

**Job Description for**

**Job Title**: Social Prescriber Co-ordinator x 2 Full Time posts

**Location:** Harrow Lodge House, Hornchurch for Mind, Havering, Barking and

 Dagenham x 1 post

 or

 Hopwa House, Inskip Drive, Hornchurch for Tapestry x 1 post

**Salary:** £24,588.20 pa

**Accountable to:** The Management Committee of Havering Mind through the Chief Executive

 The Management Committee of Tapestry through the Chief Executive

**Responsible to:** Zoey Griffin **Community Hub Quality and Communications Manager**

**Liaise with:** Havering Mind staff and volunteers, statutory agencies; voluntary bodies; Havering Mind clients and carers and other partner organisations.

Tapestry staff and volunteers, statutory agencies, voluntary bodies. Tapestry clients, carers and other partner organisations

**Main tasks of job:**

The Social Prescribing Link worker will empower people to take control of their health and wellbeing through referral to ‘link workers’ who give time, focus on ‘what matters to me’ and take a holistic approach to an individual’s health and wellbeing, connecting people to diverse community groups and statutory services for practical and emotional support. Link workers also support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local diverse partners. Social prescribing link workers will work as a key part of the primary care network (PCN) multidisciplinary team.

Social prescribing can help PCNs to strengthen community and personal resilience, reduce health inequalities (in relation to timely access and outcomes) and wellbeing 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 diverse 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.

**Duties and responsibilities**

1. Working with direct supervision by a GP, take referrals from the PCN’s Core Network Practices and from a wide range of agencies, including pharmacies, wider multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations, and voluntary, community and social enterprise (VCSE) organisations (list not exhaustive).

 2. Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health access and outcomes, as a key member of the PCN multi-disciplinary team. 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. Co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to appropriate community groups and statutory services. The role will require managing and prioritising your own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. It is vital that you have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when the person’s needs are beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner.

 3. Work with a diverse range of people and communities, to draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups (including faith groups) to receive social prescribing referrals.

 4. Alongside other members of the PCN multi-disciplinary team, work collaboratively with all local diverse partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities.

5. Social prescribing link workers will have a role in educating non-clinical and clinical staff within their PCN multi-disciplinary teams on what other services are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

6. Working with direct supervision by a GP, take referrals from the PCN’s Core Network Practices and from a wide range of agencies, including pharmacies, wider multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations, and voluntary, community and social enterprise (VCSE) organisations (list not exhaustive). 2. Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health access and outcomes, as a key member of the PCN multi-disciplinary team. 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. Co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to appropriate community groups and statutory services. The role will require managing and prioritising your own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. It is vital that you have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals/agencies, when the person’s needs are beyond the scope of the link worker role – e.g. when there is a mental health need requiring a qualified practitioner.

7. Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.

8. Be proactive in encouraging equality and inclusion, through self-referrals and connecting with all diverse local communities, particularly those communities that statutory agencies may find hard to reach.

9. Provide personalised support, meeting people on a one-to-one basis, making home visits where appropriate within organisations’ policies and procedures.

10. Give people time to tell their stories and focus on ‘what matters to me’. Build trust and respect with the person, providing non-judgemental and non-discriminatory support, respecting diversity and lifestyle choices. Work from a strength-based approach focusing on a person’s assets. Be a friendly and engaging source of information about health, wellbeing and prevention approaches.

General

1. Liaise with outside agencies and members of the public
2. Maintain statistics as required for monitoring purposes
3. Comply with Health and Safety regulations
4. Comply with Mind’s equal opportunities policy
5. Attend regular supervision meetings
6. Undertake any such other duties that are agreed between post holder and committee
7. Undertake training as required for the post and keep up to date with developments
8. Attend regular staff meeting and complete action points

The above is not an exhaustive list of duties and you will be expected to perform different tasks as necessitated by your changing role within the organisation and the overall business objectives of the organisation.

Job Description approved by: Date: