Training & Education Framework & Programme for Somerset Social Prescribing Workforce

Contents

1.0 Forward

Dr. Deborah Lane, Somerset Social Prescribing Workforce Development Lead working for the Somerset People Board for Health & Social Care was tasked in July 2020 to work in partnership with key stakeholders to:

1. Develop and publish a core competency framework for social prescribing link workers and health coaches. This will consider levels of expertise and the potential for accreditation / more formal recognition in future.
2. Develop and publish an education and training resource for the key competencies. This will use national, regional and local training already available and also identify training that would need additional resourcing including both on-line and face to face training / education.
3. Commence a multi-partner education and training programme.

This framework and training programme will support the Somerset Social Prescribing Model which forms part of a shift towards a more personalised care approach across Somerset. The Somerset Social Prescribing model was developed through listening to the experience of a wide range of local partners, a growing national evidence base and people who have themselves experienced social prescribing. Thanks go to key people and groups including, but not limited to:

- Individual people and service users who have shared their stories
- Somerset People Board for Health & Social Care
- Somerset CCG
- Members of the Frome On Track Group
- Members of the Somerset Equality Advisory Group
- The Community Council For Somerset
- Health Connections Mendip
- Taunton Health and Wellbeing Advisors
- Health Coaches from South Somerset
- Spark Somerset
- Somerset Community Foundation
- The Somerset Group of Charities
- Representatives from Primary Care Networks, Somerset Local Medical Committee and the Somerset Training Hub
- Colleagues from Somerset County Council, Public Health and District councils
- Academic advice on outcome measures from the University of the West of England

2.0 Introduction

Social prescribing, *'represents a **new 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' (NHS England, Long Term Plan).*

Social Prescribing helps to de-medicalise support where people's underlying needs require practical, emotional and community based support. It seeks to address people's needs in a holistic way and support individuals to take greater control of their own health and wellbeing. Through **social prescribing** the range of support available to people will widen, diversify and become accessible across the country

Social prescribing is one of 6 core elements to the national Comprehensive Model of Personalised Care which CCGs are mandated to develop https://www.england.nhs.uk/personalisedcare/ .

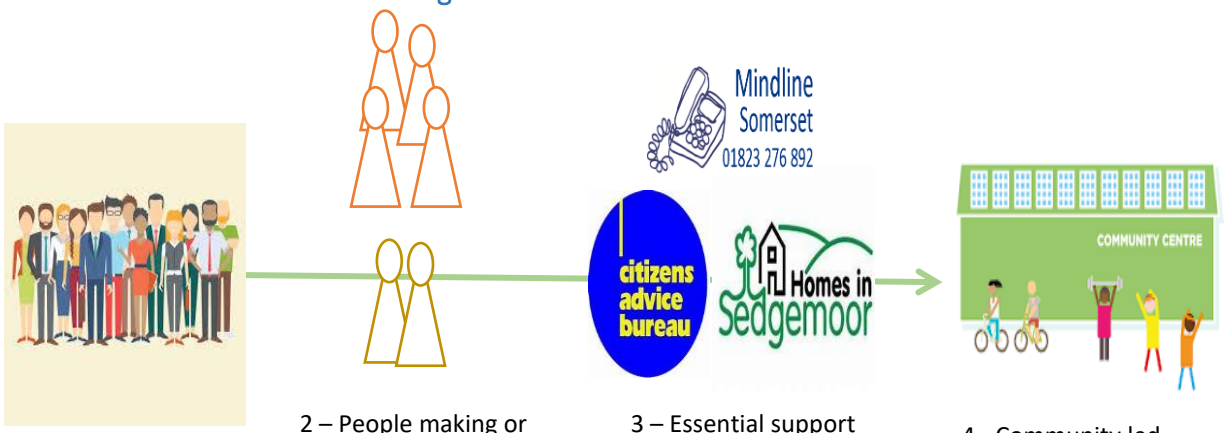
The long-term plan states that delivery of the Comprehensive Model of Personalised care will be supported by a) training of all health and care staff in a personalised care approach and b) a dedicated workforce in primary care, funded through the DES contract and Additional Reimbursable Roles Scheme (ARRS). The additional roles include **Social Prescribing Link Workers**, **Care Coordinators** and **Health & Wellbeing Coaches** (see Appendix 1 for more details).

3.0 Somerset context

The Somerset Fit for My Future programme recognises that the wider determinants of health are predominant drivers of health outcomes, service demand and system cost e.g. isolation, loneliness, debt and benefit problems, diet, exercise, confidence, personal relationships, work, and housing. Health inequalities magnify the effect of these. At least **30%-50%** of demand on Primary Care each day is estimated to be driven by issues that do not require a medical solution (LSBU, 2019). It is also known that for long term conditions such as cardiovascular disease, reductions in avoidable harm and cost is dependent on people changing or being supported to change their health behaviours.

A series of workshops held during autumn 2019 agreed a vision for a sustainable, inclusive Social Prescribing Framework for Somerset. Somerset CCG subsequently agreed a strategy for social prescribing roles, aligned to Neighbourhood/PCN developments. The Somerset Model of Social prescribing will ensure the system (i) has the capacity to provide essential support around behavioural change; (ii) can identify non-medical solutions where appropriate; (iii) has a person-centred strengths based culture and works in partnership with people and communities.

Somerset Model of Social Prescribing



1 – All of us being neighbourly and sharing knowledge

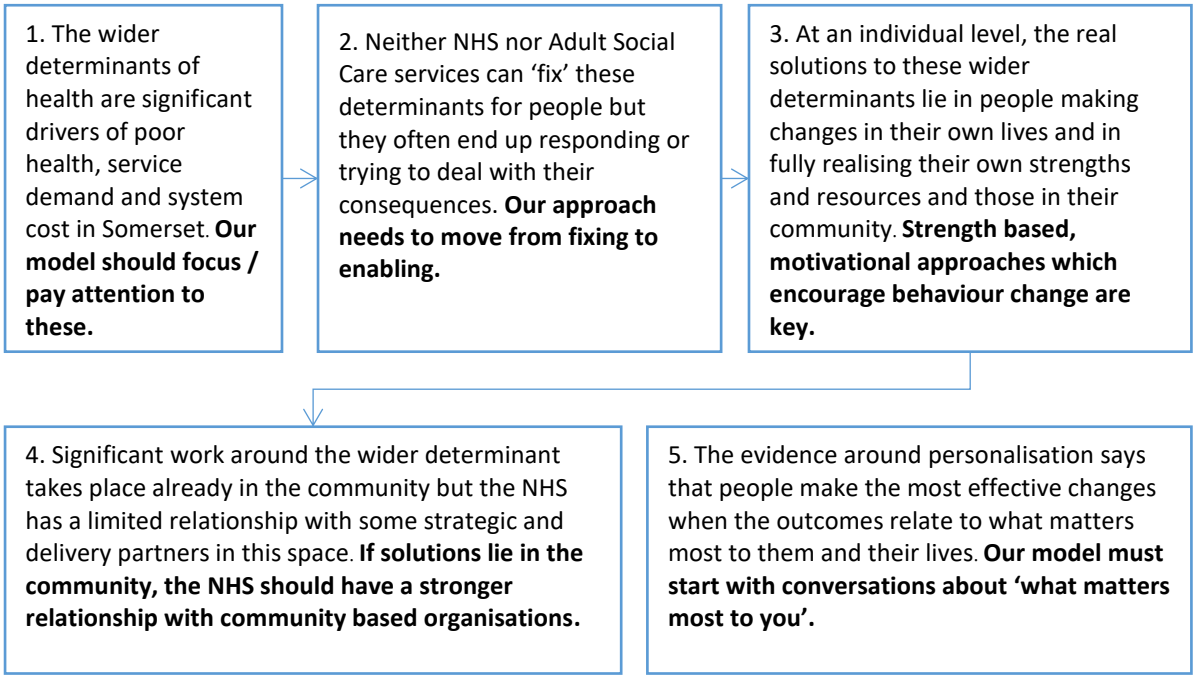
2 – People making or supported to make meaningful connections with one or more people

3 – Essential support in the community Debt, benefits, housing, mental health

4 - Community led organisations, infrastructure and volunteer support e.g. Spark Somerset

The Fit for My Future model of integrated out of hospital care includes the social prescribing workforce as a core component to address these issues. Somerset Clinical Commissioning Group (CCG) already has a significant record of accomplishment in supporting various Social Prescribing workforce models as Test and Learns in different areas of the county. This workforce included Health and Wellbeing Advisors, Health Connectors and Health Coaches. Since 2019, the DES Additional reimbursable Roles Scheme (ARRS) has funded additional roles (**Social Prescribing Link Workers**, **Care Coordinators** and **Health & Wellbeing Coaches)** and additional posts to join the existing Somerset Social Prescribing workforce. During 2021, Somerset will move towards equitable levels of Social Prescribing **Link Workers** and **Health Coaches** across the county, funded by the Primary Care Networks in collaboration with the CCG.

Logic model for Somerset Social Prescribing Model



4.0 Purpose and function of framework

Currently **Social Prescribing Link Workers "link workers"**, **Health and Wellbeing Coaches "Health Coaches"** and other similar roles in Somerset e.g. Health Connectors, are unregulated roles not associated with any one professional body. The purpose of this framework is to provide clear guidance for employing organisations on the competencies required to work as **Link workers** and **Health Coaches** in Somerset and articulates the values, behaviours and capabilities required. Some of the competencies described are common to a number of roles across the health and social care landscape, which will enable joint training where appropriate.

These roles are pulling in people new to the Health and Social Care sector and with varied background and qualifications. The nationally produced sample job descriptions from NHS England indicate that link workers are expected to have A level or equivalent qualifications whereas health coaches can be recruited with a coaching/counselling qualification/ experience or other relevant qualification/experience involving reflective listening skills (see Appendix 1). This is significant particularly in the current national and local climate where there are a large number of unemployed individuals with life experience and people skills developed in the retail and hospitality sector, ***and*** a growing interest in working in the Health and Social Care Sector.

