



What should social prescribing look like: Shaping the National Academy of Social Prescribing's new strategy

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Executive Summary

The National Academy for Social Prescribing (NASP) is a national charity that champions social prescribing by providing training and development, building partnerships and developing the evidence for what works.

It commissioned the Patients Association to run two activities: 1) a survey of people who had received social prescribing, followed by 2) a focus group of people who had not received social prescribing. The focus group enabled us to explore what people who had not experienced social prescribing would want it to look like, as well as identifying aspects that may already be in place.

Ten people from across England and Scotland took part in a 2.5 hour online focus group in August 2026. The discussion explored four areas: the barriers people may face in accessing community support; how challenges in connecting with community activities could be overcome; the qualities and skills people would expect from Link Workers; and what people would need to understand and trust about social prescribing before referral.

Challenges for people connecting with community non-medical support and activities for health and wellbeing

Participants highlighted that simply knowing what support is available can be a challenge for people trying to connect with community support and activities that could benefit their health and wellbeing. Even when people are aware of what is available, there can be practical and physical barriers to taking part, alongside emotional, social and confidence-related barriers to joining a new activity. Participants also felt that activities do not always meet individual needs, with a one-size-fits-all approach that may not take sufficient account of cultural, communication or personal circumstances. They identified variation and gaps in the support available locally.

Help to overcome challenges of connecting with community activities

Participants felt that making social prescribing more visible and easier to access could help people overcome some of these challenges. They emphasised the importance of providing clear information and ensuring that people receive the right support for their individual circumstances.

The role of a Social Prescribing Link Worker and the professionals they should connect to

Participants described a Social Prescribing Link Worker as someone who should be a “people person”: approachable, resilient and genuinely interested in people's

experiences, interests and values. They felt Link Workers should understand their local communities and build strong connections across health, care and trusted community networks. At the same time, they recognised that the role is complex and that Link Workers need appropriate training, resources and support to respond to the different circumstances and needs of the people they work with.

Understanding and trusting social prescribing before referral

Participants wanted to understand why they were being referred, what to expect and how social prescribing would complement, rather than replace, medical care. They also wanted Link Workers to understand their individual circumstances, including the wider barriers that may affect their ability to take part.

Overall, participants saw significant potential in social prescribing, but emphasised that its success depends on more than simply connecting people with an activity. They felt it needs to be accessible, personalised and well connected to the wider health, care and community system, with people supported to make choices that reflect what matters to them and the circumstances of their lives.

We concluded with recommendations for ensuring effectiveness across the following seven areas:

1. Awareness of social prescribing
2. Community activities and services are accessible and inclusive
3. Navigation and information about available support
4. Integration between organisations, activities and services
5. Link Workers have the skills, training and support they need
6. Links between Link Workers and local communities
7. Holistic, person-centred support, giving people choice and control over the support they receive.

Introduction

The National Academy for Social Prescribing (NASP) is a national charity that champions social prescribing by providing training and development, building partnerships and developing the evidence for what works. It supports and connects people, communities and organisations so that more people across the UK can access non-medical support that improves their health and wellbeing. Social prescribing enables people to access non-clinical sources of support in their communities, often through a Social Prescribing Link Worker, based on what matters to them and their individual circumstances.

It commissioned the Patients Association to run two activities: 1) a survey of people who had received social prescribing, followed by 2) a focus group of people who had not received social prescribing. Although the two activities had different purposes, the findings from the survey helped design the questions for the focus group. Findings from both activities will be used to inform NASPs strategy. This discussion with people who have not experienced social prescribing enabled us to explore what they would want social prescribing to look like, and to identify aspects that may already be in place. It is worth noting that although participants had not received social prescribing, they might have had experienced something similar to social prescribing, for example being referred to activities by health professionals.

Ten people from across England and Scotland took part in a 2.5 hour online focus group in August 2026 discussing four questions based around exploring the barriers people may face in accessing community support, overcoming challenges of connecting with community activities, what qualities and skills people would expect from Link Workers, and understanding and trusting social prescribing before referral. The report concludes with recommendations based on the views shared by participants.

Key findings

Challenges for people connecting with community non-medical support and activities for health and wellbeing

As it is widely recognised that social factors, such as housing, debt and loneliness, can have a significant impact on people's health and wellbeing, the group discussed the non-medical support and activities available in people's communities that may improve their health and wellbeing, and what they thought are the challenges for people in being able to connect with these.

