Social prescribing link workers:
Reference guide for primary care networks

DRAFT

This document is being made available in draft to inform discussions being held at local level about forming primary care networks. A final version will be published in the summer of 2019. Anybody reading this should be aware of its status and refer to the final version once published.

Social prescribing link workers:
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Other formats of this document are available on request. If required please contact england.personalisedcare@nhs.net

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1 Getting started with social prescribing link workers

Who is this guide for?

This guide has been created for practice managers and clinical leads within primary care networks (PCNs), for social prescribing link workers, commissioners and local system partners, including voluntary, community and social enterprise (VCSE) leaders, public health leaders, people with lived experience and patient groups.

Aims of this guide

This guide is provided as additional information and is not official GP contract guidance. It aims to help PCNs introduce the new role of social prescribing link worker into their multi-disciplinary teams as part of the expansion to the primary care workforce introduced under the GP contract reforms, using the new national funding available from July 2019, as part of the Network Contract Directed Enhanced Service (DES). It builds on the local system guidance provided in the Social Prescribing and Community Based Support Summary Guide.[1] It should be read alongside other guidance that will be published about PCNs and the additional roles being funded under the DES.

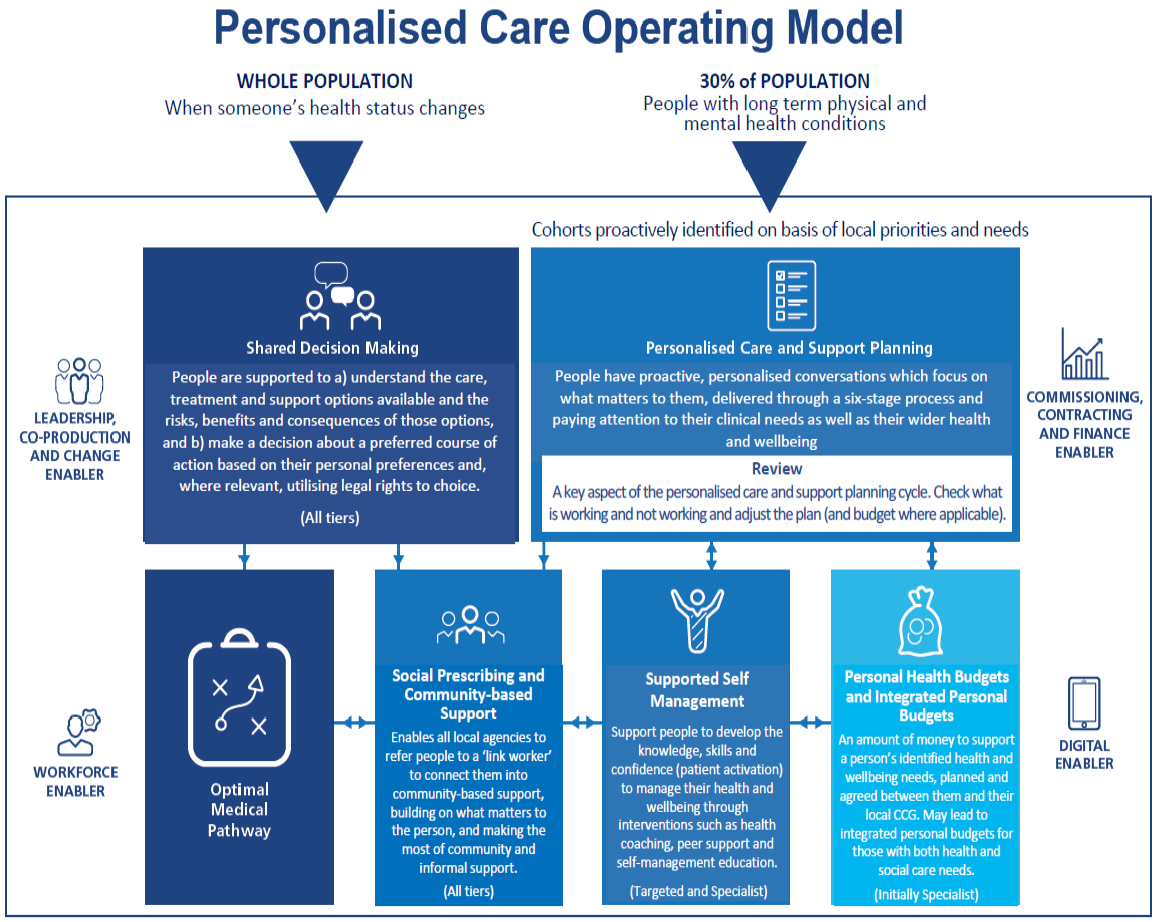
It is recognised that many PCNs are new and finding their feet. At the same time, social prescribing is at different stages in different areas across the country. Social prescribing has emerged as a highly creative and collaborative approach in local areas, but it is not the same everywhere. In this first year of operation it will be important for all partners, including NHS England, to learn from emerging practice, to build in feedback and review processes, and to hear from a wider range of perspectives in local areas and emerging primary care networks about opportunities and challenges.

Social prescribing is part of a commitment to personalised care

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters to me' and individual strengths and needs. This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in creating better outcomes and experiences. Personalised care takes a whole-system approach, integrating services around the person. It is an all-age model, from maternity and childhood through to end of life, encompassing both mental and physical health support.

Social prescribing is one of six key components of the NHS England comprehensive model for personalised care[2]. Alongside shared decision making, personalised care and support planning, supported self-management, personal heath budgets and broader choice within the NHS, social prescribing enables people to be more involved in their care. Social prescribing should be delivered as part of a broader shift to personalise care in PCNs and local areas.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf



Personalised care represents a transformative relationship between people, professionals and the health and care system. It provides a positive shift in power and decision-making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

Boosting the multi-disciplinary team in primary care

Social prescribing link workers are one of five additional roles being funded within primary care, to bring additional capacity into the multi-disciplinary team, under the Network Contract DES. The other roles are clinical pharmacists, physician associates, community paramedics, and physiotherapists. These roles will all help reduce workload on GPs and other staff, enrich the skill mix of primary care teams, and help GPs work "at the top of their licence". They are intended to become an integral part of the core general practice model throughout England[3].

[3] Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (2019)

Why social prescribing?

One in five GP appointments focus on wider social needs[4], rather than acute medical issues. In areas of high deprivation, many GPs report that they spend significant amounts of time dealing with the consequences of poor housing, debt, stress and loneliness. 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 and to bring additional capacity into the multi-disciplinary team. This approach aims to reduce pressure on clinicians, improve people's lives and strengthen community resilience.

Social prescribing enables all primary care staff and local agencies to refer people to a link worker and supports self-referral. Working under supervision of a GP, link workers give people time and focus on what matters to the person, as identified through shared decision making or personalised care and support planning. They will manage and prioritise their own caseload in accordance with the health and wellbeing needs of their population, and where required discuss and/or refer people back to other health professionals and GPs in the PCN. They also connect people to community groups and agencies for practical and emotional support. Link workers work within multi-disciplinary teams and collaborate with local partners to support community groups to be accessible and sustainable and help people to start new groups and activities.

Social prescribing can support a wide range of people, including (but not exclusively) people:

- with one or more long term conditions
- who need support with their mental health
- who are lonely or isolated
- who have complex social needs which affect their wellbeing.