There is a need, therefore, for a competency framework, education & support package that;
(i) identifies the core competencies needed to be effective in these roles
(ii) identifies the competencies for progression and achievement of the expert level in these roles and
(iii) links to nationally recognised competencies and qualifications to allow movement between these roles and registered and non-registered roles in the health / public health, social care, community and voluntary sectors.

This framework aligns to, and is designed to be used in conjunction with the Core Curriculum for Personalised Care published by the Personalised Care Institute (PCI). The PCI core curriculum forms the educational framework for the essential elements to personalised care; informs the educational aims and objectives for training courses; and provides a framework for accreditation and governance of training courses. The PCI also accredits training providers and recommends these providers should be used when commissioning training for **Social Prescribing Link Workers**, **Care Coordinators** and **Health & Wellbeing Coaches**. Where possible descriptions have been simplified and aligned with language in the PCI core curriculum. This is to support effective assessment of competency attainment in training and in the workplace, whoever the employer. It is suggested that the competencies in this framework should be used as part of a supervision process to support ongoing professional development, at appraisal and for progression

5.0 Framework Development Process

Drafts of the '**Somerset competency framework for link workers and health coaches'** were developed as an iterative process informed by;

- The Personalised Care Institute Personalised Care curriculum https://www.personalisedcareinstitute.org.uk/pluginfile.php/133/mod_page/content/28/PCI-Curriculum.pdf,
- The draft national SPLW framework (see Appendix 2) ;
- Input from the Somerset workshops (see Appendix 3);
- The results of a survey of some of the training undertaken or needed by those already in roles within the Social Prescribing Landscape in Somerset.
- Feedback from key stakeholders including lay people

The framework and training programme was endorsed by the Somerset People Board for Health & Social Care on 12th March 2021 and agreement reached about how it fits with the wider workforce priorities around employment and wider determinants of health, and also about system wide adoption and mobilisation.

6.0 The framework

The framework is aimed at those in link worker and health coach roles but may also be relevant for other workforce across Health and Social Care in Somerset. It is designed to support both those new in post and those who have been in existing roles in the social prescribing landscape for some years, and incorporates the following components:

1. Local PCN based induction (e.g. EMIS, SNOMED codes, supervision arrangements, huddles / meetings, appraisal, policies and procedures e.g. lone working, practice, PCN & wider neighbourhood team, MDT roles, mandatory training, use of PAM / ONS4)

2. Local training tailored to local provision & need combined with relationship building – this may be delivered by primary care training hub, SPARK, NHS provider staff etc (Health coaching skills, Diabetes update, Safeguarding, Community Connector training, On-line Directories, Mental Health)

3. Relevant national, regional or local on-line training that meets identified needs (e.g. Future NHS platform - Social Prescribing, South West regional personalisation collaborative, Peer support forum organised by Regional SP Learning coordinator, Primary care webinars) NB NHS e-Learning for health is accessible to those from VCSE, and social care as well as NHS workforce.

4. National formal / accredited training i.e. transferable qualifications to allow entry into or progression within the Social Prescribing Workforce *or* a pipeline into registered Health & Social Care professions *or* other roles in the NHS / Social Care / VCSE organisations. (e.g. Apprenticeship in Community Health & Wellbeing Worker, Care certificate, NVQ Level 3 / 'A' levels or equivalent).

5. National training identified under DES (see Appendix 1). Whether under the Personalised Care Institute, or NHS e-Learning for health, this all aligns with the **National Core Curriculum in Personalised Care.**

7.0 Career & remuneration structure

National guidance suggest that these roles are remunerated at *up to* Agenda for Change (AfC) Band 5, (see Appendix 4) *dependent on* Knowledge, skills, Experience and responsibilities. To support a standardised and affordable approach for Somerset that is sustainable after the end of the Additional Reimbursable Roles Scheme finishes in 2024, the following career and remuneration structure is offered as a suggestion only.

Entry Level. On recruitment, someone who meets the person specification though with no previous experience of the roles, or those following an Apprenticeship route (see Appendix 5) into the roles, the focus is on acquiring **Core Competencies & Knowledge.** This is the first level of training and describes a foundation level of knowledge and understanding of Personalised Care. Competency assessment should focus on the ability to take a **Person Centred Approach**. Individuals at this level might be paid at the bottom of AfC Band 3 or equivalent i.e. £19,737 (March 2021). Those at entry level should undertake the competencies listed in the local induction within the first few weeks. Individuals then have the opportunity to develop their skills by undertaking level 1 competencies.

Level 1 Capabilities: Competencies to Engage People – Core communication and relationship building skills. There is an expectation that the learner will build on previous knowledge and is able to apply it in a wider context. This level describes those staff who have regular contact with people and have the opportunity to create an ongoing collaborative and enabling relationship. Competency assessment should focus on the following capabilities: **Promoting Autonomy**, **Action Planning & Goal Setting** and **Managing Setbacks & Problem Solving.** Those at Level 1 might be paid within the AfC Band 3 pay range or equivalent i.e. £19,737 - £21,142, (March 2021).

Level 2 Capabilities: Competencies to enable & support people. This level builds on level 1 capabilities to further develop skills to enable and support people. Competency assessment should focus on the following capabilities: **Supporting Competence & Self Efficacy** and **Self-**

monitoring. Those achieving Level 2 capabilities might be paid within the AfC Band 4 pay range i.e. £21,892 - £24, 157, (March 2021).

Level 3 Capabilities: The learner incorporates more complexity into the capabilities already achieved. These capabilities are applied in wider contexts which might include more intensive interactions and interventions or working with the most complex individuals and settings across multiple providers and pathways. It will also include those professionals with responsibility for service pathways, delivery, evaluation and innovation across multiple partners or organisations.

Those able to achieve the competencies listed as level 3, and taking on wider responsibilities, leadership or specialisation might be paid at AfC Band 5 or equivalent i.e. £24,907 - £30,615 (March 2021). This is equivalent the level of pay usually given to a newly registered health professional such as a nurse or occupational therapist with a degree level qualification.

Table 1: *Suggested* competencies, career & remuneration structure for Somerset

Career Level	Competencies achieved	**Suggested** Payscale (2020/21)
Entry Level with no previous experience OR Apprenticeship route	Local Induction Competencies	£19,737
Early career	Core Competencies Assessed competency: **Person Centred Approach**	£19,737
Mid-career	Level 1 Competencies Assessed competencies: **Promoting Autonomy**, **Action Planning & Goal Setting** **Managing Setbacks & Problem Solving**	£19, 737 - £21,142
Established career	Level 2 competencies Assessed competencies: **Supporting Competence & Self Efficacy** **Self-monitoring**.	£21,892 - £24, 157.
Wider responsibilities, leadership or specialisation	Level 3 Competencies (Expert level)	£24,907 - £30,615.

The following Dreyfus scoring system may assist in the assessment of competency in the delivery of the competencies listed above:

Person Centred Approach, Promoting autonomy, Action Planning & Goal Setting, Managing Setbacks & Problem Solving, Supporting Competence & Self-efficacy and Self-monitoring.

The Dreyfus Scale: Scoring Instructions

The six-point rating scale based on the Dreyfus system for skill acquisition is intended to measure the competence in the delivery of person centred skills (Dreyfus, 2004). The six point scale ranges from (0) where the individual has not delivered the skill appropriately, whether it was delivered poorly or insufficiently (1) to (5) where the individual has delivered the skill appropriately, sufficiently and with a high degree of skill. To help with the scoring of competence, an outline of the key features of each is provided in appendix 6. It should be noted that the giving a 5 (expert) should be reserved for individuals who deliver skills exceptionally well, adapting for different contexts and often in the face of difficulties such as resistance from participants. It is likely that those working at Level 3 score are working at expert level (5) for each of the assessed competencies.

When rating skill at delivering a particular competence, first identify if the key features of the competence are evident. Then consider if the key features were used appropriately (misses few opportunities to deliver and when doing so, delivers them well). In this instance, the individual should be rated highly. It should be noted that the scores produced from using this measure should follow a roughly normal distribution, with relatively few individuals scoring at the extremes of the scales (low/high scores).

Table 2: Competency scoring system

Competence	**Competence Level**	**Skill descriptor**
Absence	0	Absence of and/ or highly inappropriate performance of skill
Novice	1	Minimal use of skill and /or inappropriate performance
Advanced Beginner	2	Evidence of some competence, with numerous problems or inconsistencies.
Competent	3	Competent, good skills with some minor problems or inconsistencies
Proficient	4	Very good skills, with minimal problems or inconsistencies
Expert	5	Excellent skills, no problems or inconsistencies.

