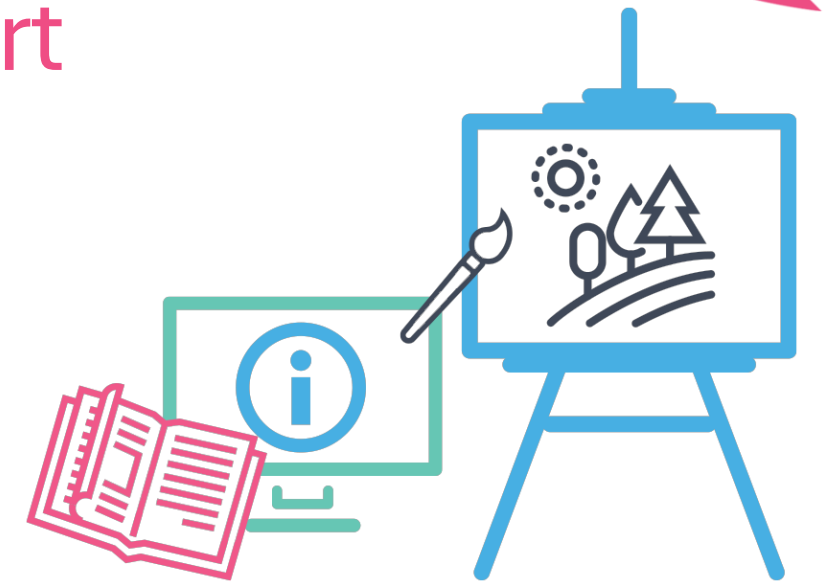
National Academy for Social Prescribing

Social Prescribing Link Worker Survey 2026 – Full Report

Prepared for NASP by Kate Sewel

May 2026



CONTENTS

Introduction

- This document presents findings from the 2026 Social Prescribing Link Worker Survey.
- The survey was administered by the National Academy for Social Prescribing (NASP).
- Similar surveys were administered by NHS England in 2022 and 2023, and NASP in 2025. Where appropriate, comparisons with these surveys are provided.
- Social Prescribing Link Workers (SPLWs) who hold a caseload and are based in England were invited to complete the online survey.
- The survey focused on service configuration, day-to-day role, training needs, workforce challenges, and data recording & outcome measurement practices.
- The questionnaire was live 11 February – 12 March 2026.
- 385 Social Prescribing Link Workers (SPLWs) submitted completed surveys
  - Every region and all but two ICSs represented in responses
  - 210 ‘PCN SPLW’ & ‘175 Other SPLW’.

Overview

- The findings paint a picture of social prescribing as an effective universal service, with link workers key to enabling positive change
- SPLWs remain highly motivated, see their work as meaningful, and have a strong sense of impact and job satisfaction.
- The workforce is becoming more established and stable, with most SPLWs in permanent roles, and over three-quarters having more than two years' experience.
- While social prescribing is embedded within the primary care infrastructure, SPLWs still feel that they face challenges in recognition and understanding of their role.
- SPLW are operating as a frontline response to social need, often supporting those with complex needs or in crisis rather than preventative, community-based intervention.
- Caseload pressure remains substantial – around 2 in 5 SPLWs report annual caseloads above the NHSE recommended maximum, with many describing increasing complexity alongside an overstretched system with limited capacity within statutory services and VCFSE community provision.
- Wider system barriers, particularly in mental health, housing, and social care, are constraining the impact of social prescribing. Coupled with this, SPLWs consistently report that lack of provision to refer to, and long waiting times limit their ability to secure appropriate support for patients.
- Awareness of career pathways and progression opportunities remain low, and training inconsistent, which may present challenges to professional identity, longer-term retention, and workforce sustainability, and limit effectiveness in more complex cases.
- Reflecting current practice, SPLWs identify particular training gaps in relation to supporting clients with mental health needs, and navigating complex systems (e.g. welfare, finance, and housing). Improving alignment of training to the reality of delivery could improve consistency and workforce retention, and will be key to sustaining positive patient/client outcomes and impact.
- Outcomes measurement remains varied and inconsistently embedded – with fragmented tools, irregular data capture, and limited use of data to drive decision-making. Lack of standardisation and inconsistent data capture creates data gaps and reduces the ability to fully demonstrate impact and value. Strengthening data collection tools, processes, and infrastructure will be key to generating meaningful insight and influence.

Sample Profile

Characteristic	Response Option	No. of respondents (n)	Proportion of sample (%)
Total	**ALL**	**385**	**100**
Gender	Man	49	13
	Woman	322	84
	Not listed/Prefer to self-define	1	0.26
	Prefer not to say	10	3
	Missing	3	0.78
Age	Under 18	-	-
	18-24	8	2
	25-34	66	17
	35-44	78	20
	45-54	113	29
	55-64	97	25
	65+	10	3
	Prefer not to say	8	2
	Missing	5	1
Ethnicity	White	306	79
	Asian/Asian British	22	6
	Mixed or Multiple	13	3
	Black/Black British	11	3
	Not listed/Prefer to self define	5	1
	Prefer not to say	25	6
	Missing	3	0.77
Disability	No	314	82
	Yes	46	12
	Prefer not to say	21	5
	Missing	4	1

Service Information

Service Information - Summary

1. How services are structured

- SPLW employment is largely PCN-based, with a slight shift away from VCFSE employers
- Most SPLW are in substantive roles (predominantly permanent, full-time)
- The SPLW workforce is becoming increasingly experienced, with the majority in role for 2+ years
- Teams vary significantly: while many work in larger teams, a notable minority work alone.