There is emerging evidence that social prescribing can lead to a range of positive health and wellbeing outcomes for people, such as improved quality of life and emotional wellbeing.[5] Whilst there is a need for more robust and systematic evidence on the effectiveness of social prescribing,[6] social prescribing schemes may lead to a reduction in the use of NHS services,[7] including GP attendance. 59% of GPs think social prescribing can help reduce their workload.[8]

How is social prescribing different to the work of care navigators and health coaches?

In many PCNs, receptionists and other staff may have been trained to provide care navigation and active signposting, in addition to their existing roles. Active

[4] Citizens Advice policy briefing (2015), A very general practice: How much time do GPs spend on issues other than health?
[5] Dayson, C. and Bashir, N. (2014), The social and economic impact of the Rotherham Social Prescribing Pilot. Sheffield: Sheffield Hallam University: https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf
[6] Bickerdike, L., Booth, A., Wilson, P.M., et. Al. (2017), Social prescribing: less rhetoric and more reality. A systematic review of the evidence, BMJ Open 2017;7: e013384. doi: 10.1136/bmjopen-2016-013384
[7] Polley, M. *et al.* (2017), A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. London: University of Westminster
[8] RCGP (2018). Spotlight on the 10 High Impact Actions: http://www.rcgp.org.uk/about-us/news/2018/may/rcgp-calls-on-government-to-facilitate-social-prescribing-for-all-practices.aspx (accessed 2 June 2018)

signposting is a light-touch approach where existing staff provide information and choice to signpost people to services, using local resource directories and local knowledge. Active signposting works best for people who are confident and skilled enough to find their own way to community groups and services, after a brief intervention. It complements social prescribing when viewed in terms of 'as well as social prescribing' not 'instead of social prescribing'.

Health coaching is a personalised approach that is based upon behaviour change theory and is delivered by health professionals with diverse backgrounds. Within the NHS there are 'health coaching' roles, both within primary care and acute settings. NHS health coaching differs from social prescribing in that emphasis tends to be placed on the behaviour change, rather than connecting people with community groups and services. However, there are many similarities, as a motivational coaching approach is an integral part of a social prescribing link worker role.

The role of social prescribing link workers, as a key part of the PCN multi-disciplinary team

The DES specification sets out the key role responsibilities for social prescribing link workers in delivering health and wellbeing services. The information can be found in section 4.5.16 (pages 22-24) of the Network Contract DES specification at https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-specification-2019-20-v1.pdf

As members of the primary care network team of health professionals, in 2019/20 social prescribing link workers will take referrals from the PCN's members, expanding from 2020/21 to take referrals from a wide range of agencies[9], to support the health and wellbeing of patients. PCNs 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.

Of the five workforce roles being funded via the Network Contract DES, social prescribing link workers and clinical pharmacists are being introduced in 2019. Physician associate and physiotherapist will be added from April 2020 and community paramedics from April 2021. PCNs will need to work through how to integrate the additional posts into their existing workforce mix.

[9] These agencies include but are not limited to: the PCN's members, pharmacies, 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.

2 Practicalities of providing social prescribing link worker services within PCNs

Appendix 1 provides a checklist for PCNs to work through, if they are new to social prescribing.

For information about the practicalities of providing social prescribing link worker services in PCNs, please refer to the following NHS England publications:

Network Contract Directed Enhanced Service Specification
https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-specification-2019-20-v1.pdf

Network Contract Directed Enhanced Service Guidance
https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-guidance-2019-20-v1.pdf

Network Contract Directed Enhanced Service VAT Information Note
https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-and-vat-information-note.pdf

A five-year framework for GP contract reform to implement the NHS Long Term Plan
https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

For a full list of all the documents relating to the new GP contract and setting up of PCNs, please go to https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/

3 Working with partners to create a shared local social prescribing plan

What is being asked of local partners?

NHS England wants to encourage all local partners to work together to create shared local social prescribing plans for 2019/20 in each CCG area. These local plans should help to inform local priorities and feed into the wider Sustainability and Transformation Partnership (STP)/Integrated Care System (ICS) Five Year plans, due in autumn 2019.

Why?

Existing practice shows there are already many areas with mature social prescribing connector schemes, mainly commissioned by CCGs and local authorities and typically provided by local VCSE organisations. Many social prescribing link workers are already working from within, or working closely with, primary care teams, supporting the health and wellbeing of patients by taking referrals from within primary care and across local systems.

In embedding social prescribing link workers within multi-disciplinary teams, PCNs have the flexibility to engage link workers themselves, or to work in partnership with existing local social prescribing connector schemes to provide social prescribing services. PCNs can use whatever contractual arrangements work best at local level to facilitate these partnerships. It is important, therefore, that all local partners, including CCGs, local authorities, PCNs, social prescribing schemes and VCSE leaders work together to find the best local arrangements for embedding social prescribing services in PCNs and that, regardless of the engagement model, link workers collaborate in local areas, to overcome isolation, make best use of limited resources and develop strong connections with local communities and partner agencies.

What is being asked of PCNs?

PCN leaders are encouraged to work collaboratively with their CCG social prescribing leads, local authority commissioners, existing social prescribing schemes, VCSE leaders and other partners to develop a shared social prescribing plan.

This partnership approach will help the PCN move towards a ‘population health’ approach, recognising the wider ‘social’ determinants of health. It will help PCNs and partners to maximise resources, share learning, nurture community assets and avoid the risk of link workers becoming isolated. Local partners should work together, building on existing social prescribing practice to achieve the following:

- enable every PCN to employ or contract for social prescribing link worker services, as a key part of their multi-disciplinary team
- build on existing local social prescribing schemes, avoiding disinvestment in current schemes or duplication, and enabling all social prescribing link workers (wherever they are employed) to work together as a wider team across the local area

- recruit new additional social prescribing link workers (using the national funding available to PCNs, via the Network Contract DES) to support expanding social prescribing services across PCNs
- work together to nurture community assets, support VCSE organisations and community groups, through funding and development support.

To support the above, an action plan template and a self-evaluation checklist has been created to help CCG commissioners, local authorities, PCNs, social prescribing connector schemes, VCSE leaders, people with lived experience and other partners work together to create a shared local plan for social prescribing. See Appendix 2 and Appendix 3.

4 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 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 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 and reduces health 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 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: £24,214 - £30,112
Key responsibilities 1. Working with direct supervision by a GP, take referrals from a wide range of agencies, including PCNs' GP practices and multi-disciplinary team in 2019/20 and from 2020/21: 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 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 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 what 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. Draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals.

4. Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local 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, 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 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 self-referrals and connecting with all 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 with the person, providing non-judgemental support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person's assets.
- Be a friendly 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 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 community groups, activities and statutory services, ensuring they are comfortable. 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 local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what's already available to create a menu of community groups and assets.
- Develop supportive relationships with local VCSE organisations, 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 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, 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.
- 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 get along with people from all backgrounds and communities, respecting lifestyles and diversity	✓	
	Commitment to reducing health inequalities and proactively working to reach people from all 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 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	✓	
	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	✓	
	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 advert

Job Title: Social Prescribing Link Worker

Working hours: 37.5 hours per week, full time

Rate of pay: £24,214 - £30,112
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 community groups, VCSE organisations and services. They will also work with 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 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.

For more information and a job pack

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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?

