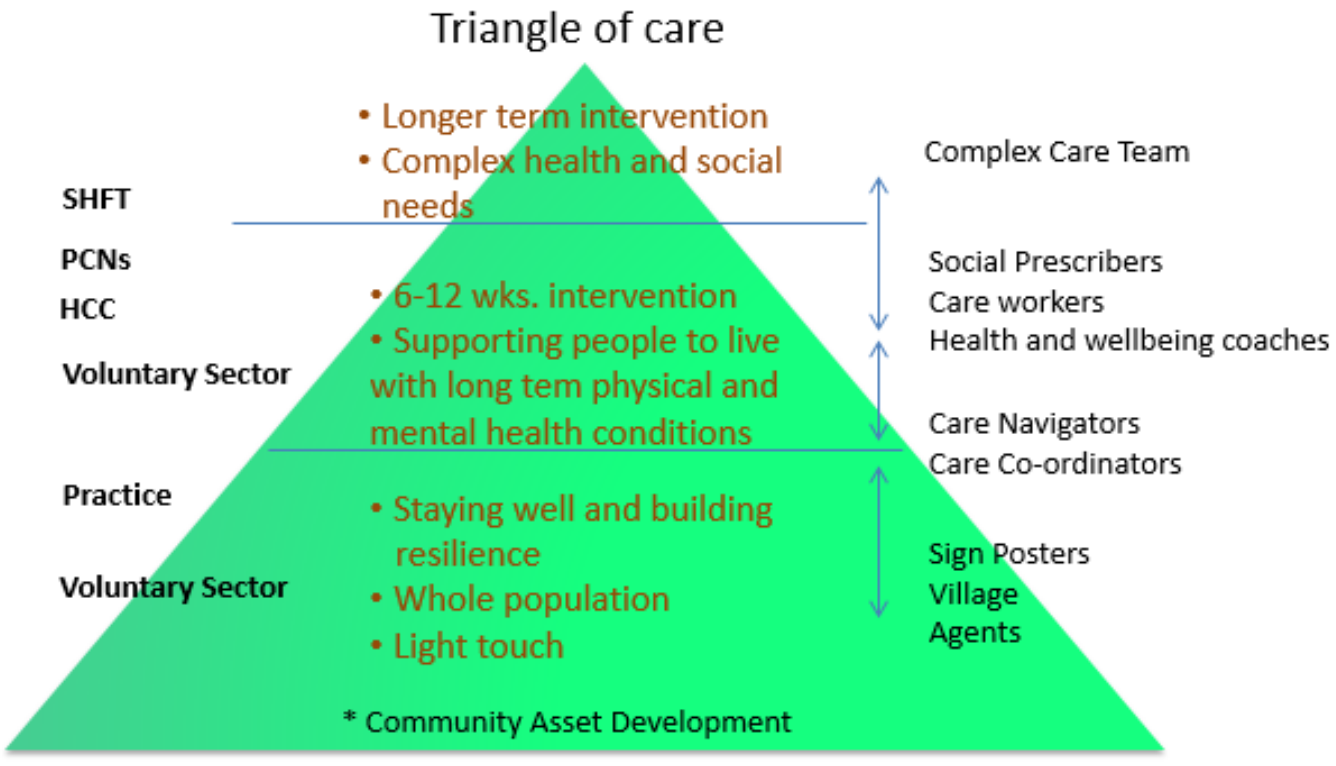
2.2 Scope of practice:

Band 5 Social Prescribing Link worker:

- Autonomy to develop and implement personalised patient care plans
- To advocate for the patient in the PCN and community space
- To link with appropriate voluntary/ community sector organisations
- Expectation that referrals will be appropriate to the skills of the Social Prescriber
- Implement Quality standards policies and procedures
- Developing the role, championing Social Prescribing
- Wider understanding of local population needs to support broad scope of patients
- Staff management roles /line managers (some PCNs have SP leads)
- Marketing support/communicating the service opportunities
- Helping to set up community based groups creating and liaising with VCSE
- Identifying gaps in the community for patients, escalating opportunities via the local Social Prescribing Network meetings (commissioners attend) including conversations with voluntary sector partners
- Networking on a regular basis with local community providers
- To accept referrals that have a clear link worker based intervention goal.

Not in scope: Patients with complex mental health needs / palliative care needs

2.3 Triangle of Care:



3. Primary Care Networks (PCNs)

Recommendations for management best practice

We have been running a Social Prescribing Network for the last year, and have been open to the learning that has come through around the good practice experienced by the Social Prescribing workforce. We would like to share the examples of good practice and would recommend these as guiding principles.

- ✓ To work with Social Prescribers to feel integrated not only into the PCN but also the core network practices: this would include inclusion in practice based meetings
- ✓ Enhance opportunities for Social Prescribing staff to be involved in MDT meetings and patient related conversations; enabling the clinical and non-clinical staff to have a holistic overview of patient care
- ✓ To implement clear channels of communication between the PCN and ARRS staff to help improve awareness across the board
- ✓ To ensure all PCN staff have equity of access to regular appraisals and clinical supervision within the local policy and in-line with core network practice staff
- ✓ Enable Social Prescribers within the PCN to access relevant training and protected time to develop community-based relationships to enhance the role. Social Prescribing - e-Learning for Healthcare (e-lfh.org.uk)
- ✓ Ensure your Social Prescribers are enabled to be part of a wider network, both locally and regionally in line with NHS England guidance for example Hants and IOW Social prescribing Network
- ✓ Training for managers to understand the role: NHS England social-prescribing-link-worker-welcome-pack
- ✓ Build relationships to help champion the new ARRS roles within the PCN
- ✓ Ensure Social Prescribers have access to the relevant IT systems, patient records and tools available within the PCN to fulfil the role
- ✓ Identify base locations and appropriate workspaces for ARRS staff.

