Community Link Worker (Social Prescribing) - Job Description

Responsible to:	Chief Executive Officer
Location:	Derby City North PCN
Hours:	37 hours per week Monday to Friday. To include occasional weekend and evening work for which time off in lieu will be arranged.
Salary:	**£25,000**
Type of contract:	Fixed term for one year with possible extension

Purpose of the role

Social Prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'Link Workers' who are able to spend time, focus on 'what matters to me' and take a holistic approach, connecting people to community-based and community-led social, practical and emotional support, as well as statutory services.

Social Prescribing aims to increase people's active involvement in their local communities. It can strengthen resilience at both a personal and community level, and it reduces health inequalities by supporting people to address the wider determinants of health, such as debt, poor housing and physical inactivity. It works particularly well for people with long-term conditions (including support for mental health), for people who are lonely or isolated, and those with complex social needs which affect their wellbeing.

A key element of the support offered by the Link Worker is to build clients' motivation and confidence for change. They do this by utilising person-centred and asset-based approaches such as motivational interviewing, coaching and resilience building. They work to increase social connectedness, increase physical activity, improve financial stability, personal safety and support the development of social networks and community assets. Link Workers enable clients to achieve their goals through one-to-one support. In Derby, our Community Link Worker will work collaboratively with our partners in the local area to maximise the potential health and wellbeing outcomes for their clients.

The Derby City North Primary Care Network and Community Action Derby are committed to developing a social model of health and to work collaboratively in new and innovative ways with partners across the health and care sector. We aim to build on the best of the NHS England Link worker Model whilst supporting a person-centred, asset-led approach at grassroots level in communities.

Effective social prescribing improves clients' health and wellbeing - and by so doing results in improvements in the appropriate use of health care services, and reduces their dependence on health care organisations.

The Link Worker salary reflects the complexity of the situations that people present with, and the need for a significant level of multi-agency working, including supporting community groups to receive referrals.

Scope and Range:

The Link worker will be employed by Community Action Derby, but will work flexibly across general practices in the Derby City North Primary Care Network.

Key responsibilities:

1. Take referrals from GP practices.
2. Undertake home visits, co-producing wellbeing action plans, focussing on asset building, prevention and self-management.
3. Provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes. Develop trusting relationships by giving people time and focus on 'what matters to me'. Take a holistic approach, based on the person's priorities and the wider determinants of health.
4. Be creative in finding loneliness-busting solutions that harness assets and resources which are already available and are low cost/non funding-dependent.
5. Co-produce a personalised action plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services.
6. Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, if what the person needs is beyond the scope of the Community Link Worker role eg when there is a mental health need requiring a qualified practitioner.
7. Draw on and increase the strengths and capacities of local communities, enabling local voluntary organisations and community groups to receive social prescribing referrals.
8. Liaise with Development Workers at Community Action to ensure that local groups have the policies and process in place for supporting vulnerable adults and the capacity to respond to needs identified in the personalised action plan.
9. Support the local mapping of community based services and assets and services in support of personalised care available, to facilitate independence and build on individual capacity and resilience.
10. Evaluate the impact of the personalised action plan on the client and on their use of health care services.

Key Tasks

Referrals

1. Promoting social prescribing, its role in self-management, and the wider determinants of health.
2. Build relationships with key staff in GP practices within the local PCN, attending relevant meetings, becoming part of the wider network team, giving information and feedback on social prescribing.
3. 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.
4. Provide practices with regular updates about social prescribing, including training for their staff and how to access information to encourage appropriate referrals.
5. Seek regular feedback about the quality of service and impact of social prescribing.

Provide Personalised Support

1. Decide on the most appropriate place to meet people: this may be at a 'clinic' held at the practice, Community Action offices, a home visit or appropriate community venue.
2. Meet people on a one-to-one basis, making home visits (or most appropriate place). Give people time to tell their stories and focus on 'what matters to me'. Build trust with the person,

providing non-judgemental support and respecting diversity and lifestyle choices. Work from an asset-based approach focusing on a person's strengths.

3. Be a friendly source of information about wellbeing and prevention approaches.
4. Help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities.
5. Work with the person, their families and carers and consider how they can all be supported through social prescribing.
6. Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.
7. Work with individuals to co-produce a simple personalised action plan, based on the person's priorities, interests, values and motivations, including what they can expect from the groups, activities and services they will be connected to and what the person can do for themselves to improve their health and wellbeing.
8. 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.
9. 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 to receive referrals

1. Forge strong links with local voluntary and community organisations and neighbourhood level groups, utilising their networks and building on what's already available to create a map or menu of community groups and assets.
2. Develop supportive relationships with local voluntary and community organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.

Work collectively with all local partners to ensure community groups are strong and sustainable

1. Encourage people who have been connected to community support through social prescribing to volunteer, working with the Volunteer team at Community Action to support them to give their time freely to others, in order to build their skills and confidence, and strengthen community resilience.
2. Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.

GeneralTasks

Data capture

1. Work sensitively with people, their families and carers to capture key information, enabling tracking of the impact of social prescribing both on their health and wellbeing and the impact on the local health system.
2. Data will be recorded both within the PCN's individual general practice clinical systems and within Community Action Derby's records.
3. Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.

4. Support referral agencies to provide appropriate information about the person they are referring.
5. Provide appropriate feedback to referral agencies about the people they referred.

Professional development

1. To undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.
2. Undertake relevant training as required.
3. Continually update own knowledge and skills within the job role and contribute to setting own work objectives.
4. Adhere to organisational policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety.

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. Undertake monitoring and evaluation as required.
4. Duties may vary from time to time, without changing the general character of the post or the level of responsibility.
5. Act at all times in a manner consistent with legislation, policy and procedures in respect of equality and diversity, and, safeguarding.
6. Attend regular staff, supervision and special purpose meetings.