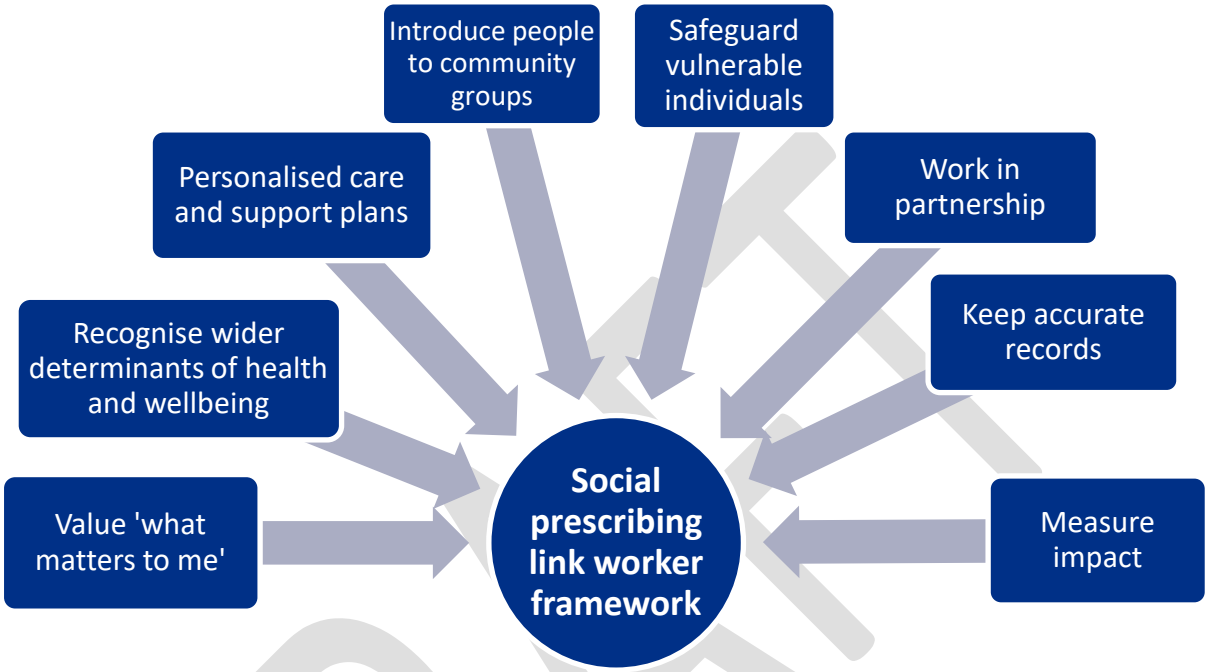
You have 10 minutes at the start of the interview to outline your approach.

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?

5 A framework for social prescribing link workers

This diagram provides a summary of the key actions that social prescribing link workers need to take to be effective in their roles.



The table below summarises what the actions mean in detail, from the perspective of people receiving support and what the link worker needs to do to perform their role effectively:

1. Value 'what matters to me'
How the person receiving support feels: • I am listened to, understood and 'what matters to me' is central to all our work together. • I am respected and treated with dignity as an individual. • My human rights are protected and I do not experience discrimination. • I experience warm, compassionate, personalised care and support. • If I raise a concern or make a complaint, it is acted on quickly.
To be effective, link workers need to: • Listen actively and show you understand what matters most to the person. • Provide non-judgemental support. • Check understanding and reflect back what people say. • Put what matters most to the person at the heart of every conversation. • Be warm and friendly. • Treat each person with dignity and respect. • Where a person is not happy with their support, enable them to make a complaint.

2. Recognise the wider determinants of health and wellbeing
How the person receiving support feels: • What matters to me is central to our work together. Whatever I am struggling with in my life is recognised as important and can be heard. • I am asked about my lifestyle preferences and aspirations and I am supported to achieve these. • I am encouraged and helped to achieve my full potential. • I am connected to support which enables me to feel a sense of belonging, deals with any practical issues I may have and gives me joy.
To be effective, link workers need to: • Understand how the wider determinants, such as housing, food, access to green space, work and transport impact on a person's health and wellbeing. • Give people time to talk about the whole of their lives, what matters most, the people they care about, what they like to do with their time, what their hopes and dreams are. • Find creative ways to connect and introduce people to their neighbours and their communities. • Work within professional boundaries, ensuring that any practical issues that stand in the way of a person managing their health and wellbeing, such as not having enough food, money or secure housing, are addressed as a priority. • Be non-judgemental in recognising and upholding the lifestyle preferences and aspirations of people. • Not act outside their remit, and escalate clinical issues back to clinicians within the PCN.
3. Personalised care and support plans
How the person receiving support feels: • I am listened to and supported to make informed choices, so that I can have more control over the things that matter to me. • I am fully involved in creating a support plan which summarises who I am and what's important to me, what support I can expect to receive and what I can do to support myself. • My plan is useful to me, as well as to people who support me. I have my own copy, which I can use at home. • I am given enough information about the services I am connected to. I know what to expect from the support I am connected to. • I have information and knowledge about what I can do to support myself, to improve my health and wellbeing.
To be effective, link workers need to: • Listen and then provide clear information about the choices a person has and explain the choices, so that the person understands everything. • Develop a rapport with the person and understand what matters to them. • Facilitate strength-based conversations, through motivational coaching, building on the person's assets. • Help the person to decide what support they want to be connected to, taking into account what matters to them.

- Where appropriate, use the Patient Activation Measure®[10] (PAM®) to identify what level of support people need and how 'activated' they are to manage their own health and wellbeing.
- Assist the person to think through the practical issues they will face in getting involved in this support, such as how they will get to a community group meeting, how they will feel being introduced to new people and what their fears are.
- Give lots of opportunities for the person to ask questions.
- Create clear goals with the person about what they want to achieve.
- Create a clear personalised care and support plan with the person, based on their priorities.
- Ensure that the support plan is 'owned' by the person and is useful to them.
- Where appropriate, review the personalised care and support plan with the person, at regular, agreed intervals, to assess progress and make changes.

4. Introduce people to community groups and services

How the person receiving support feels:

- I am introduced to community groups that I am interested in (if appropriate), so that I feel confident to get involved and make friends. I am supported to make my own choices about what groups I am connected to.
- The community groups and support services that I am connected to (such as adult learning, welfare benefits advice) are welcoming and quickly enable me to feel part of the group.
- If I need someone to go with me to the first group session, to help me take that first step, this support is available.
- Whatever I bring to the community group I'm connected to is seen as valuable. Group leaders look for my strengths. They encourage me to feel comfortable, get involved, volunteer and have fun.
- I am involved in providing feedback to my link worker about my progress within my community group.
- Whatever my interests, there is a broad range of local community groups to choose from, which cater for my needs.

To be effective, link workers need to:

- Work with local partners to identify local community services, groups and VCSE organisations in the local neighbourhood and beyond.
- Create an easy to read 'menu' of local community groups and services, which can be used to explain what support is available locally.
- Include small, informal community groups in connecting people through social prescribing, which may not have formal policies and procedures.
- Arrange to go with the person to their first community group session (where needed). Support them to get through the door, get settled and feel comfortable.
- Work with local befriending groups or recruit volunteers to act as 'buddies' for people who may need support to get involved in community groups over time, recognising that volunteers need to be supported to be effective and stay involved.
- Carefully introduce people who need ongoing support to get involved in community groups with volunteer buddies, building on their strengths and interests.