Overall, participants described barriers to community activities as being much broader than simply whether someone wants to attend. The discussion showed that a person's ability to connect with community support can depend on both the availability and suitability of the activity and the circumstances of the individual trying to access it. Participants' experiences also highlighted that someone who does not attend an activity may be facing barriers that are not immediately visible, including caring responsibilities, anxiety, accessibility issues or personal safety concerns.

Knowing what support is available and where to go

A key challenge raised was simply knowing where to go for support. One participant described a lack of awareness about where people could find help, particularly for people who may have limited digital skills and therefore cannot easily search online for information. Care home residents were given as one example of people who may face this barrier.

Participants also discussed confusion about the different roles involved in supporting people. They suggested that having a clear contact point would make it easier for people to understand who they should approach and where they can get help.

“I wonder how many people understand... the difference between a Link Worker, the Health and Welfare coach, a care coordinator, and a navigator”

There was also discussion about the lack of awareness of social prescribing itself. One participant who was already involved in community activities questioned how people could access social prescribing through their GP and whether people who were already participating in activities might be overlooked. They said they had never been told about social prescribing through their GP and had instead heard about it through people they met at a swimming session.

“The way I hear about things now is...in the swimming pool, someone will come up to me and say did you know you can get social prescribing sessions, and then they list them all, and that's the first I've heard of it.”

Emotional, social and confidence barriers

Participants described how loneliness, anxiety, stigma and confidence can make it difficult to take the first step into a new activity. One participant noted that people who are lonely or anxious, or who are living with long-term health conditions, may find attending a new group for the first time overwhelming. They suggested that having someone accompany or introduce them could make the experience easier. Another participant described the difficulty of returning after dropping out of an activity. They explained that once someone has stopped attending, it can feel embarrassing to go back, meaning that they may not return even if they would benefit from the activity.

“My issue is more like... when you go to the gym, even when you've paid more money yourself, you've promised yourself to go, you still don't go. And it's when you drop out of a thing, what works... to bring you back in. Because once they do that, then you've got a chance, but almost all of us fail to do it, and then it's kind of embarrassing to go back, or you just don't. And so it's having someone to help you when it goes wrong.”

Participants also identified stigma, both external and internal, as a potential barrier, alongside feeling depressed to have the confidence to attend. Other commitments, including work, could make it difficult to commit to activities that take place over several weeks.

“Feeling, sort of, too, kind of, anxious or depressed to be able to, you know, to have the confidence to go.”

Cultural, communication and personal circumstances

Participants highlighted that some people may face additional barriers because of language, culture or religion. One participant described how people from ethnic minority communities may not know where to find appropriate support and may lack confidence in seeking professional help where there is a language barrier. The discussion also highlighted that people may have concerns about whether they will feel comfortable in an unfamiliar environment. For example, participants discussed how someone who is immunocompromised may be anxious about entering a room full of people they do not know, or about using public transport to get there.

One participant also raised the particular difficulties faced by someone in an abusive or coercive relationship. They noted that being able to leave the house independently may not be possible, and that a person may not feel safe to disclose this to the person referring them to an activity. As a result, someone could appear reluctant to engage when there may be circumstances preventing them from doing so. Participants also raised neurodivergence, with one suggesting that some systems or activities may not be designed in ways that are accessible or meaningful for neurodivergent people.

“If you're immunocompromised, actually launching yourself into a space full of people, or even getting on the transport to get to the place it might feel like you're playing Russian roulette.”

Practical and physical barriers to taking part

A number of practical barriers were identified, including transport, money, caring responsibilities, access to the internet or phones, and the ability to commit regularly. Participants stressed that being referred to an activity does not necessarily mean someone is able to attend it. For example, one participant pointed out that people may need someone to collect their children from school, or may not have enough money for transport. One patient outlined that it is often these everyday practical barriers that can prevent people from accessing the support they need.

“It's the really simple, basic things that actually, if you haven't got anybody to take your children up from school, or you haven't got enough money for transport to get to where you need to get to. It's those kinds of things that [are barriers to social prescribing that] needs to sit alongside other things that can enable that.”

Physical accessibility was another concern. Participants discussed whether activities were held in places that people with mobility difficulties could access, including whether the activity itself, rather than simply the building, was accessible. One participant gave the example of a swimming pool where a hoist used by people who cannot manage the steps was not working. This meant they could not access an activity that they found beneficial, and travelling to another pool was not necessarily possible because of the additional physical demands of the journey.

“I use a wheelchair, and I was thinking about how that impacts, on swimming...at the moment the hoist isn't working, so...The swimming pool is reliant on the hoist for anyone who can't get down the really steep steps”

Activities do not always fit individual needs

A strong point raised in the discussion was that the availability of an activity does not necessarily mean it is suitable for the person being referred. Participants gave several examples of activities being suggested without sufficient consideration of someone's health condition, disability or individual circumstances. One participant described being referred to an exercise course despite walking with crutches, while their wife, who uses a wheelchair, was also being considered for the same course.