8.0 A Summary of the Knowledge, Skills & Competencies framework and training available

Local induction	Training & education resources available
IT Systems	Employer e.g. NHS, Voluntary sector, Social care
Supervision and appraisal arrangements	Appropriately skilled professional Role development from peer expert
Clinical escalation	Appropriately skilled professional
Policies and procedures e.g. lone working	Employer
Practice, PCN & wider neighbourhood team & MDT roles, huddles / meetings.	A resources to support the new roles in primary care https://www.e-lfh.org.uk/programmes/new-roles-in-primary-care/
Mandatory training e.g. fire, infection control, confidentiality	This e-learning covers the 11 statutory and mandatory training for all staff working in health and social care i.e. Conflict Resolution, Data Security Awareness, Equality and Diversity and Human Rights, Fire Safety, Health, Safety and Welfare, Infection Prevention and Control, Moving and Handling, Preventing Radicalisation, Resuscitation, Safeguarding Children and Safeguarding Adults. https://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/
Use of Outcome Tools e.g. Patient Activation Measure (PAM) / ONS4 /SWEMWBS /MYCAW/ Wellbeing Star or other outcome tools.	**PAM (the Patient Activation Measure)** is a licensed tool designed to measure a person's Knowledge, Skills and Confidence to manage their own health. It has been widely used as NHSE has funded a large number of licences over a number of years. Training is available through the following links. https://www.england.nhs.uk/personalisedcare/supported-self-management/patient-activation/ Insignia on-line training https://www.england.nhs.uk/publication/module-1-patient-activation-measure-implementation-quick-guide/ NB From April 15th 2021 If PCNs wish to continue using PAM locally, then they will have to purchase their own licenses direct from Insignia. The NHS England Social Prescribing Team are exploring several options for wellbeing

	tools for social prescribing with testing due to take place in 2021/22. Undertaking PAM training to understand how to tailor an approach dependent on an individual's Knowledge, Skills & Confidence to manage their own health (Activation) is useful even if unable to access licences to use the PAM tool. The **Warwick Edinburgh Mental Wellbeing Scale** (WEMWBS) is a licensed tool, free to use for non-Commercial organisations. https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/ **Measure Yourself Concerns & Wellbeing (MYCaW).** MYCaW is an individualised questionnaire designed for evaluating holistic and personalised approaches to **supporting people**. It only takes a few minutes to complete and can routinely be incorporated into a consultation to understand and prioritise what a person most wants support with. It is an annually licensed tool, free to use for non-Commercial organisations, though with an administration cost to register for a licence of £46.20 (March 2021). Training is provided for licence holders. https://www.meaningfulmeasures.co.uk/mycaw The **Well-being Star** has been designed for people living with a long term health condition, to support and measure their progress in living as well as they can. It can work as a stand-alone tool, or as part of Personal Health Plan materials. The Well-being Star is designed to either be self-completed by a patient, or ideally completed by a patient and health professional together. **Health Confidence score** https://bmjopenquality.bmj.com/content/bmjqir/8/2/e000411.full.pdf
SNOMED codes	National Guidance: 871731000000106 –Referral to social prescribing service (procedure) 871711000000103 –Social prescribing declined (situation) SP Referral (SNOMED code ending in 106) – this is used whenever a person initially engages with the social prescribing service and includes the following:

	• Personalised plan to provide practical, physical and/or emotional support • Emotional support • Referral made into NHS Volunteer Responders GoodSAM app • Delivering shopping • Delivering medication Decline (SNOMED code ending in 103) – this is used when one of the following occurs: • The person explicitly declines any support • The person does not need any support Nil Return (no code used) – this is used when the one of the following occurs: • The person doesn't answer the phone • The person hangs up the phone without giving a clear acceptance or decline of the offer SNOMED codes to support those in health coach roles are under development as part of the Health Services System Framework (HSSF) minimum data sets.
On-line directories. Need to ensure these are relevant, being kept up-to-date and used in conjunction with 'What matters to you' conversations.	Some of those already in use by SPLW & HC include the following https://wellbeingsouthsomerset.org/ https://healthconnectionsmendip.org/ https://tauntonwellbeingzone.org/ https://westsomersetcommunitydirectory.org/?fbclid=IwAR3BBc-tFE_dTPdXNMjl8LtjTBvwQnBuH4zYYCLYh5jVDWb7jYTkNemqYC0 Sedgemoor directory developed but not yet launched.
Care certificate	Developed following the review of health and social care support workers by Camilla Cavendish (2013), the Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the unregistered workforce in mind, the Care Certificate was developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support.

	The Care Certificate consists of 15 standards, all of which individuals need to complete in full before they can be awarded their certificate. The standards require both theoretical study and practical application within the student's place of work. https://www.e-lfh.org.uk/programmes/care-certificate/
Core Competencies & Knowledge Assessed competency: **Person Centred Approach.**	Training & Education resources available
Generic professional capabilities	**Cultural Competence** This e-Learning develops knowledge and understanding of the issues around culture and health; and how this might influence health care outcomes https://www.e-lfh.org.uk/programmes/cultural-competence/ **Disability Matters** This e-Learning helps the staff to understand disabilities and give them a positive view of disabled people. Some of the subjects in the e-learning are: Hidden disabilities, Activities for people with disabilities, Disability rights, Bullying, How to communicate with people with disabilities. https://www.e-lfh.org.uk/programmes/disability-matters/ **Health Inequalities** Health Creation: How can Primary Care Networks succeed in reducing health inequalities? (thehealthcreationalliance.org) **Mental capacity** This e-Learning programme is made up of 11 e-learning sessions, which cover the following: Mental Capacity Act as Part of Human Rights, Assessing Mental Capacity, Making Decisions, Best Interests, Restraint, Deprivation of Liberty, Relationship between the Mental Capacity Act and the Mental Health Act, Mental Capacity Act and

	Young People aged 16 or 17, Research involving People who Lack Capacity, Mental Capacity Act and Adult Safeguarding, Settling Disputes and Disagreements https://www.e-lfh.org.uk/programmes/mental-capacity-act/ **Safeguarding adults** To live a life free from abuse and harm is a basic human right. We are all responsible for the protection of people at risk from abuse. Vulnerable adults rely on us to take the right steps to help keep them safe. If we don't, who will? To ignore abuse and neglect is to allow it to continue and that is never acceptable. Safeguarding is everyone's business https://www.e-lfh.org.uk/programmes/safeguarding-adults/ **Safeguarding children** All health professionals have a key role to play in safeguarding children and young people. Section 11 of the Children Act places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of those they come into contact with. These e-learning sessions offer a clear and effective solution to achieve this aim and meet the National Workforce Competences. https://www.e-lfh.org.uk/programmes/safeguarding-children/
Values in Personalised Care 1. Shared-decision making 2. Personalised Care & Support Planning 3. Social prescribing and Community-based support 4. Supported self-management 5. Enabling choice	**Person centred approaches** The scope of this eLearning is to introduce the behaviours, knowledge and skills for person-centred approaches, including the values, core communication and relationship building skills, engaging people and enabling and supporting people. You will cover the core transferable behaviours, knowledge and skills for person-centred approaches, and see the application of these through five stories.

6. Personal & Integrated personal budgets.	https://www.e-lfh.org.uk/programmes/person-centred-approaches/ **Core skills in personalised care** This module is written by three experts on the subject of personalised care, who come from backgrounds of psychology, professional education, communication skills training and personal experience. The module takes a holistic view of health and care, and demonstrates the nature and benefits of personalised care. https://www.personalisedcareinstitute.org.uk/enrol/index.php?id=3 **SW Integrated Personal Care videos**. Example of a personalised care approach in practice from across the South West. https://www.youtube.com/channel/UCdjeotwSHwtF602tF6aEOrQ/videos **Shared decision making** This eLearning covers aspects of the core capabilities to communicate and build relationships, as well as to engage, enable and support people: https://www.personalisedcareinstitute.org.uk/enrol/index.php?id=8 **Personalised Care & Support Planning** Getting PCSP right is essential for people to gain more choice and control over their life and the support they are receiving. This 45min module will give a definition and overview of the criteria for a good PCSP and highlight - through a range of case studies - the key steps of the planning process. https://www.personalisedcareinstitute.org.uk/enrol/index.php?id=7 **Social Prescribing** This e-learning resource was developed for link workers and includes the core elements and skills required to do the job and deliver social prescribing as part of a PCN multi-disciplinary team. There are six sessions in total, which will take around three hours to complete: https://www.e-lfh.org.uk/programmes/social-prescribing/

	1. Introduction to the social prescribing link worker role 2. Developing personalised care and support plans with people 3. Developing partnerships 4. Introducing people to community groups and VCSE organisations 5. Safeguarding vulnerable people 6. Keeping records and measuring impact **Supported self-management** (SSM) A key part of the NHS Long Term Long-term Plan's commitment to make personalised care business as usual across the health and care system. It proactively identifies the knowledge, skills and confidence ('activation') people have to manage their own health and care, using tools such as the Patient Activation Measure® (PAM®). Health and care professionals tailor their approaches to working with people, based on the person's individual assets, needs and preferences, as well as taking account of any inequalities and accessibility barriers, and so working in a personalised way based on 'what matters' to the person. It also means ensuring approaches such as health coaching, peer support and self-management education are systematically put in place to help build knowledge, skills and confidence. https://www.england.nhs.uk/personalisedcare/supported-self-management/ **Personal health budgets** (PHBs) PHBs are one way to give disabled people and people with long-term conditions more choice and control over how the money is spent on meeting their health and wellbeing needs. The modules in this e-learning programme cover a variety of topics to support the delivery of personal health budgets at a local level. https://www.e-lfh.org.uk/programmes/personal-health-budgets/

Level 1 training

Level 1: Competencies to Engage People Assessed competencies: **Promoting Autonomy,** **Action Planning & Goal Setting** **Managing Setbacks & Problem Solving**	**Training & education resources available**
• Hello my name is • Open-ended questions • Use of open focused questions to closed questions (cone) • Reflection • Empathy • Affirmation • Normalisation • De-mystifying information • Active listening • Summarising • Clarification • Use of non-verbal / body language • Environmental awareness • Ask before advising	In addition to the training covered in the local induction plus the Core Competencies and Knowledge listed above, the following resources will help to develop communication skills further. **Hello my name is** A campaign for compassionate care https://www.hellomynameis.org.uk/ **What matters to you?** The Global 'What matters to you' community has a number of resources accessed via the following link https://wmty.world/ Lots of useful and inspiring resources on the IHI website especially the video 'a soul doctor and a jazz singer' http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx What Matters to me – a new vital sign – a Ted Talk by Jason Leitch: https://www.youtube.com/watch?v=H_Z1ZvjlKDE **Making Every Contact Count (MECC)** The MECC e-learning programme is designed to support learners in developing an understanding of public health and the factors that impact on a person's health and wellbeing. It focuses on how asking questions and listening effectively to people is a vital role for us all.A MECC interaction takes a matter of minutes and is not intended to add to existing busy workloads, rather it is structured to fit into and complement existing engagement approaches. https://www.e-lfh.org.uk/programmes/making-every-contact-count/ **Communicating with empathy** An eLearning resource to promote sensitive and effective communication in care https://www.e-lfh.org.uk/programmes/communicating-with-empathy/

Introduction to Health Coaching	**Two-day introductory Health coaching skills** Training covering topics outlined in the NHS England and NHS Improvement Implementation and Quality Summary Guide. i.e. Core skills and competencies in: • Active and empathic listening • Effective questioning • Building trust and rapport • Providing supportive challenge • Shared agenda setting • Collaborative goal setting • Shared follow up planning • Using simple health literate communication techniques such as teach-back • Structuring conversations using a coaching approach • Understanding the health coaching approach and mindset • Understanding when health coaching is an effective approach and its limitations, and how it should be tailored to lower levels of health literacy and patient activation • Applying health coaching models, conversation frames and techniques • Understanding how to integrate health coaching into current role in a way that's consistent with the values and expectations of your setting • Knowledge and recognition of the core concepts and principles of personalised care, shared decision making, patient activation, health behaviour change, self-efficacy, motivation and assets-based approaches • Developed skills to further develop their health coaching through on-going practice, reflection and planning as reflective practitioners The training should be delivered by a training organisation listed by the Personalised Care Institute. https://www.england.nhs.uk/wp-content/uploads/2020/03/health-coaching-implementation-and-quality-summary-guide.pdf https://www.england.nhs.uk/wp-content/uploads/2020/03/hc-summary-guide-technical-annexes.pdf **Other health coaching resources** Structuring a health coaching conversation https://tpchealth.com/wp-content/uploads/2020/06/Structuring-a-Health-Coaching-conversation-TPC-Health.pdf Link to a video demonstrating TGROW approach to health coaching

	https://tpchealth.com/resources/videos/ https://www.betterconversation.co.uk/ is a resource with a focus on health coaching.

Level 2 training

Level 2: **Competencies to enable & support people.** • **Assessed competencies: Supporting Competence & Self Efficacy** • **Self-monitoring**	**Training & education resources available**
• Skills to use personalised care and support planning to identify what is important to the person. • Skills to provide information in a way supports people to have more choice and control. • Skills to support the person to engage, explore, and reflect on a potential decision or way forward. • Skills to find out the individual's priorities and what outcomes are important to them. • Skills to assess individuals' levels of activation and health literacy, modify approach accordingly and support people to develop health literacy and activation.	**Health Coaching training** Attendance at a 4 day accredited health coaching programme plus formal individual and group coaching supervision which must come from a suitably qualified or experienced individual – see links below: https://www.england.nhs.uk/wp-content/uploads/2020/03/hc-summary-guide-technical-annexes.pdf https://www.england.nhs.uk/wp-content/uploads/2020/03/health-coaching-implementation-and-quality-summary-guide.pdf **Health Literacy** This e-learning module will help you understand the role health literacy plays in making sure everyone has enough knowledge, understanding, skills and confidence to use health information, to be active partners in their care, and to navigate health and social care systems. https://www.e-lfh.org.uk/programmes/health-literacy/ **Health Promotion** Evidence based e-learning to support all health and care professionals to prevent illness, protect health and promote wellbeing. https://www.e-lfh.org.uk/programmes/all-our-health/

• Skills to coproduce short term and long term goals and an action plan (personalised care and support plan). • Skills to follow up in a timely and appropriate way to support progress against goals/action plans.	**Behaviour change** Behaviour Change Literacy (BCL) is an understanding of the range of individual, environmental and policy influences that can impact on people's health behaviours and why they are important. It includes key values, principles and core communication skills essential for person-centred individual approaches. This training aims to build foundational behaviour change skills of the workforce. It will introduce learners to behaviour change, what it is, why it is important and how it can be implemented. It is designed as the first step in a learner's journey to developing their behaviour change knowledge and skills. https://www.e-lfh.org.uk/programmes/behaviour-change-literacy-for-individuals-and-workforce-leaders/ Supporting behaviour change linked to the Stages of Change and Motivational interviewing. https://www.rcn.org.uk/clinical-topics/supporting-behaviour-change/understanding-behaviour-change Motivational interviewing (MI) in brief consultations. Understand what MI is, how it can improve outcomes and where it is useful and less useful in practice. https://new-learning.bmj.com/course/10051582 Free sample modules from charged for Motivational Interviewing courses. https://www.onlinesolutions.ie/resources/MI_Manual/Motivational%20Interviewing%20Manual.pdf **Population Wellbeing Portal** The Population Wellbeing Portal is free to access by anyone who can positively impact public health and wellbeing. The Portal offers free access to education, training and professional development resources, to help deliver improvements in public health and prevention. Providing a central location for numerous e-learning resources, reading material, guidance, toolkits and videos, factsheets and many more resources relating to population health. https://www.e-lfh.org.uk/programmes/population-wellbeing-portal/

Level 3 Training

Level 3	Training & education resources available
The six components of personalised care • **Shared Decision Making** • **Personalised care and support planning** • **Social Prescribing & Community Development** • **Self-management support** • **Enabling choice, including legal rights to choice** • **Personal Health Budgets and Integrated Personal Budgets**	**Support to incorporate more complexity and apply these capabilities into wider contexts, through regular supervision, peer support, local and regional Action Learning Sets / Communities of Practice, supporting the individual to work at an expert level in the assessed competencies.** • Support via SW Social Prescribing matters forum led by rhian.loughlin@nhs.net South West Regional Learning Coordinator for Social Prescribing and South West Integrated Personalised Care Team Manager NHS E/I • Richard Kimberlee, NHS England Regional Facilitator & South West Social Prescribing Network Chair Richard.Kimberlee@uwe.ac.uk • NHSE / I SW Integrated Personalised Care Team england.swipc@nhs.net. This team run a series of Personalised Care and Social Prescribing Collaborative webinars on topics such as Personalised care planning, Patient Activation, Veterans & Armed Forces, Children & Young People. • Future NHS platform Social Prescribing workspace: https://future.nhs.uk/connect.ti/socialprescribing/grouphome • Centre for Empowering Patients and Communities (CEmPaC) - Providing Expertise in Person-Centred Care. Free online training programmes, resources and a series of expert webinars. https://cempac.org/?mc_cid=ae4563d859&mc_eid=9e2062d89a • National Academy for Social Prescribing https://socialprescribingacademy.org.uk/
Supervision, leadership, facilitation etc	Developing leadership skills https://www.e-lfh.org.uk/programmes/management-and-leadership-skills/ https://www.e-lfh.org.uk/programmes/leadership-foundations/ Facilitating workshops: This guide is designed to develop the skills to effectively facilitate workshops and group meetings. It contains practical tips, including: • Advice to help to prepare for the role of facilitator • Tools and techniques to assist in running a workshop or meeting https://www.england.nhs.uk/improvement-hub/publication/a-handy-guide-to-facilitation/

Other training

In addition to the core, level 1, 2 & 3 competencies, those already in Health Coach, Social Prescribing link worker and similar roles have reported that the following training resources may be useful, dependent on the types of individuals and situations within their current caseload.

Other training	
Adverse Childhood Experiences	Childhood experiences including adversity and toxic stress impacts on health, wellbeing, education and employment across the life course. See: https://www.youtube.com/watch?v=XHgLYI9KZ-A
Alcohol & Tobacco	The programme is intended to provide healthcare professionals with the minimum level of knowledge and skill needed to confidently and effectively identify risk and provide brief advice to patients who smoke or who are drinking at a level that could be harming them. https://www.e-lfh.org.uk/programmes/alcohol-and-tobacco-brief-interventions/
Carers	An e-learning resource for those who are providing unpaid care. https://www.e-lfh.org.uk/programmes/supporting-unpaid-carers/ The Supporting Carers in General Practice e-learning programme has been developed for primary care professionals, to help them to support people who care for others. The programme contains six e-learning sessions: Supporting those who provide care for other people, Identifying carers, Organising your practice to support carers, Supporting young carers, Support for older people and their carers, Supporting the carers of people with challenging problems. https://www.e-lfh.org.uk/programmes/supporting-carers-in-general-practice/
Community resources (support groups, social groups, etc)	**Community centred approaches to improving health and wellbeing** Module 1 will cover the background evidence and theory on why this is important and what approaches work. Module 2 involves practical exercises to apply the knowledge into your own work and enable you to make strategic and practical plans for taking community-centred approaches forward.

	https://www.e-lfh.org.uk/programmes/community-centred-approaches-to-health-improvement/ SPARK – Community connector training https://www.sparksomerset.org.uk/projects/wellbeing-south-somerset
Conflict resolution & Non-violent communication	Free resources to learn the skills of non-violent communication and conflict resolution. https://www.nonviolentcommunication.com/resources/ https://www.nonviolentcommunication.com/learn-nonviolent-communication/nvc-conflict-resolution/
COVID - 19	This interactive e-learning resource was created to support health and care staff working with people recovering from COVID-19. https://www.e-lfh.org.uk/programmes/covid-19-recovery-and-rehabilitation/
Dementia	This e-learning programme in Dementia Care focuses on the essential knowledge and skills needed to support and enable people living with dementia and their family carers to live as well as possible, wherever they live. https://www.e-lfh.org.uk/programmes/dementia/ This programme is aimed at all staff working in health and social care settings, providing a unique insight into the lived experience of dementia, increasing knowledge and understanding of the condition. Understanding the lived experience of dementia enables health and social care staff to develop a deeper appreciation of the challenges of living with dementia, focusing attention on the things that make us feel human. https://www.e-lfh.org.uk/programmes/the-lived-experience-of-dementia/ Dementia Friends training online https://www.dementiafriends.org.uk/register-digital-friend Dementia training through local Dementia Alliance

	https://www.dementiasomerset.org.uk/
Debt management	https://www.moneyadviceservice.org.uk/en/categories/debt-and-borrowing https://www.citizensadvice.org.uk/debt-and-money/
Diabetes	This is an introductory course for healthcare professionals who are not specialists in diabetes but want to know more about the condition. https://www.diabetesinhealthcare.co.uk/lnt/Login.aspx?ts=636314069927614222 The National NHS 'Healthier You' Diabetes Prevention Programme, contact Diabetes Prevention Lead Officer georgina.clayton@nhs.net Local training Gillian.Cook@SomersetFT.nhs.uk
Domestic violence & abuse	This training takes a trauma informed approach which takes account of the whole family who are experiencing domestic violence and abuse, looking at root causes of behaviour whilst also challenging and holding those perpetrating the abuse to account. https://www.e-lfh.org.uk/programmes/domestic-violence-and-abuse-e-learning-for-health-visitors-and-nurses/ Trauma informed training around domestic abuse, alcohol etc https://avaproject.org.uk/training/#Upcoming
End of life	The e-learning programme End of Life Care for All (e-ELCA) aims to enhance the training and education of the health and social care workforce so that well-informed high quality care can be delivered by confident and competent staff and volunteers to support people wherever they happen to be. https://www.e-lfh.org.uk/programmes/end-of-life-care/ Key Somerset contact re palliative care; Tracey Canavan (ECHO Coordinator) ECHO@st-margarets-hospice.org.uk