[10] The use of PAM® is licensed to NHS England from Insignia Health LLC

- Build in regular catch-ups with local community groups and VCSE organisations, to check what capacity they have for new people and to overcome any challenges.
- Use the confidence survey to review development needs of local groups, in line with the Common Outcomes Framework.
- Where there are gaps in local community activities encourage commissioners and local infrastructure agencies to support the development of new community groups.

5. Safeguard vulnerable individuals

How the person receiving support feels:

- Information about me is kept safe and confidential. It is only shared with the groups and agencies that I am connected to with my permission, on a 'need to know' basis.
- The people supporting me within community groups and agencies know about safeguarding people from harm and take active steps to ensure that I am not put in harm's way.
- Where I feel vulnerable within community groups, I am supported to trust my judgements and to safely share my concerns. I can easily be referred back to my link worker, PCN or to other agencies.

To be effective, link workers need to:

- Work within the PCN multi-disciplinary team to create safe, confidential storage systems for the social prescribing service, which comply with legal GDPR requirements and NHS policies.
- Work with their PCN to put in place local data sharing agreements, for the sharing of personal information about people with other agencies, including community groups.
- Take a proportionate, common sense approach to connecting people to community groups, seeking to include small, informal, volunteer-led groups.
- Use the quality assurance prompt sheets and/or any locally agreed quality assurance processes to make agreements with community groups and voluntary organisations.
- Seek guidance from your PCN line manager where you are unsure whether local groups are safe to be involved in social prescribing.
- Encourage local partners to make training available to local community groups and VCSE organisations in safeguarding people from harm, data protection and first aid.

6. Work in partnership

How the person receiving support feels:

- Wherever I am in the local system, local agencies can refer me to a social prescribing link worker for support. I can refer myself to a link worker.
- Local agencies work together to provide joined-up support. If I have a problem, I do not have to deal with lots of different agencies, who pass me on and don't talk to each other.
- Creative solutions are found to common problems, which show me that local agencies care about people like me.

To be effective, link workers need to:

- Build trusting relationships with a wide range of local agencies and partners.
- Help local agencies and partners to understand the role of a social prescribing link worker.
- Encourage local agencies to make appropriate referrals.

• Work together with local commissioners, other PCNs, VCSE leaders and other partners to create a shared local plan for social prescribing.
7. Keep accurate records
How the person receiving support feels: • Information about me is safe and confidential and is not shared without my permission. • Information about me can only be shared with the community groups and agencies that I am connected to, with my permission, on a need-to-know basis.
To be effective, link workers need to: • Understand and comply with GDPR and information governance. • Have access to PCN information storage and data systems, as part of their role within the PCN multi-disciplinary team. • Work with their PCN to create and use safe, confidential storage systems for information about people, which comply with legal requirements and NHS policies. • Ensure that they collect timely referral data about people referred to social prescribing.
8. Measure impact
How the person receiving support feels: • When I first meet the link worker, I am supported to think about my wellbeing and how I'm feeling about my life. • After six months, I am asked again to think about my wellbeing, which enables me to see my progress and reflect on whether, or how, my life has improved.
To be effective, link workers need to: • Use the social prescribing SNOMED codes to record social prescribing referrals taken up. • Support PCN staff to use the social prescribing SNOMED codes, when making a referral to the link worker. • Evaluate the person's wellness journey, by using the ONS wellbeing scale with everyone who is referred, at the start of their work with the social prescribing link worker, and at six monthly intervals.

This framework builds on the **Person-Centred Approaches Framework** developed by Health Education England (2017), which may also provide helpful guidance:

http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download

6 What to include in a link worker induction

Area to cover	The link worker can…	When completed/ notes:
Overview of social prescribing: what difference can social prescribing make to people's lives?	Explain what difference social prescribing can make to people's lives.	
Overview of the social prescribing link worker role within the PCN MDT.	Recognise the essential functions of the social prescribing link worker role within the PCN multi-disciplinary team.	
How social prescribing can support people to improve the wider determinants of their health and wellbeing.	• Understand how the wider determinants impact on personal health and wellbeing. • Explain what link workers can do to improve the wider determinants of personal health and wellbeing.	
Who can benefit from our social prescribing service?	Describe who can benefit from social prescribing.	
Provide a personalised care approach, through motivational coaching, giving time to focus on 'what matters to me'.	• Demonstrate how to work with people around 'what matters to me', taking a motivational coaching approach. • Involve people in decisions about them, based on the principle of 'nothing about me, without me'.	
Creating and maintaining effective professional boundaries.	Explain how a link worker can support people, whilst avoiding creating dependent relationships and being too involved in people's lives.	
Developing personalised care and support plans together.	Create a shared personalised support plan with the person.	
Introduction to PCNs – how they will support local populations to take more control over their health and wellbeing.	Explain the role of the PCN in developing a wider, proactive approach to population health.	
Introduction to the primary care network multi-disciplinary healthcare team (MDT), including shadowing reception staff.	• Understand the different roles within the MDT. • What support they can expect from the MDT. • What support they will need to provide to the MDT.	
Partnership working	Identify key partners within local agencies that they will need to work alongside.	

Introducing people to community groups	Provide information about community groups and voluntary organisations in the local areas – who are they, what support do they give?	
Connecting people to community groups	Establish supportive, developmental relationships with community groups.	
Safeguarding vulnerable individuals who are connected to community groups	Demonstrate how to use the quality assurance prompt sheets with community groups and VCSE organisations to build confidence to connect people to community groups.	
Data protection	Work with members of the PCN to create safe data storage systems for referral data, in line with GDPR regulations.	
Record keeping	Use the data storage systems created to record core data about referrals.	
Setting up systems to measure impact	Plan how to introduce the ONS4 and PAM tool to create a baseline for impact measurement on the person. Use the SNOMED codes to register social prescribing referrals	

In addition to the above, NHS England will provide a welcome pack for all new link workers, which will be available from early July 2019. Please email england.socialprescribing@nhs.net for a copy.

7 Supervision and learning for social prescribing link workers

First point of contact in each GP practice

The PCN's member GP practices must each identify a first point of contact for general advice and support for the social prescribing link worker. The role of the first point of contact will be to enable the social prescribing link worker to develop effective working arrangements with all staff within the member practices and to ensure that all staff can support the link worker role. This role could become a designated 'social prescribing champion' within each member practice.

The role of a GP supervisor

The PCN must appoint a GP supervisor (if different to the first point of contact) to provide direct supervision for the social prescribing link worker. This GP supervisor will line manage the work of the social prescribing link worker on a day-to-day basis. They should meet regularly with the link worker to provide line management and supervision, discuss and overcome or address any issues or concerns and ensure the link worker can succeed in the role. This will include ensuring that the link worker is able to raise patient-related concerns (for example, abuse, domestic violence, or other safeguarding issues) and refer individuals back to other health professionals as relevant, for further support, review or monitoring.

Where the social prescribing link worker is employed by a partner 'social prescribing provider' agency, the above GP supervisor will still be required. In this arrangement, the GP supervisor will need to additionally involve the partner organisation in regular progress updates about the link worker role, enabling clear lines of accountability, effective seamless joint working and problem-solving challenges together.

Access to 'clinical' or non-managerial supervision

In addition to the ongoing support received from the GP supervisor, the social prescribing link worker should have regular access to clinical or non-managerial supervision both with their GP supervisor and other relevant health professionals within the PCN. This 'clinical' or non-managerial supervision will enable the link worker to manage the emotional impact of their work and be guided by clinicians on dealing effectively with patient risk factors.