"I think the [GP] surgery tends to work on a tick box system for most things, they've sent me to go on a course, for exercise. Fine, except I walk on crutches. So it's not really very easy. And they've just signed up, or tried to sign my wife up, to go on the same exercise course. Do I go along with it to push a wheelchair, or what? ...They don't actually think through for individuals, and I think this is a big drawback."

Another participant discussed their experience of anorexia, explaining that over-exercising had been a symptom of their condition. They said that being directed towards gym classes or food-based activities could therefore be inappropriate and potentially exacerbate the problem. They emphasised the importance of tailoring support and ensuring that the person making a referral understands the individual's circumstances and potential risks. A further participant described being housebound and having difficulties with their legs, but said that their GP could only refer them to physiotherapy, despite their experience that this was not appropriate for their circumstances.

"I've had anorexia, and one symptom is a lot of over exercise...I know people who have been told to go along to gym classes...and actually, it just would be dangerous... One size certainly does not fit all, and I think often the people referring don't understand the nuance. I think it's the things being tailored, and the person referring having enough knowledge of your unique challenges to know this might actually exacerbate the problem."

These examples were linked by participants to a concern about "tick box" approaches, where people may be directed towards a standard activity without sufficient consideration of what would actually work for them. One participant was careful to say that they were not saying this necessarily applied to social prescribing itself, but a wider concern about what patients experience within services.

Variation and gaps in available support

Participants also described differences in what is available depending on where someone lives or which social prescriber they encounter. One participant noted that social prescribing provision can vary considerably, including between different areas within an integrated care board (ICB).

“To my knowledge, it is available nationally, but what you get in each area is very, very different, and can be a bit of a postcode lottery.”

Help to overcome challenges of connecting with community activities

Participants identified a number of ways in which the challenges of connecting with activities to improve one's health (discussed in the first question) could be addressed. Participants described a need for social prescribing to be more visible, better connected and more responsive to individual circumstances. They wanted people to be able to find information easily, understand what support is available and be involved in deciding what is right for them. They also highlighted the importance of up-to-date information about local services, appropriate training for those making referrals, better communication between organisations and ongoing opportunities to review whether support is working.

The discussion also suggested that connecting someone with an activity is not necessarily a single referral or one-off intervention. Participants described the value of practical support, buddying, peer support, volunteering and regular check-ins, particularly where someone is anxious about trying something new or encounters difficulties after they have started.

These findings highlight the importance of seeing social prescribing as a connected process rather than simply a referral to an activity: people need clear information, appropriate choices, support to overcome practical barriers and opportunities to review and adapt their support as their circumstances change.

Making social prescribing visible and easy to access

Participants felt that social prescribing should be promoted in places where people already spend time, rather than relying solely on healthcare settings. Physical community spaces such as GPs and libraries were suggested as places that could help direct people towards social prescribing and other sources of support. Other suggestions included community centres, places of worship, billboards, bus stops and

social media. One participant suggested using Facebook, Instagram and other social media platforms.

“Places like churches and mosques and temples, ... if there's any person who's having problems, the priest or whoever, can talk to the person...and if they have published any leaflets...they can just give it to the person, and they can tell them to contact such and such organisation”

Participants also saw a role for local community organisations in connecting people with opportunities. Examples discussed included local cycling and walking organisations becoming more inclusive, and initiatives that make it possible for people with mobility difficulties to participate in activities in rural areas.

“Around here we've got Sustrans [now called 'Walk Wheel Cycle Trust], that was the cycling charity...looking at wheeling and walking and all sorts of things, not just cycling. So it's... becoming more inclusive and encouraging people as something that people can be social prescribed to. And Miles Without Stiles, which opens up rural areas and Dartmoor, so you can go in your wheelchair and there's not a gate at the end of the path, meaning that you've got to go all the way back again.”

Providing clear information and the right support for the individual

Participants felt that people should be involved in deciding what support is appropriate for them. One participant described inappropriate referrals as potentially becoming a "box-ticking exercise", arguing that a conversation with the individual could help prevent this and ensure the activity is right for them. They also felt that social prescribing should be taken seriously and that people involved in signposting should have appropriate training to identify suitable support. This was linked to the importance of having good, up-to-date information about what is available locally. Participants suggested Social Prescribing Link Workers develop and maintain a directory of services that could be accessed by GPs and community organisations, covering a wide range of services, rather than focusing only on physical health.

