Job Description

Job Title: Social Prescribing Wellbeing Co-ordinator
Responsible to: Social Prescribing Project Lead
Salary: £27000 - £30 000 (pro-rata)
Pension: Employer contribution
Hours: Part time - 30 hours a week (6 months contract)
Based: Ruils is based at The Disability Action & Advice Centre 4 Waldegrave Road Teddington TW11 8HT

This role is community based and will also involve working out of GP practices in Hampton.

Introduction

Ruils is a user-led charity based in the Richmond borough that supports disabled children and adults and the elderly to live independently, be part of their community and to live life to the full. We provide information, advice, advocacy, befriending and activities to our clients and their families.

We work with the Richmond General Practice Alliance (RGPA) and our local Primary Care Networks to deliver Social Prescribing in Richmond. This project is working in partnership with the Social Prescribing team and the Hampton PCN. The NHS Plan highlighted the need to focus on the prevention of long-term conditions and reduce health inequalities faced by sections of society. This is an exciting opportunity for a motivated individual to take forward a 6 month social prescribing pilot project with a particular focus on targeting localities that are facing health inequalities due to high levels of social deprivation. This project is being managed in conjunction with South West London CCG.

Purpose of the role

As a Social Prescribing Wellbeing Co-ordinator, you will work with residents to identify their needs and requirements and link them to community groups that can help them to become more independent, physically active and connected with their community. Additionally, you will support residents to get appropriate advice and will signpost them to relevant services that will help them to lead a healthier, more fulfilling life. The post holder will target communities to help develop networks and support the identification and self-management of long-term conditions such as hypertension, depression, diabetes and asthma. Residents will access this programme through referral from GPs and other healthcare professionals, as well as through the community networks.

Key responsibilities

1. Work with the SWL CCG to implement a pilot project outreaching to a specific, identified Hampton community.
2. Take referrals from a wide range of agencies within a specific geographical community facing high levels of deprivation with the Hampton primary care network, including GP practices, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations, and voluntary and community organisations. (list not exhaustive).
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. Co-produce a personalised support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services.

4. Manage and prioritise 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 what the person needs is beyond the scope of the well-being coordinator – e.g. when there is a mental health need requiring a qualified practitioner.
5. Draw on and increase the strengths and capacities of local communities, enabling local voluntary organisations and community groups to receive social prescribing referrals. Work with them and the RCVS to ensure that groups are supported, have basic safeguarding processes for vulnerable individuals and can provide opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence.
6. Work together with all local partners to collectively ensure that local voluntary organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.

Key Tasks

- Promote social prescribing, its role in self-management, and the wider determinants of health.
- 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.
- Be proactive in developing strong links with all local agencies to encourage referrals, recognising what they need to be confident in the service to make appropriate referrals.
- 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.
- Provide referral agencies with regular updates about social prescribing, including training for their staff and how to access information to encourage appropriate referrals.
- Seek regular feedback about the quality of service and impact of social prescribing on referral agencies.
- Be proactive in encouraging self-referrals and connecting with all local communities, particularly those communities that statutory agencies may find hard to reach.

Provide personalised support

- Meet people on a one-to-one basis, making home visits 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.
- To use the Signal Tool when engaging with individual patients/residents where appropriate (training will be provided).
- Be a source of information about wellbeing and prevention approaches.
- Help people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities.

- Work with the person, their families and carers and consider how they can all be supported through social prescribing.
- Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.
- 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.
- 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.
- 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 voluntary organisations to receive referrals

- Forge strong links with local voluntary sector organisations, community and neighbourhood groups, utilising their networks and building on what's already available to create a map or menu of community groups and assets. Use these opportunities to promote micro-commissioning or small grants if available.
- Develop supportive relationships with local voluntary sector organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.
- Ensure that local community groups and voluntary organisations being referred to have basic procedures in place for ensuring that vulnerable individuals are safe and, where there are safeguarding concerns, work with all partners to deal appropriately with issues. Where such policies and procedures are not in place, signpost organisations to Richmond CVS who can support groups to work towards this standard before referrals are made to them.
- Check that community groups and voluntary sector organisations meet in insured premises and that health and safety requirements are in place. Where such policies and procedures are not in place, signpost organisations to Richmond CVS who can support groups to work towards this standard before referrals are made to them.
- Work collectively with all local partners to ensure community groups are strong and sustainable
- Work with commissioners and local partners to identify unmet needs within the community and gaps in community provision.
- Support local partners and commissioners to develop new groups and services where needed, through small grants for community groups, micro-commissioning and development support.
- 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.
- Develop a team of volunteers within your service to provide 'buddying support' for people, starting new groups and finding creative community solutions to local issues.
- Encourage people, their families and carers to provide peer support and to do things together, such as setting up new community groups or volunteering.