Arranging cover for lone link workers in PCNs

The GP supervisor should work with PCN staff to agree cover for when the social prescribing link worker is absent, to avoid a backlog of referrals and reputational damage, where patients are left waiting too long.

Additional support that link workers will need

Link workers will benefit from the opportunity to regularly connect with other link workers in the local area and across the STP area. It will be helpful for local commissioners to facilitate link worker learning across their areas, including encouraging reflective practice and action learning sets.

Learning for link workers

During 2019/20, NHS England will facilitate online learning for social prescribing link workers across England. Link workers will have access to peer support through regular webinars with other link workers, have opportunities to meet other link workers at learning events and regional social prescribing networks.

NHS England will facilitate an online community of practice for social prescribing link workers. This can be accessed by emailing england.socialprescribing@nhs.net and asking to be invited to the online social prescribing platform.

There is a wider PCN online platform, which link workers may also wish to join. For more information, email england.pcn@nhs.net. This online community is set up to support all staff in PCNs.

Publications, updates and resources are regularly shared within the online communities of practice.

In future years, it is envisaged that the Health Education England local training hubs (which are in the process of being established) will take an active role in supporting all staff within PCNs, including social prescribing link workers.

The continuing professional development of link workers will need to be addressed by all local partners, once the link worker service is established within the PCN. It may be helpful for CCG and STP teams to create peer learning and development opportunities for social prescribing link workers across their patches.

8 Creating personalised care and support plans

Where a person needs ongoing support, the social prescribing link worker should work with the person to create a simple personalised care and support plan. Each person should be given their own copy of their plan to use at home, so that it is a practical, useful resource. The plan is a summary of:

- what matters to me
- how best to support me – what people need to know about me
- any health conditions that groups and agencies need to know about
- my goals
- what support I am being connected to, such as community groups and services
- what I can do to support myself to meet my goals
- review – how it's going and what changes have taken place
- permissions – to share stories, be involved in evaluation and satisfaction surveys.

See Appendix 4 for a sample personalised care and support plan template.

Top tips for creating simple care and support plans

- Build rapport with the person. They need to trust you to create a shared plan.
- Make them feel as comfortable as possible, so they are relaxed. An informal conversation will enable you to tease out information more easily.
- Start the conversation with finding out what matters to the person, but don't just ask them outright, as it may be too difficult a question. Ask them about important people and what they like to do together. You may want to ask about the things that make a good day and what makes a bad day, including what people can do to help with the bad days. Ask them about the things they like to do each week that they would miss if they couldn't do and ask them about the things that they would never leave home without.
- Use the person's own words within the plan, as much as possible, not professional-speak.
- Keep checking what the person wants you to write. If they want to write the plan with your support, that may also work. Be flexible.
- Use open questions and ask helpful follow-ups such as 'tell me more' to tease out information.
- Create clear goals together, which are realistic and reflect the person's priorities. An easy way to find out the person's priorities for change is to ask them what is working and what is not working. The things that are not working can be things they can set goals to address.
- Discuss together what the person can expect from the support they are being connected to, so that they have realistic expectations.
- It may be helpful to think through together about any worries the person may have about being introduced to groups or agencies.
- Help the person to think about what they can do for themselves, potentially with the support of those closest to them to help them achieve their goals.
- Be clear about what the person can do if it's not working, if they need to come back to you.

9 Quality assurance for social prescribing

Quality assurance for connecting people through social prescribing needs to be more flexible than the quality assurance that NHS organisations are used to. This is because link workers connect people to small, informal, often volunteer-led community groups, which are creative and dynamic, but which tend not to have formal policies or procedures.

Social prescribing supports individuals to make informed choices and judgments about what groups they feel confident to engage with. It is therefore essential that link workers in PCNs do not become stifled by over-bureaucratic responses to health and safety and risk-taking. Their role is to support people to make their own choices and to empower people to cope with social situations, such as community group meetings.

Voluntary organisations and community groups involved in social prescribing should have appropriate arrangements in place to ensure that new people have a safe and positive experience. Quality assurance is a delicate balance, which must be proportionate and take a common-sense approach.

In some local areas, where social prescribing is well established, there may already be effective quality assurance processes that partners are happy to retain. This guidance does not seek to replace existing quality assurance practices which work for local partners. It has been created for local areas new to social prescribing and where quality assurance practices need strengthening.

Quality assurance principles

1. Social prescribing supports people to make informed choices about engaging with community groups and VCSE organisations.
2. PCNs cannot be held responsible for the choices and actions that people take after being connected to community groups and VCSE organisations. This is down to personal choice for the person.
3. Link workers (on behalf of PCNs) can make basic quality assurance checks, using the prompt sheets provided, to ensure they are not connecting people to community groups and organisations which they consider to be unsafe.
4. The prompt sheets are designed to develop constructive conversations between the link worker and the VCSE organisation or community group and building trusting relationships. They should help to build confidence and be inclusive, to celebrate informal groups and wherever possible, enable them to be involved.
5. This process should not be used in a rigid way to exclude smaller groups because they do not have formal policies. Many small, volunteer-led community groups, such as ‘knit and natter’ and men’s groups which meet in the local pub provide excellent informal peer support. It would be unrealistic for them to have formal policies and procedures. The link worker should have constructive conversations, using scenarios, to help group members think about how they safeguard group members and vulnerable people.
6. Proportionality is required, as is taking a common-sense approach.

7. Where a safeguarding concern is raised by the person, a volunteer or staff member, there should be clear procedures for dealing with this swiftly and appropriately.
8. The process will improve the connections between health, social care and the community, facilitating more effective integration of local services.

Two quality assurance prompt sheets (Appendix 5) have been created to help social prescribing link workers develop trusting relationships with community groups and organisations, to minimise risks. This process will enable the link worker to create a comprehensive menu of community activities.

Quality assurance prompt sheet 1 – for VCSE service provider organisations

Many voluntary organisations which provide services will already have quality assurance policies and procedures in place, particularly where they employ staff. This prompt sheet enables link workers to ask key questions of VCSE service provider organisations. It focuses on the necessary policies for quality assurance and gives examples of evidence that will enable link workers to connect people.

Quality assurance prompt sheet 2 – for volunteer-led local community groups

Small, volunteer-led community groups provide informal community activities, enabling people to make friends, develop skills and confidence. However, these small local groups are unlikely to have written policies in place. This doesn't mean they shouldn't be connected through social prescribing. It requires a different approach, which is lighter-touch. Prompt sheet 2 enables link workers to have semi-structured conversations around the key elements of quality assurance. These questions will enable partners to work through scenarios together and build more informal evidence, to reduce risks.

Quality assurance process

1. Initial discussion between the social prescribing link worker and voluntary organisation or community group, with regards to potentially being involved in social prescribing.
2. Link worker and community group/organisation work through the appropriate prompt sheets together and provide supporting information, as evidence of quality assurance.
3. Agreement to connect is made by the link worker, on behalf of the PCN.
4. Where the link worker is not confident to connect, they should refer to their PCN line manager for guidance. They should work with the group to identify what they can do proactively to enable participation.
5. Agreement to connect is signed by a representative of the PCN (link worker) and the voluntary organisation or community group.
6. The quality assurance process should be reviewed annually, or whenever there is a significant change of group leadership, which may be more often in the case of small, volunteer-led community groups.
7. Link workers and participating group or organisation should have regular catch-ups (at least every 6 months) to review progress and lessons learned. This will

form the basis of continuous improvement, together with participation in any local evaluations.