Housing & Homelessness	This e-learning module has been developed to help people whose health is affected by living in a cold home. It empowers professionals to direct people in cold homes to services that can help them overcome the problem. https://www.e-lfh.org.uk/programmes/cold-homes/ This programme offers two e-learning sessions to support the health and care workforce to understand the health impacts of homelessness, identify different forms of homelessness, gain practical steps to making a referral and highlights ways your organisation can implement the duty to refer effectively. https://www.e-lfh.org.uk/programmes/tackling-homelessness/ Shilpa's story: A short interview highlighting the impact of homelessness https://www.youtube.com/watch?app=desktop&v=DY3zYd9hT2M&feature=youtu.be Powerful video: https://www.youtube.com/watch?edufilter=NULL&v=xHNOL1IP47I A Soul Like Yours - A Poem by Matt Kelly - Read by Johnny Vegas - In Support of www.TheBrick.org.uk Understanding homelessness | Homeless Link
Learning disability	The Health Equalities Framework (HEF) e-learning resource is designed to provide practitioners with a practical introduction to the Health Equalities Framework tool, along with an understanding of the health inequalities experienced by people with learning disabilities, and the reasons or determinants of those health inequalities. https://www.e-lfh.org.uk/programmes/health-equalities-framework/
Mental Health	This short programme aims to raise the **awareness of mental health** amongst health care staff. It is designed to give a broad overview of what encompasses mental illness, the link between mental and physical health diagnoses and outline some possible treatment options. These sessions provide all staff working within health care with some general strategies to help support individuals who are worried about their mental health, and advice about where to find extra support. https://www.e-lfh.org.uk/programmes/mental-health-awareness-programme/

	Introduction to Mindfulness is a short e-learning programme to provide people with an overview of what mindfulness is. It provides a definition of mindfulness, the evidence for it and where to get more information for further resources and support. https://www.e-lfh.org.uk/programmes/introduction-to-mindfulness/ **MindEd** provides accessible, engaging online training in emotional and behavioural 'first aid' and essential therapeutic skills for all those involved in the mental wellbeing and care of children and young people in the UK. https://www.e-lfh.org.uk/programmes/minded/ **Suicide Prevention** is an e-learning programme designed to help everyone to feel more confident to talk about suicide. https://www.e-lfh.org.uk/programmes/suicide-prevention/ **Mental Health Resource**. A series of reference materials and resources for all about mental health including: Older People's Mental Health Competency Framework and Mental Health Directories. https://www.e-lfh.org.uk/programmes/mental-health-training-resources/ **Mental health first aid**. See this link for half day / two day training. https://mhfaengland.org/
NHS health check	The NHS Health Check programme is a Public Health programme in England targeting adults aged between 40 and 74 to help assess their risk of developing heart disease, stroke, type 2 diabetes or kidney disease. https://www.e-lfh.org.uk/programmes/nhs-health-check/
Obesity	This elearning programme introduces obesity and its implications for health, provides a knowledge base on identification of unhealthy weight and risk factors for weight gain, managing obesity, and learning on guiding and enabling behaviour change.

	https://www.e-lfh.org.uk/programmes/obesity/ Practical advice and tools to support health and care professionals make brief interventions in weight management for adults. This document offers tips on the short conversations health and care professionals should be having with overweight and obese patients about weight loss. It provides: • practical advice on how to discuss weight loss • tools to support making brief interventions https://www.gov.uk/government/publications/adult-weight-management-a-guide-to-brief-interventions The University of Oxford has created Supportive and effective conversations about weight management referrals – video guidelines offering people with obesity a free-of-charge referral to weight management services.
Pain	**Pain management**. The 12 modules of this e-learning cover knowledge ranging from how to manage acute pain well, through to in-depth learning about common pain conditions and moves on to cover how to manage pain in specialist areas, such as pain in cancer or pain in childhood. https://www.e-lfh.org.uk/updated-pain-management-e-learning-programme/ **ESCAPE-pain** – using education and exercise to support people with chronic joint pain https://www.e-lfh.org.uk/escape-pain-programme/
Physical Activity	**Physical Activity & Health**. This e-learning course prepares healthcare professionals to champion the benefits of physical activity with their patients and, in doing so, help prevent and/or manage a range of common physical and mental health conditions. The course will familiarise the learner with the UK Chief Medical Officers' physical activity guidelines, the underpinning evidence base and how to incorporate it. https://www.e-lfh.org.uk/programmes/physical-activity-and-health/ Somerset Sports & Activity Partnership

	https://www.sasp.co.uk/ Health Walks https://www.sasp.co.uk/health-walks Flexercise https://www.ageuk.org.uk/somerset/activities-and-events/flexercise-classes/flexercise-classes/
Work & Health	This e-learning course is about the crucial relationship between work and health. https://www.e-lfh.org.uk/programmes/work-and-health/

Appendix 1 DES Additional Reimbursable roles scheme

1. Social Prescribing Link Workers

Social Prescribing Link Workers have been part of ARRS since April 2019 and work people within primary care networks to develop tailored plans and connect them to local groups and support services. Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then. A PCN is able to achieve up to 25 points in the High Quality of Care Scheme based on the percentage of the PCN list size referred to social prescribing, with a lower threshold of 0.4% and a higher threshold of 0.8%.

Social prescribing empowers people to take control over their health and wellbeing through referral to social prescribing link workers (SPLWs) 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, support and statutory services for practical, emotional and social support. SPLWs support existing groups and support offers to be accessible and sustainable and help people to start new community initiatives and groups, working collaboratively with local partners.

Social prescribing can help to strengthen community and personal resilience and reduces health inequalities by addressing the wider determinants of health such as debt, housing and physical inactivity, by increasing people's active involvement with their communities. It particularly works for people with long term conditions (including support for mental health), for people who are lonely and isolated, or have complex social needs that affect their wellbeing.

The Network Contract DES Specification 2020/21 sets out the requirements where a PCN employs or engages a Social Prescribing Link Worker under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Social Prescribing Link Worker:

a. has completed the NHS England and NHS Improvement online learning programme . https://www.e-lfh.org.uk/programmes/social-prescribing/

b. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute; https://www.personalisedcareinstitute.org.uk/

c. attends the peer support networks run by NHS England and NHS Improvement at ICS and/or STP level;

Organisations employing SPLWs should ensure SPLWs are supported and trained to develop and practice the competencies set out in the framework.

It is recognised that as social prescribing matures there will be the opportunity for further development and specialism for SPLWs. However, all link workers should have an awareness and basic understanding of specialist areas These may include:

- Working with children and young people
- Carers
- Working with inclusion groups (such as gypsy travellers, homeless people, refugees and asylum seekers)
- Mental health
- Complex long-term conditions
- Green prescribing

- Arts
- Weight management

Qualifications & training required (from national sample person specification)

- NVQ Level 3, Advanced level or equivalent qualifications or working towards (essential)
- Demonstrable commitment to professional and personal development (essential)
- Training in motivational coaching and interviewing or equivalent experience (desirable)

2. Health and Wellbeing Coaches

Where a PCN employs or engages a Health and Wellbeing Coach under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Health and Wellbeing Coach:

a. is enrolled in, undertaking or qualified from appropriate health coaching training covering topics outlined in the NHS England and NHS Improvement Implementation and Quality Summary Guide, https://www.england.nhs.uk/wp-content/uploads/2020/03/health-coaching-implementation-and-quality-summary-guide.pdf with the training delivered by a training organisation listed by the Personalised Care Institute https://www.personalisedcareinstitute.org.uk/
b. adheres to a code of ethics and conduct in line with the NHS England and NHS Improvement Health coaching Implementation and Quality Summary Guide;
c. has formal individual and group coaching supervision which must come from a suitably qualified or experienced individual;
d. working closely in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider to identify and work alongside people who may need additional support, but are not yet ready to benefit fully from social prescribing

Qualifications & training required (from national sample person specification)

- Coaching/counselling qualification/ experience or other relevant qualification/experience involving reflective listening skills relevant training and experience in non-clinical SSM Health Coaching through a PCI-accredited organisation (desirable)
- Be willing to attend training with a non-clinical SSM health coaching skills programme (minimum 4 days) by a Personalised Care Institute (PCI) accredited trainer or organisation (essential)

3. Care Coordinators

The Network Contract DES Specification 2020/21 sets out the requirements where a PCN employs or engages a Care Coordinator under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Care Coordinator:

a. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute https://www.personalisedcareinstitute.org.uk/
b. works closely and in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider and Health and Wellbeing Coach(es), in order to deliver the key responsibilities outlined below.

