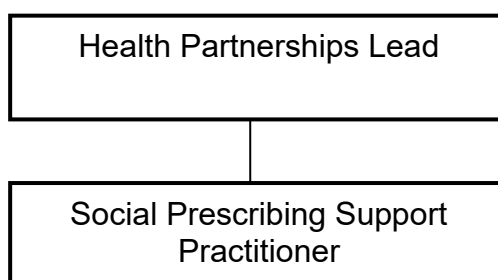




Job Description & Person Specification

Post Title	Social Prescribing Support Practitioner				
JE Reference	W1169	Grade	E	SCP Range	17 - 19

Reporting line:



Job Purpose:

Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical Support Practitioners who give time, focus on 'what matters' to an individual and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support.

Social prescribing can help to strengthen community resilience and personal resilience, reduce health 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 communities. It particularly works for people with long term conditions (including support for mental health and wellbeing), for people who are lonely or isolated, or have complex social needs which impact on wellbeing.

Social prescribing Support Practitioners have a key role in supporting delivery of the Comprehensive Model of Personalised Care.

Relationships:

Accountable to: Health Partnerships Lead

Accountable for: N/A

General Contacts: Primary Care Networks

Key duties and responsibilities:

1. To take referrals from the Primary Care Network (PCN) members and GP practice teams.
2. To provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes.
3. To develop trusting relationships by giving people time and focus on 'what matters to them', alongside using patient prioritisation, triage and assessment tools to support comprehensive personalised care planning.
4. To take a holistic approach, based on the person's priorities, and the wider determinants of health.
5. Supporting access to a range of services and resources (e.g. personal health budgets), to best meet the needs of individuals - informed by professional judgement and specialist skills and knowledge, such as motivational interviewing techniques and patient activation measures.
6. Co-produce a comprehensive personalised care and support plan to improve health and wellbeing. This may include working as part of a multi-disciplinary team, alongside a range of health and social care practitioners to support joined-up care planning.
7. Monitoring and reviewing individual's progress against identified care plans to support proactive case management and maximise the achievement of outcomes.
8. To play a lead role in implementing asset-based community development within local primary care networks – making best use of local services and building opportunities to address key gaps.
9. To work as part of the PCN multi-disciplinary teams across allocated PCNs - partaking and coordinating MDT meetings as required, to support personalised and anticipatory care planning processes.
10. To be able to access and navigate a range of GP IT systems to record patient contact and care planning, as well as using hard and soft intelligence to provide regular and informative population health feedback to primary care networks and wider system partners.
11. The role will require Support Practitioners to manage and prioritise their own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. Where required and as appropriate, the Support Practitioner will refer people back to other health professionals within the network.
12. Increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive referrals. They will ensure those organisations and 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.

13. To work together with all local partners to collectively ensure that local VCSE 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.
 14. To have a role in educating non-clinical and clinical staff within the network on what other services and support are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.
 15. The role will require the completion of the NHS England and NHS Improvement online learning programme, as well as the achievement of relevant qualifications aligned to the Personalised Care Institute.
 16. Alongside a general commitment to continued professional development, the post holder will partake in relevant peer support networks coordinated by NHS England.
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General/Corporate Responsibilities:

1. To undertake such duties as may be commensurate with the seniority of the post
2. To ensure that the Council's corporate Health & Safety policy is followed and training is undertaken in all pertinent health and safety procedures
3. To partake in the Council's and Directorate's staff training and development policies as well as the Council's system of performance appraisal
4. To treat all information gathered for the Council and Directorate, either electronically or manually, in a confidential manner
5. All employees are required to demonstrate a commitment when carrying out their duties which promotes and values diversity and the equality of opportunity in relation to employees and service users which is in line with the Council's Equality & Diversity Policy.
6. To be responsible for identifying and managing all risks associated with the job role through effective application of internal controls and risk assessments to support the achievement of Corporate and Service objectives
7. To ensure the highest standards of customer care are met at all times
8. To ensure the principles of Value for Money in service delivery is fundamental in all aspects of involvement with internal and external customers
9. To ensure that the highest standards of data quality are achieved and maintained for the collection, management and use of data.

10. To positively promote the welfare of children, young people, and vulnerable adults and ensure that it is recognised that Safeguarding is everyone's responsibility; and to engage in appropriate training and development opportunities which enhance an individual's knowledge and skill in responding to children, young people and vulnerable adults who may be in need of safeguarding.

Last Updated: November 2025

Author: Jill Calvert

POST TITLE	GRADE
Social Prescribing Support Practitioner	E

NOTE TO APPLICANTS

Whilst all points on the specification are important, those listed in the essential column are the key requirements. You should pay particular attention to those points and provide evidence of meeting them. Failure to do so may mean that you will not be invited for interview.

CRITERIA	NECESSARY REQUIREMENTS		* M.O.A.
	Essential	Desirable	
EXPERIENCE	- Substantial experience in engaging and working with hard to reach individuals with complex health and social issues - Close partnership working with other organisations/services - Assessing suitability for services and working with people in person-centred and strength-based ways - Working independently in the community - Using outcome measurement tools with individuals	- Project development - Developing and designing new systems and processes - Working closely with or within primary care settings	A, I
SKILLS AND ABILITIES	- Well-developed skills to communicate effectively, orally and in writing, complex or sensitive information to people, their families, carers and other professionals - Able to use different approaches to assess individual needs and make appropriate decisions collaboratively with people about their goals and their support needs - Clinical risk assessment and risk management	A knowledge of social prescribing and its benefits to recipients, the NHS and the wider community	A, I

	- skills • Able to develop good therapeutic relationships with people using services • Excellent relationship building and influencing skills • Ability to work under pressure • Ability to manage own caseload and varied workload and prioritise effectively • Ability to work with minimum supervision, use own initiative and make appropriate decisions • Able to secure advice/guidance on practice issues when necessary • Computer literate		
EDUCATION/ QUALIFICATIONS/ KNOWLEDGE	• Experience of barriers and difficulties faced by people with health and social issues • Knowledge of a range of emotional, health, social and vocational interventions and techniques • Child and adult safeguarding issues and other relevant legislation • Community and specialist services and support available to people in Redcar & Cleveland • Local geographic knowledge of Redcar & Cleveland and its communities	• Structures and systems within primary care and secondary care health settings	A, I
OTHER REQUIREMENTS	• Flexible approach to work by responding to the needs of the services including, at times, requirements to work beyond normal working hours • Commitment to own continuous personal and professional development • Strong team player, committed to an ethos of continuous improvement • Caring, compassionate and person-centred	• Full driving licence • Evidence of own continuous personal and professional development	A, I, C

	approach • Recovery focused, promotes independence, autonomy and personal control • High level of enthusiasm and self-motivation • Ability to use supervision and personal development positively and effectively • Ability to be self-reflective, whilst working with beneficiaries and in own personal and professional development and in supervision • Car driver and use of own transport for work purposes		
COMMITMENT TO EQUAL OPPORTUNITIES	• Commitment to equal opportunities and the ability to recognise the needs of different service users	• Evidence of having completed training in equality and diversity awareness	A, I
COMMITMENT TO SERVICE DELIVERY/ CUSTOMER CARE	• Commitment to provide a customer-focussed service	• Evidence of surpassing customer expectations or service targets / goals	A, I

METHOD OF ASSESSMENT: (*M.O.A.)

A = APPLICATION FORM C = CERTIFICATE E = EXERCISE I = INTERVIEW P = PRESENTATION T = TEST AC = ASSESSMENT CENTRE
 R = REFERENCE