Development support for community groups from local infrastructure agencies

Where local infrastructure agencies exist, such as councils for voluntary service (CVSs), their role is to provide development support to the local VCSE sector. The social prescribing link worker should therefore connect with, and support the work of, local infrastructure agencies, helping them to identify and meet development needs of local community groups and organisations.

It is important that social prescribing link workers operate in partnership with local community workers, infrastructure agencies, local area coordinators and whatever roles are in place locally to nurture community groups and assets towards sustainability. This avoids the burden of development support for community groups being left to link workers, on their own.

Learning opportunities for the local voluntary, community and social enterprise sector

Many local areas enable small voluntary and community groups to access free training around issues such as health and safety, first aid, safeguarding and risk assessment, such as local authorities and CVSs. The link worker should work with local partners to signpost VCSE groups and organisations to this training.

10 Social prescribing referral systems

All link workers embedded within PCN multi-disciplinary teams should have access to the GP information system used within the PCN. To successfully track the number of people benefiting from social prescribing, the following SNOMED codes should be used as flags for activity:

871691000000100 - Social prescribing offered (finding)
871711000000103 - Social prescribing declined (situation)
871731000000106 - Referral to social prescribing service (procedure)

These codes should be used by GPs and other staff making referrals to the social prescribing link worker within the PCN. The 2019/20 General Medical Services (GMS) Technical guidance will include further information about how these codes will be used to understand referral activity. It will be published in due course and will be available on the NHS England GP Contracts webpage.

Throughout 2019/20 consideration will be given as to how activity carried out by a social prescribing link worker can be captured.

In addition to the above codes, it would be helpful for social prescribing link workers within PCNs to collect the following information:

Date referred to link worker	• For indication of waiting times
Who made the referral	• To capture which agencies or individuals are making referrals to social prescribing
Reasons for referral	• Why the person was referred to the link worker
Contacts with link worker	• First contact – when, where • Number of phone calls/meetings with link worker, including amount of time spent with the person.
Where the person is being connected to	• Money/welfare rights • Housing support • Statutory services • Employment support • Practical support (e.g. aids/adaptations, food banks) • Arts-based activities and groups • Access to nature (such as gardening groups) • Physical activity support • Local neighbourhood groups • Adult learning classes • Other (please state)
Outcomes for the person	• What support were they connected to? • How did their wellbeing and activation levels change after 6 months? • What changes took place? • How satisfied were they with the service?

11 Measuring impact: people's wellbeing

Everyone who is referred to the social prescribing link worker should be asked at regular intervals to give easy feedback about the impact of social prescribing on their personal wellbeing.

The table below includes easy, free tools which all link workers in PCNs are asked to use. The aim is for this information to be incorporated into the network dashboard in subsequent years. These tools have been chosen because they are free to use, widely used and tested across the country. The ONS4 tool is both short and easy to use.

Tool	What is it?	Why should it be used?	Who should it be used with?	How often should it be used?
ONS Wellbeing Scale	Four short questions (ONS4) on life satisfaction, how worthwhile they feel their life is, happiness and anxiety levels.	ONS4 is a free nationally validated wellbeing scale, based on the person's own views.	Everyone who is referred to the link worker service.	When the person is initially referred to the link worker and at least every 6 months, for one year.
Patient Activation Measure (PAM®)	PAM is a short questionnaire to identify the skills, knowledge and confidence of people to manage their own health and wellbeing. People are assessed at 4 levels of activation, which indicate how much support a person is likely to need.	This tool helps link workers to tailor their support more effectively. Free (licenses currently paid for and distributed by NHS England)	Everyone with above level 1 literacy standard (reading age of 12 years) and health needs; excluding severe mental health, dementia or learning disabilities.	When the person is initially referred to the link worker and every 6 months, for a minimum of one year.

Where social prescribing connector schemes already exist, they may have established impact measurement tools, such as Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWEBs), or the Wellbeing Star, which are working well. This guidance does not require local social prescribing schemes to stop using existing impact measurement tools, but to consider adding the above tools, where referrals are made to social prescribing link workers embedded in PCNs.

It is important to develop a consistent set of impact measures that are used across PCNs, to avoid different tools being used, which cannot be compared. Using the above will enable a consistent national dataset to be developed.

What should social prescribing link workers do with these tools?

- Use the web links above to find out more about the tools and use them in line with the above criteria, upon referral into the link worker service and at least every six months.
- Create a safe system for storing the information and capturing impact for a minimum of one year.

Full details of the tools are available in Appendix 6.

12 Measuring impact: on community groups

It is important to capture the impact of social prescribing on local community groups and VCSE organisations involved in social prescribing.

Social prescribing link workers are asked to conduct a brief 'confidence' survey with community groups and VCSE organisations, every six months. The survey results can be used locally to:

- shape the capacity of community groups to receive new people through social prescribing
- capture the number of local volunteers
- identify gaps in community provision and facilitate the commissioning of new community support.

<table>
<tr><td colspan="4">1. How many people have been connected to your group/organisation by link workers over the past 6 months?</td><td></td></tr>
<tr><td colspan="5">2. To what extent do you agree with this statement?

'We have coped well with receiving new people through social prescribing link workers in the past 6 months.'

(Please tick one box below)</td></tr>
<tr><td>Strongly agree</td><td>Agree</td><td>Neither agree nor disagree</td><td>Disagree</td><td>Strongly disagree</td></tr>
<tr><td colspan="4">3. If you strongly disagree with the question above, what number of new people would you have been able to cope with in the past 6 months?</td><td></td></tr>
<tr><td colspan="4">4. How many volunteers are currently involved in your group or organisation?</td><td></td></tr>
<tr><td colspan="5">5. Are there any gaps in community provision that you have identified, and which local commissioners need to be aware of? If so, please tell us more in the box below:</td></tr>
<tr><td colspan="5">Free text box</td></tr>
<tr><td colspan="5">6. What development support does your group require from link workers and local partners over the next 6 months, to enable you to continue to be involved in social prescribing? Please use the box below to tell us more.</td></tr>
<tr><td colspan="5">Free text box</td></tr>
</table>

Appendix 1 – Checklist for introducing social prescribing link workers into PCNs

Action	Notes
1. Partnership working and shared local planning • Are you working with all partners, including VCSE sector leaders, local infrastructure organisations, CCG, local authority commissioners and referral agencies to create a clear local plan for social prescribing? • Are you building strong local relationships with VCSE sector organisations and community groups? • How do you plan to work with local partners in future years, to take social prescribing referrals from other agencies across the local system, to integrate services?	
2. Providing social prescribing link worker services • Will your PCN employ social prescribing link workers directly or work with existing social prescribing connector schemes, for them to employ link workers and embed into your MDT? You have local discretion to use whatever contractual arrangements work best locally. • Have you worked through the job description, person specification and framework to ensure that the link worker can provide dedicated, holistic support to people, based on 'what matters to me'? • How will you integrate social prescribing link workers, ensuring they are fully involved in the MDT? • Who will act as the GP supervisor for the link worker?	
3. Working with people on 'what matters to me' • Will link workers have the flexibility to undertake home visits, spend time and build trust with people? • Can link workers create simple personalised care and support plans with people, based on the person's own priorities?	
4. Connecting people to community groups • Can link workers take people to community groups to introduce them, ensuring they are comfortable and included? • Is there scope to recruit volunteers to buddy with people around befriending and connecting them to groups? • Are link workers able to collaborate with local partners to increase the capacity of community groups/VCSE organisations to receive more people?	
5. Access to IT systems, data gathering and impact measurement • Will all PCN staff making referrals to link workers use the social prescribing SNOMED codes to log referrals?	