Where a PCN employs or engages one or more Care Coordinators under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Care Coordinator has the following key responsibilities, in delivering health services:

a. utilise population health intelligence to proactively identify and work with a cohort of patients to deliver personalised care;
b. support patients to utilise decision aids in preparation for a shared decision-making conversation;
c. holistically bring together all of a person's identified care and support needs, and explore options to meet these within a single personalised care and support plan (PCSP), in line with PCSP best practice, based on what matters to the person;
d. help people to manage their needs through answering queries, making and managing appointments, and ensuring that people have good quality written or verbal information to help them make choices about their care;
e. support people to take up training and employment, and to access appropriate benefits where eligible;
f. support people to understand their level of knowledge, skills and confidence (their "**Activation**" level) when engaging with their health and wellbeing, including through the use of the Patient Activation Measure;
g. assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing and increase their activation level;
h. explore and assist people to access personal health budgets where appropriate;
i. provide coordination and navigation for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals; and
j. support the coordination and delivery of MDTs within the PCN.

The following sets out the key wider responsibilities of Care Coordinators:

a. work with the GPs and other primary care professionals within the PCN to identify and manage a caseload of patients, and where required and as appropriate, refer people back to other health professionals within the PCN;
b. raise awareness within the PCN of shared-decision making and decision support tools; and
c. raise awareness of how to identify patients who may benefit from shared decision making and support PCN staff and patients to be more prepared to have shared decision-making conversations.

A PCN must be satisfied that organisations and groups to whom its Care Coordinator directs patients:
a. have basic safeguarding processes in place for vulnerable individuals; and
b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the PCN's Care Coordinator(s). This could be provided by one or more named individuals within the PCN.
A PCN will ensure the PCN's Care Coordinator(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Care Coordinator(s).

Appendix 2 Draft SPLW competencies framework

A team at NHSE / I established carried out a desk top review of existing documents referring to competencies for link workers, health coaches and personalised care/person centred care. The main publications identified were:

1. **Person-Centred Approaches: a core skills education and training framework**, Health Education England, Skills for Health and Skills for Care, 2017, addendum 2020. https://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download
2. **Curriculum for Personalised Care Institute** Personalised Care Institute, August 2020. https://www.personalisedcareinstitute.org.uk/pluginfile.php/133/mod_page/content/28/PCI-Curriculum.pdf
3. **Social Prescribing Link Workers: Reference Guide for Primary Care Networks** – Technical Annexe, Annex D – A framework for social prescribing link workers NHS England and NHS Improvement, 2019. Updated 2020. https://www.england.nhs.uk/wp-content/uploads/2020/06/pcn-reference-guide-for-social-prescribing-technical-annex-june-20.pdf
4. **Health Coaching: Implementation and Quality Summary Guide**: Technical Annexes, Annex C – Minimum Standards for training health, social care and voluntary sector staff to use health coaching skills. NHS England and NHS Improvement, 2020. https://www.england.nhs.uk/wp-content/uploads/2020/03/health-coaching-implementation-and-quality-summary-guide.pdf
5. **Care Navigation: A Competency Framework** Health Education England, 2016. https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf
6. **Community and Healthcare Link Worker Competency Framework**, Northumbria University, Commissioned and funded by Health Education England and Public Health England North, 2017. https://www.healthcareers.nhs.uk/career-planning/developing-your-health-career/career-and-competency-frameworks
7. **Maternity Support Worker: Competency, Education and Career Development Framework**, Health Education England, University of West of England, 2018. https://www.hee.nhs.uk/sites/default/files/document/MSW_Framework_MayUpdate.pdf
8. **Level 3 Certificate in Social Prescribing**, Skills & Education Group (SEG) Awards Certa, v1.3, 2019. http://skillsandeducationgroupawards.co.uk/wp-content/uploads/Qualifications/2085-TOP-3__Qualification%20Guide.pdf
9. **Code of Practice for Employers of Social Prescribing Link Workers and Social Prescribing Link Workers**, National Association of Link Workers, 2019. https://www.nalw.org.uk/
10. **Non-Clinical Link Worker Professional Learning Syllabus**, National Association of Link Workers. https://www.nalw.org.uk/
11. **Welcome and induction pack for link workers in PCNs.** https://www.england.nhs.uk/wp-content/uploads/2019/09/social-prescribing-link-worker-welcome-pack-web-2.pdf
12. **Social prescribing and community support summary guide**, NHS England and NHS Improvement, 2020. https://www.england.nhs.uk/wp-content/uploads/2020/06/social-prescribing-summary-guide-updated-june-20.pdf

13. **Social prescribing handout for Primary care staff**. https://www.england.nhs.uk/wp-content/uploads/2019/09/social-prescribing-link-worker-A5.pdf

14. **Social Prescribing e-learning.** Health Education England. https://www.e-lfh.org.uk/programmes/social-prescribing/

These were tabulated and the main competencies identified and used to develop a draft national Social Prescribing Link Worker Competency Framework, which was then circulated and further refined through an iterative process involving a wide range of stakeholders nationally.(Deborah Lane was one of these stakeholders).

Competencies to engage people

These competencies are largely skill based and are acquired through interactive training, coaching and assessment.

At the heart of the social prescribing landscape is the relationship between the SPLW / H&WC / CC and the people they are supporting. This relationship is built through meaningful communication centred on what matters to the person they are supporting, taking into account their values, social and environmental circumstances, ability to engage and understand and their motivation.

This is strongly influenced by how we say things, how we listen, non-verbal communication and personalised care value base. It is much more than gathering and sharing information about support options. It is about communication that engages, motivates and instils trust.

The specific skills are

open-ended questions	Open ended questions are questions that cannot be answered with a yes or no. They invite broader responses during information gathering and allow the person to share their broader thinking and perspective. They also create a more equal conversation. E.g. 'What is important to you?', 'How was that…' 'What are you doing that you find helpful?...' 'When do you notice that?...' 'Who supports you in your day to day life?...
Use of open focused questions to closed questions (cone)	Knowing how and when to move from open exploratory questions to ones that are more focused around a particular topic or subject. Understanding the place and value of closed questions.
Reflection	Using words to let the other person know you have heard what they have said. Non-verbal body language and facilitative cues are not enough on their own. Using the person's language helps them feel heard, builds rapport and ensures that the person is an active partner in the dialogue. It is also very powerful to have your own thoughts and words reflected back.
Empathy	A deep reflection and using words to let the person know you understand or are trying to understand how it is for them emotionally. It is a complex skill however there are some key guiding principles including taking the other person's perspective, avoiding judgement, recognising emotion and communicating what you notice.
Affirmation	A positive statement and acknowledgement of the effort or achievement somebody has made, offering emotional support or encouragement. E.g. 'you told me you tried to change before, that shows great determination'

Normalisation	An acknowledgement that the feeling, process or symptom is normal and other people report similar experiences. It helps the person feel validated, that they are not alone and that the worker has experience of working with people like them.
De-mystifying information	An awareness that the person may have different assumptions. Being able to ask what the person thinks are the Benefits, Risks, Alternatives, or outcome or Doing nothing (BRAN) and talking with them about what each possibility means, translating from the jargon to the persons life and expectations
Active listening	Being present psychologically, socially and emotionally, making a conscious effort to hear and understand what people are saying. Picking up on and responding to verbal and non-verbal cues. Active listening requires the listener to feedback what they hear to the speaker re-stating what they have heard. These are valuable skills which can be developed with practice.
Summarising	The deliberate step of providing an explicit verbal summary to the person. There are two kinds of summary; 1. Internal summary which focusses on a specific part of the conversation 2. End summary which concisely pulls together the entire conversation Both are useful to pull information together, review where we have got to, order information, identify gaps and allow space to consider next steps.
Clarification	Confirming and checking, making it more understandable and accurate [for example clarification of words, statement or situation].
Use of non-verbal / body language	This is the information we convey non-verbally including: • Posture • Proximity • Touch • Body movements • Facial expression • Eye behaviour • Vocal cues • Use of time • Physical presence • Use of pausing and silence • Gentle cues such as nods.
Environmental awareness	How the room, chairs, tables, desk etc. are arranged. Who is taking part, where the conversation is taking place, how public or private it is for example? Understanding the impact of the environment, including remote/digital environments, on an individual and adapting for this
Ask before advising	Before giving information checking what the person knows, what they would like to know, that they would like to receive the information and how they would like to receive it.

Competencies to enable and support people

These are largely skill based and are acquired through interactive training, coaching, and assessment. Some components require knowledge of a model and is covered in the appropriate section.

Social prescribing is more than sharing information on support options and signposting. It is a dynamic process that involves identifying what matters to the person, their priorities and collaboratively developing a shared action plan for the way forward.

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 can I 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

As an example, for people with low self-confidence and self-esteem, further action may involve active support over a number of sessions to support the person through the first steps this may be as diverse as supporting a person to access debt management advice through to seeking help for feelings of despair.

This requires an understanding of the process involved and how people change

- To be able to use personalised care and support planning to identify what is important to the person both generally and in the context of a conversation
- Understanding what is important to the person and providing information in a way that promotes self-determination and supports people to have more choice and control over their lives and support
- Through engagement skills support the person to engage, explore, and reflect on a potential decision or way forward, sharing and checking understanding of the full range of options, including taking no action.
- Find out the individual's priorities and what outcomes are important to them
- Assess individuals' levels of activation and health literacy through communications skills or specific tools such as the patient activation measure, or relevant tool, modify conversation accordingly and support people in a way that develops these two factors
- Be able to coproduce short term and long term goals based on what matters to the person and an action plan / personalised care and support plan with steps that are achievable and appropriate to the persons levels of confidence, capability and opportunity
- Be able to follow up in a timely and appropriate way to support progress against goals/action plans.

Knowledge of models and theoretical frameworks and tools

These are largely knowledge based and can be acquired through online learning, reading relevant publications. The implementation in practice is supported by the skill-based competencies.

Models and theoretical models help give structure to practice. Many people who come into social prescribing already have good communication skills and are empathetic. Models and frameworks provide context, boundaries and structured approaches that help keep the client and link worker safe and working in a professional space.

They can act as a tool to explore issues in supervision and identify what may be occurring- slipping into giving unsolicited advice, creating unconscious dependency and over identifying with a person's situation.