4. Data Sharing

All PCN and practice staff should have equitable access to the clinical notes to gather information to assist in the delivery of personalised care, and update the care record in accordance with local protocols.

Best practice indicates that there is one set of notes to ensure consistency of record keeping and patient care.

5. Next steps:

How can PCNs maximise the Social Prescribing resource to ensure that we truly value and support the Social Prescribing role within our core-networked services?

TOP TIPS

- How can your Social Prescribers improve integration between the PCN activities and the core-networked practices?
- Do you include your Social Prescriber in core networked practice communications? What form does this take? What more do you need to do to enhance this?
  (Are your Social Prescribers involved in PCN/practice newsletter development?)
- What are the local opportunities to include the Social Prescribers in MDT or other patient centred conversations?
  Have you clearly defined a role within the MDT for the Social Prescriber?
- Have you or your Social Prescribers accessed information and/or training around personalised care? (links in the above document, or ask your social prescribers to talk to you or your teams about it)
- Within the PCN, do you have any clinical champions to support and share learning around the Social Prescribing role?
- How does your Social Prescriber link in with health and wellbeing coaches and care co-ordinators? Are the different roles defined?
- Are you fully utilising your Social Prescribing asset within your PCN?
- What can you do to work with them to develop this role further?
- Do you have a referral form (set criteria) in your PCN?
  - Does it identify clearly, what the required goal/intervention is?
  - Are all core network practices using this appropriately and who is monitoring the quality of referrals?
  - Are you ready to be able to provide evidence of outcomes of the Social Prescribing resource?
- Do you have regular appraisal structures in place to support staff development:
  - Are there opportunities to formalise this?
  - Do you use a standard framework across your core-networked services?
- Do you know how the end service user feels about the Social Pprescribing service? (evaluation template below)
- Are you enabling your Social Prescribers to attend training and network events, to expand key knowledge and share experience with other practitioners?

Examples documents from practice:

Social prescribing service evaluation te

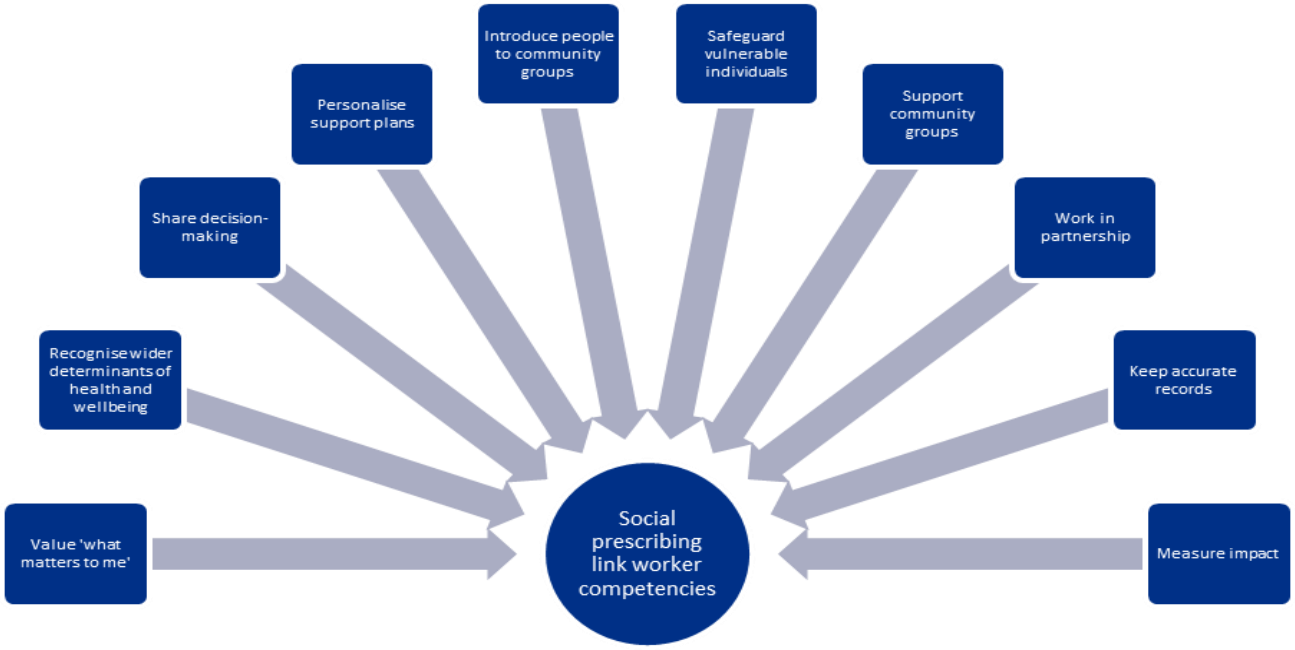
Social prescribers Introduction letter t

Social prescibing - reasons for referral

socialprescribinglinkworkerA5.pdf

6. Appendix

6.1 key competencies



Have your Social Prescribing staff completed training on the above 10 domains?

Note: free training options are widely available:

Personalised Care Institute www.personalisedcareinstitute.org.uk

e-learning for health resource for Link Workers - Social Prescribing - e-Learning for Healthcare (e-lfh.org.uk)

6.2 Competency assessment current model and proposed new framework (in draft)

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6.3 Social Prescribing Link Workers referral form templates

Referral form EMIS templates for Social

*Last edited by South East Hampshire Community/Primary Care teams 25/11/21 for further information around the development of this document please contact Anne-marie.milllard@nhs.net