• Can link workers establish local data systems in order to gather core referral data? • Will you support link workers to use the ONS4 Wellbeing Scale to measure the impact on patient wellbeing and PAM to assess how activated patients are to support themselves?	
6. Safeguarding and quality assurance • Can link workers use the prompt sheets to build rapport with local groups and VCSE organisations and ensure that everyone is confident to safeguard vulnerable people? • Can your PCN work flexibly, inclusively and proportionately with small community groups who lack formal policies, to enable them to be involved in social prescribing?	

Appendix 2 - Local shared plan for social prescribing template 2019-20

Aim: This template has been created to help CCG commissioners, local authorities, PCNs, social prescribing connector schemes, VCSE leaders, people with lived experience and other partners work together to create a shared local plan for social prescribing social, which;

- enables every PCN to integrate social prescribing link workers within their multi-disciplinary team either through direct employment or contracting for a social prescribing link worker service
- builds on existing local social prescribing schemes, avoiding duplication and enabling all social prescribing link workers (wherever they are employed) to work together as a wider team across the local area
- recruits new additional social prescribing link workers (using the national funding available to PCNs)
- works together to nurture community assets, support VCSE organisations and community groups, through funding and development support.

Partner details – please include representatives from your CCG, local authority, PCNs, VCSE leaders, existing social prescribing connector schemes, people with lived experience and other local partners, throughout the planning process.

Outcome	Actions	Who will lead/be involved	Timescales	Resources needed
1. Every PCN has a social prescribing link worker embedded within their multi-disciplinary team				
2. Existing social prescribing schemes are supported to work collaboratively with PCNs to embed additional link workers in multi-disciplinary teams				
3. Additional PCN link workers are successfully recruited from within the local health and care economy				
4. VCSE organisations and community groups are supported to receive social prescribing referrals and nurture community assets.				
5. All PCNs are supported to use the new national social prescribing SNOMED codes, to capture the number of social prescribing referrals.				

Appendix 3 - Social prescribing self-evaluation checklist for CCGs 2019-20

Questions: To what extent are staff:	**Self-assessment** 5 = high 1 = low	**Rationale**
1. Comfortable to bring all local partners together (including PCNs, local authorities, existing social prescribing schemes and VCSE leaders) to create a shared local plan for social prescribing by July 2019, when funding becomes available?		
2. Able to support PCNs to work collaboratively with existing local social prescribing schemes to recruit additional link workers? This may include sub-contracting or seconding new, additional link workers into PCN Multi-Disciplinary Teams from existing social prescribing connector schemes, using the most effective contractual mechanisms available, to be determined locally.		
3. Confident that local PCNs understand the difference between existing practice staff who undertake care navigation and social prescribing link workers who are employed to work intensively with people who struggle to make their own connections?		
4. Able to support PCNs to use national SNOMED social prescribing codes: 871691000000100 Social prescribing offered 871711000000103 Social prescribing declined 871731000000106 Referral to social prescribing service		
5. Confident to work collaboratively with your local authority and other partners to support the VCSE sector to receive social prescribing referrals, including providing local funding and development support to community groups and VCSE organisations.		

Appendix 4 – Sample personalised care and support plan

Name and contact details for person: **NHS number:**	
Part one – to be completed together at the start	
1. What matters to me:	
2. How best to support me, what people need to know about me and my life:	
3. Any health conditions that agencies need to know about:	
4. My goals:	
5. Summary of support that I am being connected to, including what I can expect from support:	
6. What I can do to support myself to meet my goals:	
7. Review – when shall we check how it's going?	
Part Two – to be completed after 6 months	
8. What changes have taken place?	
9. I am happy to share my personal story?	
10. I am willing to complete a satisfaction survey?	
11. I am happy to participate in ongoing data collection and evaluation?	

Note: Link workers should feel free to use whatever works with people to create personalised care and support plans and should not feel bound to use the sample provided here. It has been created to guide thinking and is not meant to be a rigid template for everyone.

Appendix 5 – Social prescribing quality assurance prompt sheet for VCSE organisations

Your organisation - key documents: please provide copies of the following:	
Your charity registration and company number. If unregistered, your governing document.	Received: yes/no
Your annual accounts. If you are a new organisation, please provide your latest bank statements and management accounts.	Received: yes/no
Your certificate of Public Liability Insurance	Received: yes/no

Policies and supporting evidence:		
What we need to check	**Why we need to check it**	**Examples of supporting evidence**
Safeguarding policy Safeguarding policies and processes must be up to date and comply with current legislation. This should include Disclosure and Barring Service (DBS) check for all relevant staff and volunteers. There should be clear procedures for what to do when a safeguarding concern is raised, either by the person, their family or carers, volunteers or staff member.	Children and vulnerable adults who are referred must be protected from harm. Any organisation working with children, young people or vulnerable adults should have a clear set of guidelines about how it will keep people safe from harm and respond to any concerns.	• Records of DBS checks for staff and volunteers involved in social prescribing. • Safeguarding training records or certificates. • Risk assessments for lone working. • Procedure for dealing appropriately and swiftly with a safeguarding concern.
Notes		
Confidentiality and data protection policy Information governance procedures must comply with current legislation and include appropriate arrangements for GDPR, data security, data protection and confidentiality.	Organisations need to protect people's personal information and keep it safe. Your policy helps us to understand what your organisation does to keep personal information safe.	• Confidentiality and data protection/ procedures, dated, when last received. • Copy of induction programme for staff/ volunteers, including GDPR, confidentiality and data protection induction. • Confidentiality and data protection training records for

		staff/volunteers involved in social prescribing.
Notes		
Health and Safety policy Health and safety policies, risk assessments and procedures must comply with current legislation. Food handling certificates (if your organisation provides catering).	Health and safety policy and procedures aim to protect both the people and the environment where your services and activities take place. Your policy will outline the steps your organisation has taken to make sure that you have made things as safe as possible.	• Copy of Health and Safety policy/ procedures, dated, when last reviewed. • Risk register and examples of appropriate risk assessments. • Accident reporting procedure. • Food handling certificates.
Notes		
Equality and diversity policy Equal opportunities policies and procedures must comply with all current legislation.	Equality is about being fair and making sure that everyone can fulfill their potential. Diversity is about recognising and valuing everyone's differences. Your policy tells us how your organisation is striving to be fair and equitable.	• Copy of Equality & Diversity policy dated, when last reviewed. • Examples of how your service actively takes steps to include people with protected characteristics.
Notes		
Recruitment policy (staff and volunteers) Recruitment policy and procedures must comply with current legislation.	These policies demonstrate how you go about finding new people to join your organisation in a fair and effective way. This should include the recruitment of paid staff and volunteers.	• Recruitment policy. • Induction checklists for staff and volunteers involved in social prescribing. • Evidence of how you support volunteers, which may include a volunteer policy and volunteer role descriptions.
Notes		

Training and development Training and development plans for staff and volunteers enable you to provide an effective service.	To ensure that all roles (voluntary & paid) supporting social prescribing are suitably supported with appropriate training and people have sufficient skills and competencies to fulfill their roles. To ensure that the organisation meets legal requirements for first aid training.	• Training and development plans for staff and volunteers involved in social prescribing. • First aid certificates.
Notes		
Actions agreed:		
Agreement to connect through social prescribing: **Representative of primary care network:** Name: Signature: Date: **Representative of VCSE organisation:** Name: Signature: Date:		

