**C360 Engagement Officer Appendix 1 – Social Prescribing (My Social Prescription®) JD**

**Introduction**

Social prescribers connect people with local community activities and services that can help improve their health and wellbeing.

Launched in 2013, ‘My Social Prescription® (MSP) is a community based scheme led by Community360 across Colchester. It serves to address the social issues that can affect people’s well-being. MSP does this by connecting people to voluntary and community services, volunteering as well as providing support with health conditions and encouraging self-care. MSP is designed to empower individuals.

This is achieved through a personalised service where the MSP team identifies the most appropriate services, club or support to meet the needs of individuals. The result being that people see an improvement in their well-being, feel supported and connected with their community and the demand on public services is reduced.

It has been designed to reduce time spent finding the help people need by informing them of the right service, in the right place, first time.

A social prescriber will use an Asset Based Community Development approach at all times within their role.

**Principal Duties:**

1. Process referrals received from a range of agencies such as pharmacies, multi-disciplinary teams, hospital discharge and many other stakeholders along with self referrals (this list is not exhaustive) to identify the most appropriate service, club or support to meet the needs of the individuals that offer practical social and emotional support that will improve their health and wellbeing.
2. Generate referrals through outreach and proactive conversation.
3. Build relationships with the people you are helping by listening carefully to what is important to them and what motivates them.
4. Work with individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes, including setting of personal action plans.
5. Connect individuals with local community and voluntary groups offering support with activities or practical advice.
6. Manage and prioritise your own caseload in accordance with the needs, priorities and any urgent support required by the individuals.
7. Have a strong awareness and understanding of when it is appropriate or necessary to refer people back to other health professionals or agencies, when what the person needs is beyond the scope of this role.
8. Work together with local partners to collaboratively ensure that local voluntary and community assets are nurtured.
9. Build relationships with all stakeholders within the community as well as in clinical settings, attending relevant meetings, providing information and feedback on social prescribing.
10. 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.
11. Meet people on a one-to-one basis, making home visits where appropriate, giving people time to tell their stories, building trust and providing non-judgemental support, respecting diversity and lifestyle choices.
12. Help people identify the wider issues that impact on their health and wellbeing such as debt, poor housing, being unemployed, loneliness and caring responsibilities.
13. Help people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards.
14. Complete insightful monitoring and evaluation of the impact made, including updating a bespoke database system and compiling case studies.