Bucks Charitable Alliance

Community Link Worker

Job Description

Role:	Community Link Worker (Social Prescribing)
Hours:	18.75 or 37.5 p.w.
Location:	See attached list – based in GP surgeries
Salary:	£21,000 - £23,400 p.a. (pro rata if part time)
Contract Duration:	Permanent
Annual Leave	27 days plus Bank Holidays per annum (pro rata if part time)
Reporting to:	Team Manager.

Introduction
Bucks Charitable Alliance (BCA) is a consortium of local charities, with an excellent track record of delivering high quality services in the communities they serve. Community Link Workers will be managed by staff with experience of social prescribing and have access to a range of training and personal development opportunities.

This new Social Prescribing service will be delivered by Community Link Workers working from GP surgeries in Primary Care Network (PCN) areas. Each Community Link Worker will be directly employed by one of the three BCA organisations: Carers Bucks, Connection Support or Buckinghamshire Mind.

Purpose of the role
Social prescribing empowers people to take control of their health and wellbeing through GP referral to non-medical Community Link Workers (CLW's) based in GP surgeries who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Community Link Workers work collaboratively with all local partners.

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

Key Responsibilities

1. Take referrals from GP practices within a primary care network in year 1 and expand the service to a wide range of other referrers from year 2.
2. Provide personalised, holistic support to individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes.
3. Develop trusting relationships by giving people time and attention to their priorities and 'what matters to me'.
4. Co-produce a personalised support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services.
5. Managing and prioritising your own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload.
6. To refer people back to other health professionals/ agencies, when what the person needs is beyond the scope of the Community Link Worker role.

Key Tasks: Referrals

1. Promoting social prescribing to patients; its role in improving health outcomes, reducing social isolation and the ability to remain independent in one's own home for longer.
2. Build relationships with key staff in GP practices within the local Primary Care Network (PCN), attending relevant meetings, becoming part of the wider network team, giving information and feedback on social prescribing.
3. Be proactive in developing strong links with GP surgery personnel to encourage referrals, recognising what they need to be confident in the service to make appropriate referrals.
4. Work in partnership with all local agencies to raise awareness of social prescribing and how partnership working can reduce pressure on statutory services, improve health outcomes and enable a holistic approach to care.
5. Provide referrers with regular updates about social prescribing, including information on the types of people most likely to benefit from the service, how to refer and outcomes of referrals
6. Seek regular feedback about the quality of service and impact of social prescribing on referrers.
7. Work in close collaboration with the Prevention Matters service to maximise the availability of social prescribing across the county whilst ensuring there is no duplication of resources.

Provide personalised support

1. Make contact with people on a one-to-one basis, making home visits or using digital technology such as Skype where appropriate. Give people time to tell their stories and focus on 'what matters to me'. Build trust with the person, providing non- judgemental support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person's assets.
2. Be a friendly source of information about wellbeing and prevention approaches.
3. Help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities.
4. Work with the person, their families and carers and consider how they can all be supported through social prescribing.

5. Help people maintain or regain independence through developing skills, adaptations, enablement approaches and simple safeguards.
6. Work with individuals to co-produce a simple personalised support plan – based on the person's priorities, interests, values and motivations – including what they can expect from the groups, activities and services they are being connected to and what the person can do for themselves to improve their health and wellbeing.
7. Where appropriate, physically introduce people to community groups, activities and statutory services, ensuring they are comfortable. Follow up to ensure they are happy, able to engage, included and receiving good support.
8. Where people may be eligible for a personal health budget, help them to explore this option as a way of providing funded, personalised support to be independent, including helping people to gain skills for meaningful employment, where appropriate.

Support community groups and VCSE organisations.

1. Develop supportive relationships with local Voluntary, Community, Social Enterprise groups/organisations and statutory services, to make timely, appropriate and supported referrals for the person being introduced.
2. Work with commissioners and local partners to identify unmet needs within the community and gaps in community provision.
3. Support local partners and commissioners to develop new groups and services where needed, through small grants for community groups, micro-commissioning and development support.
4. Encourage people who have been connected to community support through social prescribing to volunteer and give their time freely to others, in order to build their skills and confidence, and strengthen community resilience.
5. Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.

General tasks: Data capture

1. Work sensitively with people, their families and carers to capture key information, enabling tracking of the impact of social prescribing on their health and wellbeing.
2. Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.
3. Support referral agencies to provide appropriate information about the person they are referring. Use the case management system to track the person's progress. Provide appropriate feedback to referral agencies about the people they referred.
4. Work closely with GP practices within the PCN to ensure that social prescribing referral codes are inputted to EMIS and that the person's use of the NHS can be tracked, adhering to data protection legislation and data sharing agreements with the clinical commissioning group (CCG).

