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**Social Prescriber**

**Role Purpose**

Social Prescribing is a way of connecting health and social care users to sources of support, information and advice in order to improve their wellbeing, tackle social isolation, and prevent illness. The Social Prescriber will be responsible for delivering a person-centred holistic service, supporting clients to improve their health and wellbeing by signposting to and connecting with local services and assets in their community that meet their practical, social and emotional needs, including specialist advice services, arts and culture, physical activity, and nature based activities.

Social prescribers take a whole population approach, working with a range of people who may benefit from social prescribing, including people who are lonely, have complex social needs, low level mental health needs and long-term conditions.

The Social Prescriber will support the client over a time limited period, using coaching and motivational interviewing techniques to help them achieve the goals outlined in the personalised care & support plan, whilst encouraging and supporting clients to self-manage their conditions(s) and develop healthier behaviours and lifestyles.

The role requires extensive liaison with statutory and non-statutory services, in order to generate referrals into the service, enable access to relevant local services for the client, and support community development by monitoring gaps in provision and working in partnership with others to develop accessible and sustainable community offers.

**Responsible to:** Head of Wellbeing Services

**Hours of work:** Monday to Friday, according to the demands of the service. Occasional work out of hours may be necessary.

**Place of work:** Malvern office with travel across South Worcestershire.

**Main duties and responsibilities**

* Take referrals from the PCN and a wide range of local agencies as agreed.
* Undertake holistic assessments of client’s circumstances and issues to determine the nature and extent of their non-clinical needs and co-design a simple health and well-being personalised plan with individual service users, identifying support needs to ensure maximum engagement in improving health and well-being;
* Work with supervision to manage and prioritise your own caseload, in accordance with needs, priorities and support required by individuals. Refer people back to other heath professionals/agencies, as appropriate or necessary;
* Build ongoing relationships with local infrastructure organisations, community activities and support services to increase knowledge of the community support offer, and work collaboratively to ensure the sustainability of community assets, monitoring gaps in provision and sharing intelligence with commissioners and local authorities;
* To develop and maintain effective and positive relationships with referral partners and stakeholders including health, voluntary, social and education resources, attending relevant meetings as necessary;
* To work with the team to ensure information on sources of voluntary and community support is up to date at all times to enable effective and accurate signposting and linking of individuals with services;
* Act as an advocate and champion for the social prescribing service across local stakeholders, the public, and professionals through outreach and communication mechanisms;
* To gather and share good practice on Social Prescribing services;
* Promote social prescribing as an approach and provide education on the community support offer and the value of non-medical community based interventions. This may include verbal or written advice and guidance.

**Service Delivery**

* Act as the central point of contact for referrals to Social Prescriber service within agreed timescales;
* Meet people on a one-to-one basis in person or via telephone/online consultation, making home visits and visits to community organisations where appropriate and within SWCA policies and procedures;
* Give people time to tell their stories and focus on the question ‘what matters to me?’;
* Build trust and respect with the person, providing non-judgmental and non-discriminatory support, taking a strengths based approach;
* Undertake initial assessments to help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities, and provide relevant information, advice and guidance including signposting where appropriate;
* Take a proactive, problem solving approach in helping support people to connect and access services, including giving information on what people can expect from the groups they are being connected to and physically introducing people where appropriate so that they are comfortable to engage;
* Empower and motivate clients to reach the goals within the personalised support plan, including providing information on what the person can do for themselves to improve their health and wellbeing;
* Use judgement to ascertain the number and length of sessions required, responding to the needs of the individual and their circumstances, for approximately 6-12 contacts over 3-6 months;
* Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards, seeking advice and support around issues that fall outside the scope of the role and following SWCA safeguarding policies around reporting and/or escalating concerns;
* Support community development as outlined above, as well as encouraging volunteering and helping participants to explore potential to start new community based groups or activities.

**Monitoring, Report and Evaluation**

* Support referral agencies to provide appropriate information about the person they are referring, including demographic data;
* Provide appropriate and timely feedback to referral agencies about the people they referred;
* Work sensitively with people to capture key information to measure the impact of social prescribing on their health and wellbeing using validated tools such as the ONS4 wellbeing scale;
* Participate in the on-going development, monitoring and evaluation of the programme;
* Maintain systems to keep accurate records relating to the delivery of Social Prescriber service;
* Report on client outcomes post intervention, including case studies where appropriate
* Adhere to SWCA and PCN policies around data protection legislation and data sharing agreements, ensuring people give appropriate consent.

**Continuing professional development**

* Work with the Head of Wellbeing Services to undertake continual personal and professional development in line with the social prescribing Workforce Development Competency Framework;
* Take an active role in reflecting, reviewing and developing professional knowledge, skills and behaviours;
* Attend appropriate mandatory training before working with people and be aware of own competence, maintaining boundaries around scope of practice and referring onwards for people whose needs fall outside of these boundaries.
* Attend one-to-one meetings and annual performance appraisal meetings with line manager.

**Additional Responsibilities**

* Adhere to local primary care and SWCA policies and procedures at all times including confidentiality, safeguarding, lone working, information governance, equality, diversity and inclusion and health and safety;
* Responsible for producing own correspondence, performing and maintaining administrative and reporting tasks;
* Engage with other Social Prescribers across the county to share learning and develop the service;
* Undertake any other duties or tasks that are consistent with the level of the post and fall within the scope of the role thereby ensuring that the overall business and operational priorities of the project are delivered in a timely and effective manner.