Social prescribing quality assurance prompt sheet for small volunteer-led community groups

Documents and supporting evidence The social prescribing link worker will work with your community group to support your readiness to be involved in social prescribing.		
What we need to check	**Why we need to check it**	**Examples of questions to ask**
Public Liability Insurance Does your community group have its own public liability insurance or meet in premises with public liability insurance?	It is necessary to have appropriate public liability insurance in place in case anyone has an accident and is injured at your group. If you don't have your own public liability insurance, you should meet in public premises that are insured.	• What would happen if someone who had been connected to your group tripped over an object and fell during a group session?
Notes		
Safeguarding for vulnerable adults and children Does your group include children and/or adults who are vulnerable? If so, do you have Disclosure and Barring Service (DBS) checks for people who work with vulnerable people? Does your group have any written guidelines for how to keep vulnerable people safe, including any procedures for responding when someone says they don't feel safe or raises a safeguarding concern?	Children and vulnerable adults who are referred must be protected from harm.	• Are group members ever in 1-1 situations with vulnerable adults or children? What can you proactively do to avoid group members being in 1-1 situations with vulnerable adults? • If group leaders are worried about the physical or mental health of people who have been referred by you, what steps would you take to refer people back to the PCN or to emergency medical support? • If someone raises a safeguarding concern or says they feel unsafe, what would you do to deal with this appropriately and swiftly?
Notes		

Confidentiality and data protection Does your group keep information about members or people who are referred on paper files or online? If so, you should have procedures that comply with GDPR to protect data and confidentiality.	All data that is kept about a person should be held according to GDPR legislation.	• How does your community group keep personal information about group members secure? • Who is allowed to see personal information about group members?
Notes		
Health and safety risk assessments Health and safety risk assessments should be carried out, when starting new activities and using equipment. Food handling certificates are needed (if your community group provides catering).	Health and safety procedures protect people (and the environment) from harm.	• If your group is about to undertake a new activity, such as a trip to the seaside, or gardening session, which introduces new tools, do you carry out risk assessments? • Can you show examples and talk through how you carry out risk assessments?
Notes		
Equality and diversity We need to ensure that community groups are inclusive and accessible. No one should be discriminated against, on the grounds of race, age, disability, gender and the other protected characteristics covered by the 2010 Equality Act. We need to consider the active steps your group takes to ensure that everyone can be fully involved.	It is illegal to discriminate against people on the grounds of the protected characteristics. Equality is about being fair and making sure that everyone can fulfill their potential. Diversity is about recognising and valuing everyone's differences.	• Can you explain how your community group ensures that everyone is comfortable and included? • Could you give some examples of how your group actively takes steps to include everyone, such as ensuring meeting places are accessible? • A participant with limited knowledge of the English language is referred to your group and is finding it difficult to understand and engage in the activities you offer. How would you support this person?
Notes		

Recruitment of new members and training volunteers
 	
We need to check that community groups recruit new members and volunteers fairly.
 	
If you have volunteers, they are supported through:
• clear roles
• ongoing support
• regular training, where needed.
	To ensure that everyone is supported to build skills, knowledge and confidence within the group.
	
	To ensure that all volunteers are supported with appropriate training to fulfill their roles.
	
	To ensure that the group meets legal requirements for first aid training.
		• How does your community group support new members?
		• How are people within your group supported to build knowledge, skills and confidence?
		• Do you have volunteers? If so, do they have:
		  • role descriptions
		  • ongoing support/ supervision (particularly when they are new in their role)
		  • training (including training records and plans).
		• Do relevant volunteers have First Aid certificates?

Notes		
Governance arrangements: does your group have a constitution which guides how the group operates? Please provide a copy.		Received: yes/no
Financial accounts: does your group have a bank account and keep records of income and spending? Please show latest bank statements and accounts.		Received: yes/no
Actions agreed:		
Agreement to connect through social prescribing: **Representative of primary care network:** Name: Signature: Date: **Representative of community group:** Name: Signature: Date:		

Appendix 6 – Measuring impact

1. Office of National Statistics Wellbeing Scale (ONS4)

Questions	Scale
Overall, how satisfied are you with your life nowadays?	0 – 10 scale 0 = not at all 10 = completely
Overall, to what extent do you feel the things you do in your life are worthwhile?	0 – 10 scale 0 = not at all 10 = completely
Overall, how happy did you feel yesterday?	0 – 10 scale 0 = not at all 10 = completely
On a scale where 0 is “not at all anxious” and 10 is “completely anxious”, overall, how anxious did you feel yesterday?	0 – 10 scale 0 = not at all anxious 10 = completely anxious

2. Patient Activation Measure (PAM®)

What is the Patient Activation Measure?

The PAM is a validated tool that measures people’s knowledge, skills and confidence (referred to as ‘patient activation’) in managing their own health and wellbeing. The PAM comprises 13 questions and the responses assign a score out of 100, matching the respondents to one of four levels of ‘activation’ (one being the lowest level and four being the highest). Each level of activation reveals insight into a range of health-related characteristics, including behaviours and outcomes.

Why is it important?

A person’s PAM score is indicative of how much/what type of support a person will need to be able to actively take part in managing their own health and wellbeing. Therefore, the PAM assessments will enable link workers to tailor services and support to ‘meet patients where they are’. This will ensure that those with the lower levels of knowledge, skills and confidence (levels one and two) can be identified to receive the additional support they require, and enables link workers to make the most efficient use of their resources.

Higher activation levels correlate to healthier behaviours, better health outcomes and experiences of care, and fewer episodes of unplanned and emergency care. Therefore, changes within PAM score will support links between social prescribing and impacts on the wider health system.

How should it be applied?

A link worker should use the PAM on the initial meeting with a person. As far as possible, the questions should be read exactly as they appear without further

explanation. The system will return an activation level, which will inform decisions on the level of support required (e.g. number of meetings and which intervention/support approach to adopt). Specific responses to questions could also be used to inform further discussions on the person's needs.

A follow up PAM assessment should be done at least every six months to measure any changes. A PAM reassessment can be undertaken sooner than six months (but no less than three months) if a person has accessed and undertaken the prescribed support/intervention. Link workers should complete online PAM training before implementing the PAM. Insignia Health will release online training to PCNs with PAM licenses (see below).

Who is PAM suitable for?

Though understanding people's knowledge, skills and confidence is important to their ongoing health, there are some people for whom PAM is not recommended. PAM should not be used with people with severe mental health problems, dementia, where a person has limited use of the English language or those with moderate to severe learning disabilities.

To understand the questions, a person will require level 1 national literacy standard (reading age of 12 years). However, if a person is struggling to understand the questions, as they should not be reworded, the PAM is likely to be unsuitable.

Due to the nature of some of the questions, PAM is only effective for those with an existing health need that requires some management; however, this can include those at risk of developing a health issue (e.g. smokers, pre-diabetes).

How do we get access to PAM?

PAM is licensed by Insignia Health. NHS England has purchased licenses from Insignia Health and will provide licenses for each PCN to use, free of charge. Each PCN will distribute PAM licenses, the administration tool and associated resources to link workers.

For more information contact: england.patientactivation@nhs.net