JOB DESCRIPTION

Job title	Team Leader (Specialist)
Department	Public Health Substance Misuse
Reports to	Wellbeing Services Manager
Grade	Grade 4

Job purpose	To effectively lead and manage the service and team in order to empower individuals within the geographical region assigned and surrounding areas , to take control of their health and wellbeing by supporting people over time, focusing on 'what matters to me' and take a holistic approach to improving an individual's health and wellbeing. The Team leader will provide line management support and supervision to the link worker teams, provide advice and support on the role of a link worker, managing a caseload of clients with a range of support needs focusing on Individual Goal Setting, Motivational Interviewing and Health Coaching. They will also liaise with the various partners and Steering Group on behalf of the Link Workers they manage. As well as having line management responsibility the Team Leaders will also hold a caseload, which will include; providing personalised information and advice via 1 to 1 sessions. Together with social prescribing link workers, the team leader will work as a key part of the primary care network (PCN) multidisciplinary team, connecting with; • people with long term conditions • people who are lonely or isolated people who have complex social needs which affect their wellbeing. • who have experienced great difficulty in engaging with local services
Key accountabilities	**Referrals (Incoming)** With support from GP staff, take referrals from the PCN's Core Network Practices and from a wide range of local and community agencies, as defined within the service eligibility criteria. The Team Leader will: • Work closely in collaboration with GPs, and the Clinical Lead in each PCN to deliver a coordinated and high-quality Specialist Social Prescribing Link Worker service – supporting clients to access and engage with the extensive range of support in the community, depending on the complexity or nature of their individual needs • Support the development of Social Prescribing in the assigned geographical area and represent and promote the service to stakeholders. • As part of the PCN multi-disciplinary team, ensure excellent working relationships are built with staff in GP practices within the local PCN, being an active member of relevant MDT meetings, sharing information and feedback on caseload progress

	• Proactively developing strong links with all local agencies to encourage referrals, recognising what is needed to make appropriate referrals. • Positively raise awareness of social prescribing with local organisations and communities, highlighting how partnership working can reduce pressure on statutory services, improve health access and outcomes and enable a holistic approach to care. • Provide referral agencies with regular updates about caseloads, including training for their staff and how to access information to encourage appropriate referrals. • Seek regular feedback about the quality of service and the impacts of outgoing referrals have, on partner organisations. • Identify, promote and action equality, inclusion and reasonable adjustments, through self-referrals and connecting with all diverse local communities, particularly those communities that statutory agencies may find hard to reach.
	Provide personalised support, high quality information, guidance and facilitation based on local and national evidenced based best practice: As a key member of the PCN multi-disciplinary team, provide personalised support to individuals with multiple and high level needs, their families and carers to take control of their health and wellbeing, live independently and improve their health access and outcomes. The Team Leader will: • Meet people on a 1-1 basis, making home or outreach visits, where appropriate within organisational policies and procedures and focus on 'what matters to me'. • Build trust and respect with the person, providing non-judgemental and non-discriminatory support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person's assets. • Effectively support the Wellbeing Team Leader to ensure that all information provided is based on local and national evidenced based practice around health, wellbeing and prevention approaches • Supporting people to tackle the wider issues that impact on their health and wellbeing (such as debt, poor housing, being unemployed, loneliness and caring responsibilities) by providing support on practical coping mechanisms and signposting • Co-produce a personalised wellbeing plan to address the person's health and wellbeing needs 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. • Use coaching techniques to support people in 1- 1 sessions identifying changes they want to make and set goals according to their wellbeing plan. This will • Support people to maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards • Work flexibly and responsively to changing complexity of needs and intensity of support required – including the provision of urgent and extended support where appropriate • 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. • Support access to appointments through accompanying people on initial visits • Seek advice and support from the Team Leader 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. • Provide telephone support available for carers
	Support community groups and VCSE organisations to receive referrals Work with a diverse range of people and communities, to draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups (including faith groups) to receive social prescribing referrals. • Forge strong links with a wide range of local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what's already available to create a menu of diverse community groups and assets, who promote diversity and inclusion. • Develop supportive relationships with local diverse VCSE organisations, culturally appropriate community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.
	Work collectively with all local partners to ensure community groups are strong and sustainable Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local diverse partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps in local provision with commissioners and local authorities The Link Worker will: • Work with commissioners and local partners to identify unmet diverse needs within the community and gaps in community provision. • Encourage people who have been connected to community support through social prescribing to volunteer, building their skills and confidence and strengthening community resilience. • 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. • Inform non-clinical and clinical staff within PCN multi-disciplinary teams on what other services are available within the community and how and when patients can access them.
	• **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. • Ensure that clinical systems are used correctly (as outlined in the Network Contract DES), adhering to data protection legislation and data sharing agreements.
	Professional development • Work with your line manager to participate in appraisal and personal development review, taking an active part in reviewing and developing the roles and responsibilities. • Partake and contribute to learning and development opportunities • Share progress, learning and challenges at team meetings and supervision
	Managerial: • Lead, develop, supervise and support a team of SPLWs that deliver a range of wellbeing and social prescription services. • Contribute to the knowledge and skills of the link workers, ensuring a culture of learning and development. • Ensure that risk assessments and Wellbeing plans are up to date and accurate, are in the correct format and are being followed by the whole team. • Oversee all health and safety actions and ensure compliance with Turning Point policies. • With the support of the team - escalate and share issues of concern if a situation is unsafe or presenting a risk. Also take immediate action to address wherever trained to do so. • Conduct regular team meetings (as appropriate and as a minimum monthly) with the team to ensure information is given and received. • Ensure they and the team follow work instructions and will ask if not clear. • Complete the Quarterly Report for commissioners with the team -ensuring all required information is included and submit within the agreed deadlines.
	To provide guidance to the team by: • Allocating work to team members & overseeing the completion of tasks in a timely and effective manner. • Ensuring that required quality standards are being met. • Coaching team members in the proper way to undertake the task • Undertaking return to work interviews after absence, and liaising with line manager regarding any areas of concern. • Induct new employees and liaise with line manager regarding probationary period reviews. • Monitor team's performance to ensure it meets expectations and agreed performance criteria (acting upon this, failing to do so). • Ensure the service and the wider organisation of Turning Point is represented in a professional manner at all times. • Proactively contribute to the continuous improvement of the service by

	making positive suggestions, providing constructive feedback and assisting in the implementation of agreed new way of working. • Meeting agreed performance targets and outcomes
	Any other duties • Manage own time effectively and identify any problems and concerns promptly with your line manager • Maintain professional boundaries with individuals • Work within Turning Point's policies and procedures • Understand and comply with all health and safety requirements relating to oneself and individuals you are working with • Work as part of the healthcare team and with other local link workers to seek feedback, continually improve the service and contribute to business planning. • Act as an ambassador for Turning Point and the Social Prescribing Service at external meetings and develop excellent working relationships with local voluntary/community and statutory partner organisations across the social care, health, housing, education and learning, employment support and welfare advice sectors • Contribute to the development of Turning Point's policies, projects and plans relating to equality, diversity and health inequalities. • Ensure good news stories are shared and good links with communications is established, people's stories should be shared appropriately with consent and contribute to evaluation of the service and potential development opportunities in other geographical locations. • 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. **Undertake any other duties within your capabilities that are relevant to the job and reasonably requested of you by your manager.**

Dimensions	Direct reports	Link Worker team.
	Total staff overseen	5
	Internal contacts	Area Manager Regional Head of Operations (SM/PH) Link Workers Members of the SM/PH Business Unit Wider Turning Point colleagues, particularly from Learning Disabilities & Mental Health PCNs
	External contacts	• People using the service • Family carers/Support staff from other providers • Wider community • Local community and voluntary sector, Warwickshire County Council and NHS services (referrals in and out of the service) • Commissioners of the service
	Planning outlook	• Planning required for 1 to 1 sessions

		• Planning to ensure appropriate cover for scheduled activities provided by the service. • Effective planning to ensure managerial tasks are completed within agreed administrative hours.
	Problems solved	• Building rapport and trust in order to engage people using the service • Finding out about local groups and services • Building trust with local community groups & voluntary sector organisations • Persuading local groups/organisations of the benefits of the service • Modelling, coaching and support problem solving skills in others
	Financial authority	• Manage own expenses. • Ensure best value from resources within budgets for the service. • Manage petty cash and daily expenditure. Ensure all expenditure is managed in line with Turning Point policy. • Prepare for and attend all required budget/financial meetings

PERSON SPECIFICATION

Job title	Team Leader

Personal effectiveness	Essential	Desirable
	• A good working knowledge of the geographical area and organisations that the service could benefit from working with • Ability to actively listen, empathise with people and provide person-centred support in a non-judgemental way • Able to provide a culturally sensitive service, by supporting people from all backgrounds and communities, respecting lifestyles and diversity • Commitment to reducing health inequalities and proactively working to reach people from diverse communities • Ability to support people in a way that inspires trust and confidence, motivating others to reach their	• Fluency in one or more Community Languages

	potential • Ability to communicate effectively, both verbally and in writing, with people, their families, carers, community groups, partner agencies and stakeholders • Ability to identify risk and assess/manage risk when working with individuals • Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when the person's needs are beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner • Able to work from an asset-based approach, building on existing community and personal assets • Ability to maintain effective working relationships and to promote collaborative practice with all colleagues • Commitment to collaborative working with all local agencies (including VCSE organisations and community groups). Able to work with others to reduce hierarchies and find creative solutions to community issues • Can demonstrate personal accountability, emotional resilience and ability to work well under pressure • Ability to organise, plan and prioritise on own initiative, including when under pressure and meeting deadlines • High level of written and oral communication skills • Ability to work flexibly and enthusiastically within a team or on own initiative • Understanding of the needs of small volunteer-led community groups and ability to support their development • Able to provide motivational coaching to support people's behaviour change	

	• Knowledge of, and ability to work to, policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety	

Technical effectiveness	Essential	Desirable
	• At least 6 months of management/ supervisory experience • 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 the social and health needs of people with varying degrees of complexity • Caseload management of a complex nature • Demonstrable skills and knowledge in assessing risk presented by clients to themselves and others • Harm reduction, suicide and self harm awareness • Management of incidents of a violent or aggressive nature • Understanding of, and commitment to, equality, diversity and inclusion. • Knowledge of community development approaches • Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports	• Local knowledge of VCSE and community services in the locality • Knowledge of how the NHS works, including primary care

Acquired experience & qualifications	Essential	Desirable

	• NVQ Level 3, Advanced level or equivalent qualifications or working towards
	• Demonstrable commitment to professional and personal development
	• Experience in one of the following:
	  ○ Learning Disabilities & Autism
	  ○ Complex Mental Health
		• Previous experience of supporting marginalised groups and/or people with high level of social and health need
		• Training in motivational coaching and interviewing or equivalent experience

	○ Substance Misuse ○ Homelessness	

Other requirements	Essential	Desirable
	• 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	