Participants also felt that information needs to be understandable. One specifically raised the need to reduce healthcare jargon and for clinicians to communicate in language that patients can understand. They referred to existing jargon-busting resources but felt there was further work to do.

The discussion also highlighted the importance of considering the wider circumstances of the individual when making a referral. For example, if someone has caring

responsibilities, simply referring them to an activity at a particular time may not be enough; someone may need help thinking through who will care for the person they support while they attend.

Joining up services and improving communication

A strong theme was the need for a more coordinated approach. Participants described social prescribing as involving many different organisations and services, including GP practices, gyms and Citizens Advice, and said it can be difficult to understand who is responsible for what.

One participant gave the example of a GP being able to refer someone to Citizens Advice, while Citizens Advice could not book an appointment back with the GP. They described this as a lack of a "feedback loop", where someone can be passed from one service to another without information travelling back with them.

"So you've got: the GP practice...the gym...Citizen's Advice...And it's really hard to find who's in charge of which. So, in social prescribing, it's usually the doctor that starts and has the links to Citizens Advice. But Citizen's Advice can't book an appointment back in the doctors, so there's no feedback loop. So you get passed on to somewhere, but you can't get back, which is, for me, one slight problem."

Another participant described services as often working in isolation. They said that when someone is referred between services, they may have to explain their circumstances and support needs again. Housing and community support groups were given as examples of services that may not be sufficiently connected.

Participants therefore highlighted the importance of cross-communication and better integration, so that responsibility is not simply passed from one organisation to another.

Providing ongoing and flexible support

Participants felt that connecting someone with an activity should not necessarily be the end of the process. Regular check-ins could provide opportunities to review how someone is getting on and make changes if the activity is not working for them. This could also help people who stop attending to re-engage, rather than feeling embarrassed about returning after an absence.

The value of peer support and buddying was also highlighted. One participant described peer support as "hugely beneficial" and suggested that having someone accompany a

person to an activity, particularly for the first few visits, could make attending feel less intimidating.

“The idea of maybe having a buddy system, somebody to go with you to these things, even if not every time...just the first couple of times, so that it is that little bit less intimidating...it's just somebody to...support you.”

Volunteering was another example of an activity that participants felt could provide meaningful support. One participant described volunteering as particularly valuable because it allowed them to make a commitment that could fit around their circumstances, while volunteers treated them like everyone else rather than requiring them to disclose or focus on their problems. They also valued the opportunity to get out, meet people and contribute to something that benefited others.

Participants also suggested that social prescribing should not necessarily be limited to activities traditionally associated with health and wellbeing. Volunteering and peer support could provide different but complementary forms of support.

“Just doing volunteering with the local groups, it actually does you good, as well as benefiting everyone else. And so, that for me, was a real help.”

Practical issues around accessing activities were discussed, and one participant suggested that the responsibility should not always fall on the individual to work out how they will travel to an activity, whether they can afford it or what happens if a bus route changes. Better communication between services could help identify these problems and respond to them.

“With transport, ...if you are referred for something... the onus isn't on you to work out how you're going to get there, can I afford to get there, if that bus route is suddenly diverted, has anyone else picked up on the fact that actually you can no longer get there because that bus doesn't go there anymore?...There are so many layers in terms of accessibility”

Participants also highlighted the importance of feedback from patients about whether support is actually working. One described a tendency for someone to be referred to an activity and then effectively considered "sorted". They suggested regular opportunities to discuss whether the activity was useful, whether unexpected challenges had emerged and whether something else might be more appropriate.

The role of a Social Prescribing Link Worker and the professionals they should connect to

Participants described the ideal Social Prescribing Link Worker as empathetic, non-judgemental, genuinely interested in people and their individual circumstances, well trained and well connected to their local community. They felt the role should involve listening and understanding what matters to each person, rather than simply matching people with a standard list of activities.

However, participants also questioned whether it is realistic to expect one individual to possess all the knowledge, skills and connections needed to support the full range of issues that people may bring to social prescribing. Instead, they described a need for Link Workers to be part of a wider, well-resourced network, bringing together healthcare professionals, charities, community organisations, local services and trusted community figures.

The discussion therefore suggests that the effectiveness of a Link Worker may depend not only on who the individual is, but also on the network around them: whether they have the training, time, resources and relationships needed to connect people with the right support. Participants also highlighted the potential value of widening routes into social prescribing beyond GP practices, including through hospitals, community organisations and trusted community networks.

The qualities and skills of a good Link Worker

Participants placed considerable emphasis on the personal qualities of the person undertaking the role. They described an effective Link Worker as someone who is empathetic, caring, approachable, resilient and genuinely interested in people's experiences, interests and values. Being a "people person" was seen as particularly important, including someone who is embedded in and understands their local community. One participant described the ideal person as someone who is active and respected in their community, approachable, motivating and encouraging, while also being able to communicate effectively with health and social care professionals.

“[A social prescriber should be] someone who's very much a people person, and I had the absolute pleasure of working with somebody like this...what made her so special? She was very much a people person...really embedded, active in her community, respected, had built up those relationships over time, and was a real doer, but was really approachable. Motivating, encouraging, that ability to be able to...communicate with health and social care professionals, but also able to speak to the most vulnerable members of society and adapt

their approach...accordingly. I think ultimately has genuine care and understanding, and is non-judgmental of the challenges”

Participants also stressed the importance of listening and recognising that one size does not fit all. A Link Worker should be willing to understand what matters to an individual rather than assuming that a particular activity will be suitable for everyone. One participant described the need for "genuine creative interest" in people's interests and values, alongside the ability to think creatively when conventional activities are not appropriate.

Being non-judgemental was another important quality. Participants wanted someone who could understand the challenges people face without making judgements about them. They also suggested that some of these qualities cannot simply be taught through training, but are characteristics of the individual themselves.

Training needs to reflect the complexity of people's lives

Alongside personal qualities, participants felt that Link Workers need appropriate and sufficiently comprehensive training. Trauma-informed practice was highlighted particularly strongly. One participant was concerned that training on trauma-informed care can sometimes be limited to a short session, rather than providing the depth of understanding needed to recognise and respond appropriately to people's vulnerabilities and previous experiences.

“I think being trauma-informed is really important, and I have a bit of a fire in my belly about this, because so often, organisations offer training so people can become trauma-informed, and it's a 3-hour workshop...but (we need people to be) properly trauma-informed...Rigorously trained and really mindful of the vulnerabilities and trauma that people have that are likely to be using these services.”

Participants also highlighted the importance of communication skills and having access to the tools needed to overcome language barriers, including interpreters, translators and technology.

Strong connections across health, care and the community

Participants described the role as needing to be well connected across a wide range of organisations and services. Suggestions included GPs and other healthcare professionals, pharmacists, dentists, social services, charities, local activity organisations, Citizens Advice and food banks. Participants felt that Link Workers could help bring together organisations that currently work separately. One participant

described how community organisations can sometimes compete for funding, meaning that they may be reluctant to refer people to another organisation. They felt that a Link Worker should have the empathy and resilience to overcome this competition, encouraging organisations to work together and ensuring that the person's needs come before organisational interests.

“Areas of society where you get the full cross-section of people...people are told to reach out for support... but I think that ... knowing the local community inside out, so that there aren't these pockets and gaps that people fall into. I think a Link Worker...really has to have that sense of the wider context, both in terms of people and their lives and their families, but the context of the community and all the different threads that run through it.”

This was linked to a wider concern that one person cannot realistically hold all the knowledge required to support every individual. Participants suggested that the role should therefore be supported by a wider network of people and organisations with different areas of expertise. One participant described the need for someone who works directly with individuals alongside another person or function focused on the organisational side of connecting services and expertise.

Another participant similarly described the ideal situation as having "a whole rack of people to call upon", so that the Link Worker does not need to personally know everything but can identify who has the relevant expertise. They again emphasised the importance of having someone who is a "people person" and embedded in the community.

Participants also suggested that Link Workers need to be well resourced and supported if they are expected to maintain these relationships and connections. There was a recognition that the breadth of the role could otherwise become unrealistic.

Working with trusted community networks

A particularly strong theme was the potential role of trusted people within communities. One participant suggested that religious leaders could be trained to signpost people to appropriate services because, in some communities, they may be an important first point of contact and may be trusted with concerns that people do not feel comfortable discussing with healthcare professionals. They described religious leaders as providing emotional, physical and other forms of support to their congregations. The same participant suggested that community leaders could also be trained to identify appropriate services and provide accurate information to the people they support.

This suggestion was not viewed as applying equally to every community, however. Participants recognised that levels of community connection vary, and one participant questioned whether religious leaders would have the same role in areas where fewer people attend places of worship. Another participant suggested that there are many other people within communities who already have relevant expertise, such as those working in Citizens Advice, and that these existing resources should also be better connected. The discussion therefore pointed towards a broad network of trusted community organisations and individuals, rather than relying on one particular type of community leader.

