JOB DESCRIPTION

Job title: Wellbeing Coordinator

Service: North East Hampshire & Farnham Social Prescribing Service

Salary: Grade 2 Point 16 – 19

Hours: 21 hours per week

Location: Aldershot, Farnham, Fleet, Farnborough and Yateley

Responsible to: Project Manager

Summary of job:
To deliver the Social Prescribing Service to specific GP consortia across North East Hampshire & Farnham. To work with GPs, other health and social care professionals to provide holistic assessments for patients to design an individual social prescription focusing on 'what matters to me'. Taking a holistic approach to an individual's health and wellbeing, connecting people to community groups and statutory services for practical and emotional support to improve health and well-being and reduce GP appointments.

Key tasks and responsibilities:

1. Undertake holistic assessments and co-design Health and Wellbeing Plans with service users, focusing on 'what matters to me' principles, identifying support needs to ensure maximum engagement in improving health and well-being.

2. Provide service users with continuity and a coordinated experience of care, remaining a point of contact throughout the individual's social prescription.

3. Be a friendly source of information about health, wellbeing and prevention approaches.

4. Help people identify the wider issues that affect their health and wellbeing, such as debt, poor housing, unemployment, loneliness and caring responsibilities.

5. Work with the individual, their families and carers and consider how they can all be supported through social prescribing.

6. Offer emotional and practical support to parents and their families, in their own homes and in the community & health care settings

7. Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.

8. Work with individuals to co-produce a simple personalised support plan to address the person's health and wellbeing needs – based on their individual 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.

9. Where appropriate, physically introduce people to community groups, activities and statutory services, ensuring they are comfortable. Follow up to ensure they are happy, included, receiving good support and able to engage.

10. 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.

11. Seek advice and support from the GP supervisor and/or identified individual(s) to discuss patient-related concerns (e.g. abuse, domestic violence and support with mental health).

12. Forge strong links with local VCSE organisations, community and neighbourhood level groups, utilising their networks and building on what is already available to create a menu of community groups and assets.

13. Develop supportive relationships with local VCSE organisations, community groups and statutory services, to make timely, appropriate and supported referrals for the person being introduced.

14. To establish and maintain effective liaison with stakeholders including health, voluntary, social and education resources, attending relevant meetings as necessary.

15. Work with commissioners and local partners to identify unmet needs within the community and gaps in community provision.

16. Encourage people who have been connected to community support through social prescribing to volunteer and give their time freely to others, building their skills and confidence and strengthening community resilience.

17. Encourage people, their families and carers to provide feedback and to share their stories about the impact of social prescribing on their lives.

18. Work with your line manager to undertake continual personal and professional development, taking an active part in reviewing and developing the roles and responsibilities.

19. Work with your line manager to access regular supervision/clinical supervision, to enable you to deal effectively with difficult issues that people present.

20. To work in partnership with all voluntary and community organisations to build a comprehensive database of resources to design and support the Social Prescription Menu.

21. To ensure information on sources of voluntary and community support are up to date at all times to enable effective and accurate signposting and linking of service users with services.

22. As part of the PCN multi-disciplinary team, build relationships with staff in GP practices within the local PCN, attending relevant MDT meetings, giving information and feedback on social prescribing.

23. 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.

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

25. To train and develop GPs and health teams' knowledge on how to identify patients suitable for social prescribing services on a quarterly basis

26. Set up and maintain comprehensive data and evaluation systems, including outcome tools (Outcomes & Outcome Stars as well as others).

27. Set up steering group including representation from all stakeholder groups to support the ongoing development, monitoring and evaluation of the programme.

28. Contribute to quarterly comprehensive outcome focussed reports detailing the progress of the service.

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

30. To recruit, train and supervise volunteers, matching them to service users for specific time-limited support in achieving positive engagement in activities promoting health and well-being.

31. To keep timely and accurate records of your work whilst at all times adhering to confidentiality, GDPR, information sharing protocols and provide monitoring information as required.

32. To take part in Family Action's and other organisations' meetings and events to promote, support and celebrate the work of the service and the agencies.

33. To work collaboratively with stakeholders and raise the profile of the service in the local area, in order to strengthen community resilience and capacity. Working in partnership with all local agencies to raise awareness of social prescribing, how partnership working can reduce pressure on statutory services, improve health outcomes and enable a holistic approach to care.

34. To have an understanding of, and comply with Family Action's procedures for promoting and safeguarding the welfare of children and vulnerable adults.

35. To ensure the implementation of Family Action's Equality & Diversity Policy and Ethical Policy in every aspect of your work and positively promote the principles of these policies amongst colleagues, service users and other members of the community.

36. To comply with Family Action's Health and Safety Policy, Data Protection, GDPR Policy and to protect your own and others' health, safety and welfare.

37. To work flexibly as may be required by the needs of the service and carry out any other reasonable duties as required.

Person Specification

1. Educated to Degree level in a relevant subject with experience of supporting individuals and /or families; and a genuine commitment to continuing professional development.

2. Ability to use different therapeutic approaches such as Motivational Interviewing techniques, CBT, Solution Focused Therapy.

3. Comprehensive working knowledge of the welfare benefits systems, housing systems and welfare grants in order to quickly signpost parents.

4. Excellent holistic assessment as well as consultation skills and experience of providing empowering support to adults in a planned and structured way to improve health, recovery and wellbeing outcomes.

5. Proven skills in collating information and data on community resources and organizing these in up-to-date and accessible formats for a range of different service users from various communities.

6. Excellent record keeping skills and the proven ability to write comprehensive reports for a variety of stakeholders.

7. Excellent IT skills and the ability to do own administration using databases, PowerPoint and other IT packages.

8. A confident and professional approach to working with a variety of stakeholders.

9. Excellent written, verbal, listening and presentation skills.

10. A proven understanding and an up to date knowledge and understanding of Working Together to Safeguard Children, as well as demonstrable ability to work in accordance with local and organisational Safeguarding policies and procedures for all vulnerable groups.

11. The ability to work autonomously and to plan, prioritise, work under pressure and adapt to new models of working.

12. A commitment to equal opportunities and an understanding of the impact of ill health, deprivation, discrimination on communities, families and individuals.

13. Ability to work flexible hours, including evenings and weekends to meet the needs of the service.

14. To be able to evidence Family Action's values at all times, which underpin Family Action's mission of 'building stronger families' by:
    a) Being people focused
    b) Reflecting a 'can do' approach
    c) Striving for excellence in everything we do

d) Having mutual respect for everyone we work with, work for and support through our services.