Professional development

1. Work with your line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.
2. Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.
3. Work with your line manager to access regular 'clinical supervision', to enable you

to deal effectively with the difficult issues that people present.
4. Attend team meetings with the other Community Link Workers, organised by the Team Manager.
5. Work with allocated GP who will have oversight of the successful embedding of this role into the surgeries and support with patient issues as required.

Miscellaneous

1. Work as part of the team to seek feedback, continually improve the service and contribute to business planning.
2. Undertake any tasks consistent with the level of the post and the scope of the role, ensuring that work is delivered in a timely and effective manner.
3. Duties may vary from time to time in this new and developing service, without changing the general character of the post or the level of responsibility.

Person Specification

	Criteria	Essential	Desirable
Personal Qualities & Attributes	Ability to listen, empathise with people and provide person- centred support in a non-judgemental way	✓	
	Able to get along with people from all backgrounds and communities, respecting lifestyles and diversity	✓	
	Able to support people in a way that inspires trust and confidence, motivating others to reach their potential	✓	
	High level of written and oral communication skills with the ability to apply these effectively with people, their families, carers, community groups, partner agencies and stakeholders	✓	
	Ability to identify risk and assess/manage risk when working with individuals	✓	
	Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when what the person needs is beyond the scope of the Community Link Worker role – e.g. when there is a mental health need requiring a qualified practitioner	✓	
	Able to work from an asset based approach, building on existing community and personal assets	✓	
	Ability to maintain effective working relationships and to promote collaborative practice with all colleagues and other partners.	✓	
	Commitment to collaborative working with all local agencies & community groups and in particular with the Prevention Matters service. Able to work with others to reduce hierarchies and find creative solutions to community issues	✓	
	Demonstrates personal accountability, emotional resilience and works well under pressure	✓	
	Ability to organise, plan and prioritise on own initiative.	✓	
	Ability to work flexibly and enthusiastically within a team or on own initiative.	✓	
	Understanding and responding to the needs of small volunteer-led community groups.	✓	
	Knowledge of and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety	✓	
Qualifications & Training	Demonstrable commitment to professional and personal development	✓	
	Training in motivational coaching and interviewing or equivalent experience		✓
	Working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work)	✓	

Experience	Supporting people, their families and carers in a related role (including unpaid work)	✓	
	Supporting people with their mental health, either in a paid, unpaid or informal capacity		✓
	Working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups		✓
	Data collection and providing monitoring information to assess the impact of services		✓
Skills and knowledge	Partnership/collaborative working and of building relationships across a variety of organisations	✓	
	Motivational coaching and interview skills	✓	
	Knowledge of the personalised care approach		✓
	Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports	✓	
	Knowledge of VCSE and community services in the locality		✓
	Meets DBS reference standards, in line with the law on spent convictions	✓	
Other	Access to own transport and ability to travel across the locality on a regular basis, including to visit people in their own homes	✓	
	Able to provide evidence of your right to work in the UK	✓	

Information for Candidates

Community Link Workers will be working from groups of GP surgeries known as Primary Care Networks (PCN's). The PCN locations are as follows:

1	Aylesbury BMW PCN	Berryfields Medical Centre Meadowcroft Surgery Whitehill Surgery
2	Central MAPLE PCN	The Mandeville Practice Oakfield Surgery Poplar Grove Practice
3	Aylesbury Vale South PCN	Cross Keys Surgery Haddenham Medical Centre Unity Health
4	Mid Chiltern PCN	Hughenden Valley Surgery John Hampden Surgery Prospect House Surgery Rectory Meadow Surgery Amersham Health Centre
5	Dashwood PCN	Stokenchurch Medical Centre Chiltern House Medical Centre Cressex Health Centre Carrington House Surgery Riverside Surgery Wye Valley Surgery
6	South Bucks PCN	Denham Medical Centre Burnham Health Centre Southmead Surgery Threeways Surgery Iver Medical Centre
7	The Arc Network	Cherrymead Surgery Highfield Surgery Marlow Medical Group Millbarn Medical Centre The Simpson Centre The Bourne End & Wooburn Green Medical Centre

There is one Community Link Worker vacancy in each PCN. If you would like to apply for more than one area, please indicate this on the application form on the final page.

You may select a maximum of up to 3 preferences.

Candidates who have been shortlisted for interview will be contacted by e-mail and or phone and offered an interview appointment.

In order to comply with Safer Recruitment guidelines, all candidates must complete a full application form prior to the interview. If you have only provided us with a CV, the application form will be sent to you (preferably) by email. So please be sure to provide us with your email address.

Candidates may be required to attend a second informal interview for final selection.

We regret that we are unable to reply to the candidates who have not been shortlisted for an interview. If you have not heard from us by Friday 23rd August, you have been unsuccessful in your application this time.