“She's saying we should train up religious leaders...which I think is good. On the other hand, we've got lots and lots of other people in the communities who've got these resources, and we're sometimes not using them...I work with Citizens Advice...those people have to be empathetic. They have to help with housing issues...immigration issues...all these different intersecting issues. ... I just think, possibly, we're asking too much of this one person, given that there's so many things from disability, mental health, physical.”

Social prescribing should not necessarily rely solely on GP practices

Participants also questioned whether GP practices should remain the main route into social prescribing. One participant argued that GPs should not necessarily be the "gateway" to everything, and suggested that a Link Worker could potentially be an earlier point of contact within the health service.

Others pointed out that people may have much more contact with hospitals or community organisations than with their GP. One participant described regularly attending hospital but rarely seeing their GP, and said they had never been offered social prescribing through their hospital experience.

Participants suggested that community organisations could also have a role in identifying people who might benefit from social prescribing. For example, someone attending a singing group or other community activity could potentially be referred to social prescribing if they needed additional support.

“I go to singing for wellness, which is for people with respiratory disease. It would be really useful if (Social Prescribing Link Workers) could refer, so there's such a variety out there.”

There was also a suggestion that information about social prescribing could be incorporated into digital platforms used by patients, such as patient apps, so that

people could encounter information about it outside a traditional GP appointment.

“The main thing is the NHS app. Can it not be part of that?... a poster thing in there, or, you know, something that someone can click on.”

The role needs to balance connection with independence

There was some discussion about the potential tension between locating Link Workers within GP practices and allowing them to operate more independently in the community. One participant felt that being based within a surgery could risk creating a "tick box" culture, where the focus becomes the number of people seen rather than the time spent understanding an individual's circumstances.

At the same time, participants recognised that there needs to be somewhere accessible for people to find and contact a Link Worker. This led to a broader discussion about whether the role needs to be connected to primary care without necessarily being limited by it.

Understanding and trusting social prescribing before referral

In a recent Patients Association survey, patients who had previously received social prescribing support told us they felt the service was poorly understood before they had been referred. Participants wanted social prescribing to be clearly explained, personalised and taken seriously, with people involved in decisions about whether it was right for them. They wanted to understand why they had been referred, what they could expect and how social prescribing would work alongside other care. Trust was also closely linked to the quality of the relationship with the Link Worker, including empathy, confidentiality, reliability and continuity. Participants emphasised that these conversations need to take account of people's wider circumstances and potential barriers, rather than assuming that the same activities or approach will work for everyone.

Clear information about the referral and what to expect

Participants wanted clear, practical information before their first appointment. This included knowing what social prescribing is, what they were being referred for, why it had been recommended, where and when the appointment would take place, and how it was expected to benefit them. One participant said:

“I personally would want to know everything. I'd need to know exactly what it was that I was being referred for, what it was, where it was, when it was, and how it was anticipated to benefit me.”

Participants also suggested that providing information in advance could help people [prepare for an appointment](#). One person suggested having something similar to a calendar or information sheet beforehand, allowing people to consider what they might want to discuss and prepare questions. They felt that going into an appointment without information could mean only thinking of important questions afterwards.

There was also a desire for greater clarity about the practical aspects of support. This included what services or activities might be available, how long support or subsidised activities would last, whether there would be any costs, and what would happen after the initial support ended.

Confidence that social prescribing complements, rather than replaces, medical care

Participants wanted reassurance that social prescribing would complement medical treatment rather than replace it. One participant specifically said they would want to be certain that being referred to social prescribing did not mean losing access to other medical treatment or being removed from a waiting list. They wanted both forms of support to remain available where appropriate.

“I would want to be absolutely sure that I wasn't being prescribed as an alternative to medical treatment, or that it wasn't an either-or, and it's like... well, she's had social prescribing, so we won't put her on this waiting list for this other treatment... I would want to really be very sure that both streams were open to me, and that one didn't exclude the other.”

There was also a strong view that social prescribing should be taken seriously. One participant felt that there should be adequate time for a proper conversation about someone's circumstances, what might benefit them and why, rather than social prescribing being treated as a quick referral.

Understanding the individual, rather than making assumptions

Participants emphasised that trust would depend on the person making the referral understanding their individual circumstances. This was particularly important for people living with multiple or complex conditions, where an activity that might be beneficial for one person could be inappropriate for another. One participant said they would want the person making the referral to understand not only their conditions, but how they

experienced those conditions and the practical impact they had on their life. They felt that an inappropriate referral could do more harm than good and damage trust in both the individual professional and services more generally.