- Provide a regular ‘confidence survey’ to community groups receiving referrals, to ensure that they are strong, sustained and have the support they need to be part of social prescribing.

General tasks Data capture

- 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.
- Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.
- 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.
- Work closely with GP practices within the PCN to ensure that social prescribing referral codes are inputted to EMIS/SystmOne/Vision 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).
- To use the agreed electronic system to record data / notes etc.

Professional development

- Work with your line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.
- Undertake any training necessary to improve performance.

General

The post-holder is expected to work in line with the Ruils’ policies and procedures including health and safety, confidentiality, safeguarding adults and children, and equal opportunities and diversity. In carrying out their duties the post-holder should endeavour to maximise the opportunity for disabled individuals to be independent and to create opportunities that enable them to reach their full potential.

It is necessary for all employees to be flexible, and all employees may be required from time to time to perform other duties that may be required by the employer to provide effective services to individuals and to ensure the efficient running of the organisation.

The post-holder will:

- Promote the work of Ruils
- Be self-servicing and will maintain efficient files and records and record on the Ruils database;
- Attend monthly staff meetings;
- Attend personal supervision and appraisal meetings;
- Attend and contribute to Planning Days and Events as and when required;
- Comply with all relevant legislation.
- Ensure that confidentiality of client information is maintained in line with GDPR regulations.

Special Requirements:

Flexibility to work outside of normal office hours on occasion.

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	✓	
	Commitment to reducing health inequalities and proactively working to reach people from all communities	✓	
	Able to support people in a way that inspires trust and confidence, motivating others to reach their potential	✓	
	Ability to communicate effectively, both verbally and in writing, 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 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	✓	
	Able to provide leadership and to finish work tasks	✓	
	Ability to maintain effective working relationships and to promote collaborative practice with all colleagues	✓	
	Commitment to collaborative working with all local agencies (including VCSE organisations and community groups). 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, including when under pressure and meeting deadlines	✓	
	High level of written and oral communication skills	✓	
	Ability to work flexibly and enthusiastically within a team or on own initiative	✓	
	Understanding of the needs of small volunteer-led community groups and ability to support their development		✓
	Knowledge of and ability to work to policies and procedures, including confidentiality, safeguarding, lone working, information governance, and health and safety		✓
Qualifications & Training	NVQ Level 3, Advanced level or equivalent qualifications or working towards	✓	
	Demonstrable commitment to professional and personal development	✓	
	Training in motivational coaching and interviewing or equivalent experience		✓
Experience	Experience of working directly in a community development context, adult health and social care, learning support or public health/health improvement (including unpaid work)	✓	

	Experience of supporting people, their families and carers in a related role (including unpaid work)	✓	
	Experience of supporting people with their mental health, either in a paid, unpaid or informal capacity		✓
	Experience of working with the VCSE sector (in a paid or unpaid capacity), including with volunteers and small community groups	✓	
	Experience of data collection and providing monitoring information to assess the impact of services		✓
	Experience of partnership/collaborative working and of building relationships across a variety of organisations		✓
Skills and knowledge	Knowledge of the personalised care approach		✓
	Understanding of the wider determinants of health, including social, economic and environmental factors and their impact on communities		✓
	Knowledge of community development approaches		✓
	Knowledge of IT systems, including ability to use word processing skills, emails and the internet to create simple plans and reports	✓	
	Knowledge of motivational coaching and interview skills		✓
	Knowledge of VCSE and community services in the locality		✓
Other	Meets DBS reference standards and has a clear criminal record, in line with the law on spent convictions	✓	
	Willingness to work flexible hours when required to meet work demands	✓	
	Access to own transport and ability to travel across the locality on a regular basis, including to visit people in their own homes	✓	