They also help in understanding how social prescribing interacts with other parts of the local health and care ecosystem

This is divided into four sections

i. Theoretical models, tools and approaches
ii. Awareness and understating of legislation and policy
iii. Awareness and understanding of key conditions
iv. Awareness and understanding of social prescribing activities

i Theoretical models, tools

- Social model of disability
- Social determinants of health and impact on health and wellbeing
- Understating the dynamic between the person, environment and occupation
- COM-B model of behaviour change
- Transtheoretical model of change
- Patient activation, health literacy and self-efficacy
- Use the ONS4 well-being tool and other tools as appropriate to capture individual levels of knowledge, confidence and skills at regular intervals to assess impact.
- Use of technology, tele health and remote consultation
- Personal health budgets
- Personalised Care and Support Planning
- Asset based community mapping
- Solution focussed therapy/positive psychology
- Creating and maintaining professional boundaries and understanding role boundaries

ii Awareness and understanding of legislation and policy

- Policy context of Universal Personalised Care (Values in Personalised Care (as defined by UPC) and social prescribing
- Understands what social prescribing is and how it can improve people's health and wellbeing and core features of the role
- Safeguarding for children and adults
- Confidentiality and Information Governance and handling data
- Lone Working
- Equality and Diversity Awareness
- Health and Safety Awareness
- Information governance
- Duty of care and negligence
- Domestic Abuse Awareness
- Mental Capacity Act Awareness
- Emotional Resilience awareness
- Understand the structure of the local health and care system,
- Social Welfare Awareness
- Cultural awareness
- Awareness of healthcare, social care, community care and VCSE sector
- Carer awareness
- Prevention (primary, secondary and tertiary)
- Multi-Disciplinary Team (MDT) working awareness
- Making every contact count
- Patient and Public Involvement (PPI)
- Strategic co-production

iii. Awareness and understanding of key conditions

- Overview of supporting people (across the age range) who are lonely and isolated
- Overview of supporting people or have,
    - long term conditions

- mental health needs
- complex social needs which affect their health and wellbeing
- addictions and their impact on emotion health, wellbeing and confidence

iv. Awareness and understanding of social prescribing activities

- Overview of evidence of use of the arts, sports and exercise and nature based activities to promote health and wellbeing
- Overview of where to connect people to for practical support available to support people with complex social needs that affect their health (such as housing, debt management, relationship difficulties)

Community development

These competencies apply solely to the SPLW role. The competencies around asset based community development are developed through knowledge and factual based learning, application of key skills of engaging and enabling and an in depth understanding of a locality developed over time and working with people experienced in this area.

Effective social prescribing relies on a range of activities and support to refer people to. As set out in the NHSE/I reference guide social prescribing link workers should work with local authorities, community and voluntary sector organisations, commissioners and other partners to identify, nurture and support the development of community resources.

A key part of the SPLW role is; interaction with local community groups, Voluntary, Community and Social Enterprise organisations and other local partners to make the most of local community assets and build a diverse menu of community activities to connect people to, including providing basic safeguarding guidance and ensuring that voluntary sector partners are confident to refer people back to the NHS in emergency situations or where there are concerns about people.

Where required, SPLWs should accompany people to community groups to introduce them, ensuring they are comfortable and included.

SPLWs should be supported to acquire knowledge and skills in the following areas through reading, shadowing, doing and online learning.

- Connecting people to community groups
- Identifying and mapping community assets
- Awareness of national and local grants
- Peer support- structure of effective peer support groups
- Use of micro commissioning and small grants to support people to access local groups or activities and promote health and wellbeing
- Use of personal heath budgets to support people to meet the outcomes in their PCSP and access local groups or activities

Professional behaviours and practice

Professional behaviours and practice are what are seen when a SPLW is working competently within their role. They are less easy to define and assess but have been included to begin to set out the expectations of how the competencies are applied specifically to the role. These have been drawn from the core

curriculum in personalised care, the NHSE/I Social Prescribing Reference Guide and the National Association of Link Worker's Code of Practice for social prescribing link worker.
A SPLW will,

1. Give time to people, actively listen, build and maintain trust and focus on what matters most to the person, building support around their priorities.
2. Promote the holistic wellbeing, independence, rights and interests, of individuals and carers
3. Create a shared plan with the person that identifies outcomes that matter to the person connect them to community support, groups and services including how they will be introduced, to ensure maximum take-up of support.
4. Work with local community groups, Voluntary, Community and Social Enterprise organisations and other local partners to identify and make the most of local community assets and build a diverse menu of community activities and support to connect people to, including providing basic safeguarding guidance and ensuring that voluntary sector partners are confident to refer people back to the NHS in emergency situations or where there are concerns about people.
5. Work with all local partners, including local authorities, police, fire service, job centres, primary care and secondary care and others to recognise people who would most benefit from social prescribing and enable easy referral and self-referral of these priority people and communities, to reduce health inequalities.
6. Work collaboratively with local commissioners and voluntary sector partners to identify gaps in community support and find creative ways to work together to nurture local community assets.
7. Understand the structure of the local system (including health, care, VCSE and community groups, welfare, housing, the role of these partners and how to work with them, including the various roles, responsibilities and organisations within it, applying this understanding to improve the quality and safety of the care you provide.
8. Facilitate appropriate support that is realistic and avoids dependence by utilising appropriate support groups and agencies targeted to the needs of the person and/or his or her family and carers.

Appendix 3 Core Competencies for Social Prescribing - Somerset workshop 4/11/2019

Patient Centred Care

Respecting people as individuals with strengths and resources	• Understanding what matters to people • Helping people understand, make use of and build on their strengths, assets and the resources around them • Recognising the experience and potential of each person • Adopting a non-judgmental approach • Providing support based on what's meaningful to the person • Empowering individuals to take control
Working in partnership with people	• Adopting a strength-based, solution orientated approach (not a deficit/what's lacking approach) • Active listening skills • Trust and rapport building, giving time and patience • Boundary setting and pushing skills • Care planning and goal setting skills • Active support to get started • Suggesting and introducing or reconnecting people to community groups and statutory services
Encouragement and advice	• Motivational interviewing skills and knowledge • Brief intervention skills, e.g. lifestyle advice • Group work skills • Evaluate if care and support plans are meeting the individual's health and wellbeing needs
Right time approach	• Knowing when to escalate to GPs, Social Care teams and other professionals • Developing a sense of when, how and for how long to offer support – and knowing when to stop to avoid dependency
Practical approach to problem solving	• Ability to explain things simply • Understand the options available or where to seek advice • Find creative solutions to everyday problems

General Skills

Communication	• Good verbal and written communication skills • Understanding the importance of information recording • Skilled in the use of appropriate tools eg PAM but able to adapt to each individual patient • Empathy • Creativity and problem solving
Ethical	• Knowing the boundaries so that processes are followed • Respecting individual choice and professional boundaries
Local Knowledge	• Understanding of local systems – what's available and access criteria, ensuring knowledge is kept up to date
Relationship building	• Establish working relationships with key people across the community • Ability to develop a credible reputation • Being appropriately assertive • Patience and understanding of system and individual pressures, whether clinicians, staff or patients and their families

Appendix 4 NHS Agenda for Change Pay scales 2020-2021:

At the time of writing, NHS Agenda for Change pay scales for 2021- 2022 are not known.

Band 3

Years Experience	Hourly	Annual
0-1	£10.12	£19,737
1-2	£10.12	£19,737
2-3	£10.84	£21,142
3-4	£10.84	£21,142
4-5	£10.84	£21,142
5-6	£10.84	£21,142
6+	£10.84	£21,142

Band 4

Years Experience	Hourly	Annual
0-1	£11.22	£21,892
1-2	£11.22	£21,892
2-3	£11.22	£21,892
3-4	£12.38	£24,157
4-5	£12.38	£24,157
5-6	£12.38	£24,157
6+	£12.38	£24,157

Band 5

Years Experience	Hourly	Annual
0-1	£12.77	£24,907
1-2	£12.77	£24,907
2-3	£13.83	£26,970
3-4	£13.83	£26,970
4-5	£14.05	£27,416
5-6	£14.05	£27,416
6-7	£15.70	£30,615
7+	£15.70	£30,615

Appendix 5 Apprenticeship Route

A level 3 Community Health and Wellbeing Worker apprenticeship standard is under development and is likely to provide an apprenticeship route into roles such as Social Prescribing Link Worker and Health and Wellbeing coach. The draft standard was amended in January 2021 following a period of consultation. The full standard will be published on the Institute for Apprenticeship and Technical Education's website when it has been approved for delivery.

Occupation summary: The role of a Community Health and Wellbeing Worker is to respond to the needs of individuals and their communities, however the needs present, to improve their health and reduce inequalities. To do this the workers will need to:

- focus on the causes of poor health and wellbeing in the broadest sense (causes of the causes), and by taking a holistic 'whole person' approach regarding physical, mental, emotional and social health and wellbeing and resilience
- understand the services or support that can help to address the needs and what is available in their local area

This occupation is found in different organisations, commissioned by a range of agencies including local government, the NHS, and other funders such as voluntary, community and social enterprise (VCSE) organisations. They work closely with health services, local government and voluntary sector organisations in their everyday work.

Appendix 6 Competency assessment

Core Competencies - Assessed competency: Person Centred Approach

Key features: Communication should be person centred, with a focus on 'what matters to you', encouraging individuals; maximising their autonomy and sense of intrinsic motivation.

Interaction: Facilitators should build rapport, be empathetic, seek to listen and understand the individual's context, situation, strengths and what matters to them. They should avoid jumping to offering solutions, advice or being didactic.

Rating	Score	Example
0	Absence	Absence of Person-centred approach. A completely 'didactic' and / or highly inappropriate style of interaction, which could result in resistance. No attempt at building rapport or listening to individual.
1	Novice	Minimal use of person-centred approach with an overly didactic and/ or inappropriate style of interaction. Limited attempts at building rapport or listening. Tendency to take same approach with every individual.
2	Advanced Beginner	Some evidence of competence using person-centred approach (but these are infrequent), and may not be carried out to sufficient detail (missing key issues, lack of reflexive listening). There are numerous problems or inconsistencies e.g. a facilitator who sometimes dominates the discussion or a focus on identifying solutions too early in the conversation.
3	Competent	Competent and appropriate use of person-centred approach however some difficulties are evident (e.g. failing to identify an individual's strengths). Awareness of and ability to cope with different contexts and situations but some minor problems or inconsistencies.
4	Proficient	Numerous and appropriate usage of person-centred approach. Facilitator encouraging the individual to be actively involved and driving the discussion. The facilitator is able to discriminate between a variety of contexts and situations with minimal problems or inconsistencies.
5	Expert	Highly appropriate and sufficient use of person-centred approach. Facilitator encouraging the individual to be actively involved. Able to make more subtle, refined discriminations between situations and contexts and able to adjust accordingly. No problems or inconsistencies.

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Level 1 Competencies - Assessed competencies: Promoting Autonomy

Key Features: Facilitators should encourage individuals to be pro-actively, rather than passively, involved in discussions. The aim is to maximise autonomy by developing intrinsic rather than extrinsic motivation, through a shared understanding of what matters to the individual and by encouraging them to be the driver of their own success, while developing a sense of control. Facilitators should seek to understand the individual's perspectives, strengths, ideas and choices and share their own expertise and ideas in a collaborative fashion.

Interaction: Facilitators should build rapport, use open-ended questions and reflective listening to identify the individual's strengths, knowledge, confidence, experience and skills, and use these to promote autonomy and choice.

Rating	Score	Example
0	Absence	Absence of attempts to promote autonomy and choice and /or highly inappropriate delivery.
1	Novice	Minimal attempts to promote autonomy and choice and / or inappropriate delivery.
2	Advanced Beginner	Some evidence of competence and adapting appropriately to the context when attempting to promote autonomy or choice (but this is infrequent), and these may not be carried out to sufficient depth or detail. There are numerous problems or inconsistencies such as lack of rapport and missed opportunities. This often leads to the individual becoming dependent on the facilitator.
3	Competent	Competent delivery and appropriate attempts to promote autonomy or choice. The facilitator is engaged, aware and able to cope with different contexts and situations but there are some minor problems or inconsistencies. Occasionally the facilitator may find that the individual is becoming dependent.
4	Proficient	Numerous appropriate attempts to promote autonomy or choice. The facilitator is able to discriminate between a variety of contexts and situations with minimal problems or inconsistencies.
5	Expert	Highly appropriate and sufficient attempts to promote autonomy or choice. The facilitator is able to make more subtle, refined discriminations between situations and contexts and able to adjust accordingly. No problems or inconsistencies.

Level 1 Competencies - Assessed competencies: Action Planning & Goal Setting

Key features: Facilitators should work with individuals to agree on a verbal plan of action. This should include identifying and / or negotiating goals, goal setting and identifying support to achieve those goals and any barriers that may arise.

Interaction: Facilitators should build rapport, be empathetic, seek to listen and understand the individual's context, situation, strengths and what matters to them; work with them to understand what might be a realistic and achievable goal given the support available and any potential barriers and acknowledge participant effort or success thus far.

Rating	Score	Example
0	Absence	Absence of attempts to encourage action planning and goal setting and or highly inappropriate interaction.
1	Novice	Minimal attempts to encourage action-planning and goal setting and / or inappropriate interaction.
2	Advanced Beginner	Some evidence of competence and adapting appropriately to the context involved when discussing action planning and goal setting (but these are infrequent) and may not be carried out to sufficient detail. There are numerous problems and inconsistencies such as lack of rapport, missed opportunities or a tendency to take the same approach with every individual.
3	Competent	Competent delivery and appropriate attempts to encourage action-planning and goal setting. The facilitator is engaged, aware and able to

		cope with different contexts and situations but there are some minor problems or inconsistencies.
4	Proficient	Numerous appropriate attempts to encourage action planning and goal setting. The facilitator is able to discriminate between a variety of contexts and situations with minimal problems or inconsistencies.
5	Expert	Highly appropriate and sufficient attempts to encourage action-planning and goal setting. The facilitator is able to make more subtle, refined discriminations between situations and contexts and able to adjust accordingly. No problems or inconsistencies.

Level 1 Competencies Assessed competencies: Managing Setbacks & Problem Solving

Key features: The facilitator should work with the participant to review progress with all planned changes and with achieving the targets set out in the action plan. The facilitator and individual should celebrate and reinforce and reflect on any successes achieved. The facilitator should encourage discussion of any setbacks and work with the individuals to revise plans accordingly. When setbacks occur, facilitators should support individuals to reframe and normalise setbacks so rather than being viewed as failures they are opportunities for learning and development. When approaching problem solving facilitators should focus on working with individuals to break the problem down into achievable parts, and where appropriate consider the sustainability of any change, the ways in which others can be supportive as well as introducing the idea of using coping plans to avoid setbacks.

Interactions: The facilitator should reinforce any self-monitoring activity and any successes using Affirmation. Reframing should be used to normalise setbacks and see them as an opportunity to learn from experience (trial and error) rather than as failures. Problem solving should also use clarification and demystify information to identify barriers and explore ways to overcome them. Problem-solving may specifically focus on issues of connectedness (social influences, involvement of others in supporting activities) and sustainability, or on breaking the problem down into more manageable chunks. Goals or action plans should collaboratively be reviewed and revised if necessary.

Rating	**Score**	**Example**
0	Absence	Absence of discussion to review participant setbacks or appropriate problem-solving strategies and/or highly inappropriate interaction.
1	Novice	Minimal discussion to review participant setbacks or appropriate problem-solving strategies and/or inappropriate delivery.
2	Advanced Beginner	Some evidence of competence when discussing participant setbacks or problem-solving strategies but these are infrequent) with some adaptation to context. However, there are numerous problems and inconsistencies such as lack of rapport, or missed opportunities.
3	Competent	Competent and appropriate attempts to review participant setbacks or problem-solving strategies. The facilitator is engaged, aware and able to cope with different contexts and situations. However, there are some minor problems or inconsistencies.
4	Proficient	Numerous appropriate discussions to review participant setbacks or problem-solving strategies. The facilitator is able to discriminate between a variety of contexts and situations with minimal problems or inconsistencies evident.
5	Expert	Highly appropriate and sufficient review of participant setbacks or problem-solving strategies. The facilitator is able to make more subtle refined discriminations between contexts and able to adjust accordingly. No problems or inconsistencies.

Level 2 Competencies; Assessed competency: Supporting Competence & Self Efficacy

Key features: Competence and self-efficacy is essential to individuals feeling able to enact skills and behaviours outside of sessions. Facilitators should seek to support competence and self-efficacy by encouraging individuals, identifying and breaking down barriers to change & supporting them to set achievable goals. Facilitators should encourage gradual and sustainable progress, give appropriate and constructive feedback, encourage problem solving and ascertain individual's knowledge, confidence and skills (activation) and health literacy so these can be built upon throughout the sessions.

Interactions: Facilitators should support individuals to break down goals into manageable chunks, regularly check in with, and build upon existing and skills by using skills such as open questions, clarification and summarising. The aim is to gradually build skills and confidence in abilities, by breaking down barriers to change and promoting a positive approach to managing setbacks (i.e. to see them as a learning opportunity, rather than failure).

Rating	Score	Example
0	Absence	Absence of attempts to build and reinforce competence and self-efficacy and / or highly inappropriate interactions.
1	Novice	Minimal attempts to build and reinforce competence and self-efficacy and /or inappropriate interactions.
2	Advanced Beginner	Some evidence of competence and adapting appropriately to the context involved when supporting competence and self-efficacy (but these are infrequent) and may not be carried out to sufficient depth or detail. There are numerous problems and inconsistencies, such as lack of rapport or missed opportunities.
3	Competent	Competent delivery and appropriate attempts to build and reinforce competence and self-efficacy. The facilitator is engaged, aware, and able to cope with different contexts and situations but there are some minor problems or inconsistencies.
4	Proficient	Numerous and appropriate attempts to support competence and self-efficacy. The facilitator is able to discriminate between a variety of contexts and situations with minimal problems or inconsistencies.
5	Expert	Highly appropriate and sufficient attempts to support competence and self-efficacy. The facilitator is able to make more subtle, refined discriminations between situations and contexts and able to adjust accordingly. No problems or inconsistencies.

Level 2 Competencies; Assessed competency: Self-Monitoring

Key Features: Facilitators should discuss with individuals their current strategies for self-monitoring and self-reflection on their progress towards their goals and how this was achieved. Facilitators should work with individuals on ways they can self-monitor and what support is needed.

Interactions: The facilitator should use all opportunities to acknowledge and reinforce participant attempts to self-monitor and progress they have made towards their goals.

Rating	Score	Example
0	Absence	Absence of discussion on self - monitoring behaviours and participant reflection on progress and or highly inappropriate delivery.
1	Novice	Minimal discussion on self - monitoring behaviours and participant reflection on progress and or highly inappropriate delivery.
2	Advanced Beginner	Some evidence of competence and adapting appropriately to context involved (but these are infrequent) when discussing participant self - monitoring behaviours and participant reflection on progress. There are numerous problems and inconsistencies such as lack of rapport or missed opportunities.
3	Competent	Competent and appropriate attempts to discuss self –monitoring behaviours and participant reflection on progress. The facilitator is engaged, aware and able to cope with different context and situations. There are however some minor problems or inconsistencies.
4	Proficient	Numerous appropriate discussions on self – monitoring behaviours and participant reflection on progress. The facilitator is able to discriminate between a variety of contexts and situations with minimal problems or inconsistencies.
5	Expert	Highly appropriate and sufficient discussions on self - monitoring behaviours and participant reflection on progress. The facilitator is able to make more subtle refined discriminations between situations and contexts and able to adjust accordingly. No problems or inconsistencies.

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