Participants also discussed the importance of being believed and listened to. One participant described experiences of being told that their symptoms were anxiety when they subsequently received treatment for an infection, and another participant referred to experiences of not being believed about their health problems. These experiences contributed to a desire for social prescribing to be personalised and for people's circumstances to be taken seriously.

“If you've got multiple overlapping conditions, complex conditions, you're already spending a lot of your time and energy going to six or seven different consultants, or...following certain pathways that you've been prescribed. So you want to know... what the value-added aspect is of the social prescribing. You want to be sure you're not being pushed towards social prescribing because they...don't really believe that you've got a rare condition... you want to be sure that they're thinking about your overall well-being.”

Trust, empathy and continuity

The relationship with the Social Prescribing Link Worker was seen as particularly important. Participants said they would need to be able to trust the person supporting them, feel that they were empathetic and know that information shared with them would be treated confidentially. Reliability and continuity were also important, with one participant saying that having the same person wherever possible would allow a relationship to develop.

Participants also wanted opportunities for ongoing review rather than being referred to an activity and then left to manage it alone. Regular check-ins could provide an opportunity to discuss whether an activity was working, whether there were any difficulties and whether another option might be more suitable.

Understanding the wider circumstances and potential barriers

Participants highlighted that people may have concerns about the practical consequences of taking part in social prescribing. For example, one participant raised concerns about the implications of attending activities or appointments for employment and benefits, including whether participation in activities such as swimming could be misunderstood when someone was being assessed for PIP. They felt these wider considerations needed to be understood rather than assuming that participation in an activity meant someone's health problems had been fixed.

“And if I'm going to a social prescribing appointment that takes me away from work, am I then going to get punished for it? Because...disabled people are being told we don't work when we do, and so if it goes on your PIP form...I've gone swimming...you then get punished for it, because...in their eyes, you're then fit.”

There were also questions about how social prescribing could respond to wider issues such as housing. Participants recognised the value of social prescribing but stressed that it could not be expected to resolve wider societal problems on its own. This led to discussion about the resources available, the role of community organisations and the choices that have to be made about who social prescribing can support and how much time can be offered to each person.

Awareness, accessibility and who provides the service

Participants felt that increasing awareness of social prescribing should be a priority. They also wanted people to have confidence that the service was credible and accessible to them, including knowing who provides it and what support is available for people with similar circumstances.

The discussion also highlighted the importance of having Social Prescribing Link Workers from a range of backgrounds. Participants suggested that greater diversity among Link Workers could help them communicate with and understand people from different communities, including where language may otherwise create a barrier. The importance of linking services together was raised, creating more straightforward referral pathways so that people do not face lengthy waits after being referred.

“Empowering [Social Prescribing Link Workers] in areas that can support people better, and having diverse social prescribers... a lot of people have different challenges and support needed, and the challenge is ... meeting someone that can actually speak the language that they speak. And it becomes useless if they can't actually help someone.”

Participants also raised the potential role of social prescribing for children and young people, noting that although some children already participate in activities such as sports, clubs or Scouts, these opportunities may not work for everyone. They felt this was an area worth considering further.

Conclusion

This discussion with people who have not experienced social prescribing enabled us to explore what they would want social prescribing to look like, and to identify aspects that may already be in place.

Participants highlighted that simply knowing what support is available can be a challenge for people trying to connect with community support and activities that could benefit their health and wellbeing. Even when people are aware of what is available, there can be practical and physical barriers to taking part, alongside emotional, social and confidence-related barriers to joining a new activity. Participants also felt that activities do not always meet individual needs, often with a one-size-fits-all approach that may not take sufficient account of cultural, communication or personal circumstances. They also identified variation and gaps in the support available locally.

Participants felt that making social prescribing more visible and easier to access could help people overcome some of these challenges. They emphasised the importance of providing clear information and ensuring that people receive the right support for their individual circumstances. Joining up services and improving communication were also seen as important, as was providing ongoing and flexible support rather than simply making a referral and leaving the individual to manage on their own.

Participants described a Social Prescribing Link Worker as someone who should be a “people person”: approachable, resilient and genuinely interested in people's experiences, interests and values. They felt Link Workers should understand their local communities and build strong connections across health, care and trusted community networks. At the same time, they recognised that the role is complex and that Link Workers need appropriate training, resources and support to respond to the different circumstances and needs of the people they work with.

The Patients Association's recent survey found that social prescribing was poorly understood by many people before they were referred. In this discussion, participants reinforced the importance of trust, empathy, continuity and clear information in helping people understand social prescribing and feel confident that it is right for them. They wanted to understand why they were being referred, what to expect and how social prescribing would complement, rather than replace, medical care. They also wanted Link Workers to understand their individual circumstances, including the wider barriers that may affect their ability to take part.

Overall, participants saw significant potential in social prescribing, but emphasised that its success depends on more than simply connecting people with an activity. It needs to be accessible, personalised and well connected to the wider health, care and community system, with people supported to make choices that reflect what matters to them and the circumstances of their lives.

Recommendations

Ensure effectiveness across the following seven areas:

1. Awareness of social prescribing

Make social prescribing more visible and easier to understand, so that people know what it is, who it is for and how they can access it. Information should be available through a range of trusted settings and community networks.

2. Community activities and services are accessible and inclusive

Work with community organisations and providers to ensure activities and services are welcoming and accessible to people with different needs, backgrounds, and circumstances, including addressing physical, financial, cultural, communication, transport and confidence-related barriers to participation.

3. Navigation and information about available support

Ensure people receive clear, accessible and up-to-date information about the activities and services available to them, including what to expect, who will be there and how they can access them. People should also have a clear point of contact to help them navigate support where needed.

4. Integration between organisations, activities and services

Ensure effective communication and collaboration between social prescribing, health and care services, community organisations and other sources of support, such as housing and financial advice. This should include appropriate feedback and follow-up between services so that people do not become lost between organisations and problems with support can be identified and addressed.

5. Link Workers have the skills, training and support they need

Link Workers should have the interpersonal skills, empathy and understanding needed to build trusting relationships with people, alongside knowledge of their local communities and appropriate professional training, including trauma-informed practice. They should also be adequately resourced and supported to carry out the breadth of their role.

6. Links between Link Workers and local communities

Ensure strong relationships between Link Workers and local community organisations, groups, leaders and trusted networks so that Link Workers understand what is available locally and communities can help identify and respond to gaps in support.

7. Holistic, person-centred support, giving people choice and control over the support they receive

Ensure social prescribing considers the whole person, including their health, wellbeing, circumstances, priorities and individual barriers, rather than offering a one-size-fits-all approach. Social prescribing should complement, rather than replace, medical care, with clear understanding of the role it plays alongside other services. This should include appropriate follow-up and flexibility where people's circumstances or needs change.

Appendices

Questions discussed in the focus group

Participants were provided with these in advance.

1. It is widely recognised that social factors (such as housing, debt and loneliness) can have a significant impact on people's health and wellbeing. Thinking about the non-medical support and activities available in people's communities that may improve their health and wellbeing, what do you think are the challenges for people in being able to connect with these?
2. What would help to overcome these challenges of connecting with community activities to improve health and wellbeing?
3. A Social Prescribing Link Worker is a role, often in GP surgeries, which helps people to connect with non-medical support, based on what matters to the individual, to improve their health and wellbeing. You may have heard of social prescribing before. What do you think that role would need to be like (e.g. the qualities, skills, type of support they offer) and which professionals do you think they should be connected to?
4. In a recent survey, led by the Patients Association (mentioned above), with people who had received this support, they told us that social prescribing was poorly understood before referral. Do you think this would matter to you and what would you need to know about this type of service for you to trust that it was right for you?

Demographics

Amongst our ten participants, four were aged 25-49 years, three 65-79 years, two 50-64 years, and one preferred not to say.

Of the five men and five women, seven were heterosexual, two were gay men, and one lesbian.

Seven were White -English/ Welsh/ Scottish/ Northern Irish/ British, one was Asian Chinese, one Black African, and one Asian Indian.

Four were Christian, two had no religion, two were Quaker, one was Muslim, and one a Buddhist.

In terms of household income, six stated £10-20k, four £40-50k, four preferred not to say, two £20-30k, one below £10,000.

Two lived in the North West, two in the South East, one Scotland, one East Midlands, one London, one North East, one South West, and one Yorkshire and Humberside.

Eight had a disability, all had at least one mental or physical health condition, and four were carers.

The Patients Association

The Patients Association is an independent charity campaigning for improvements in health and social care for patients.

Our vision is a health and care system where patients get the care they want and need, when they need it, and where their voices shape how that care is designed and delivered.

Our mission is to amplify patient voices and ensure they are heard, acted on and embedded in how healthcare is delivered. We listen to patients, translate their experiences into evidence, and use that evidence to influence policy, hold systems to account, and drive real and lasting improvements in care.

Membership of the Patients Association is open to anyone interested in health and social care. If that's you, we'd love you to be a part of our growing community - [Join us today](#).

Our [helpline](#) is free and available to anyone with a question about their care or that of a loved one. You can contact our helpline advisers by email or phone (details below).

To support our work, [visit our website](#).

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