2. How services operate

- Services are typically universal rather than targeted, with few cohort-specific models
- Where targeted, focus is mainly on mental health and long-term conditions
- Around half of SPLWs report their PCN or social prescribing service offering proactive social prescribing
- Access to SPLWs is generally timely, with most patients/clients seen within 4 weeks.

3. System integration & awareness

- There is variation in how social prescribing is integrated with wider systems:
  - Only around half of SPLWs report connection to neighbourhood health structures
  - High levels of uncertainty suggest limited visibility or communication in this regard

4. Funding & sustainability context

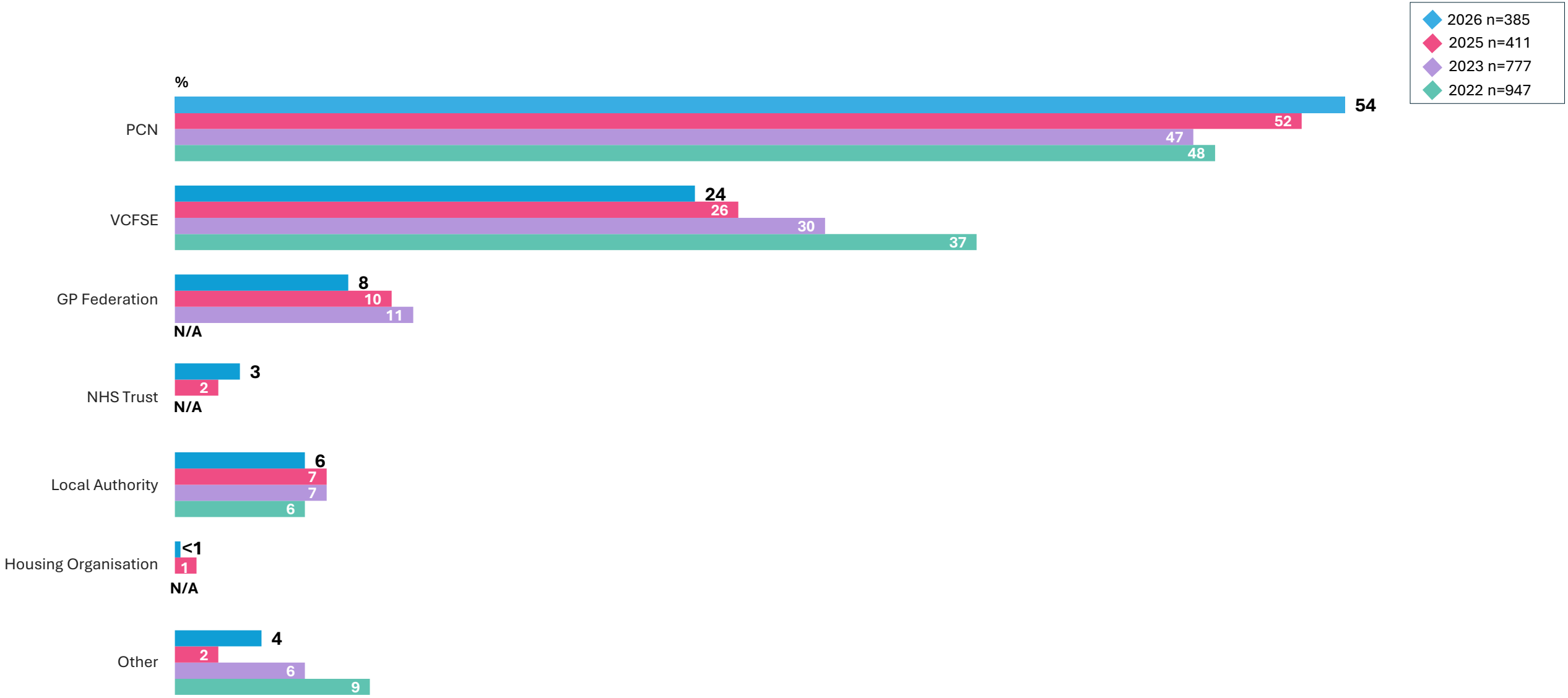
- Funding is dominated by ARRS (sometimes combined with other sources)
- Funding models remain largely unchanged compared to 2025
- Services generally report overall stability, with some signs of growth but ongoing uncertainty about future direction.

5. What shapes delivery

- Social prescribing is becoming an established part of primary care infrastructure, but not yet fully system-integrated
- Variation in team size, service model, and system awareness creates uneven delivery experiences
- Stability in workforce and funding supports continuity, but uncertainty and fragmentation may limit future development.

Q. Which of the following best describes your role? Employed by...

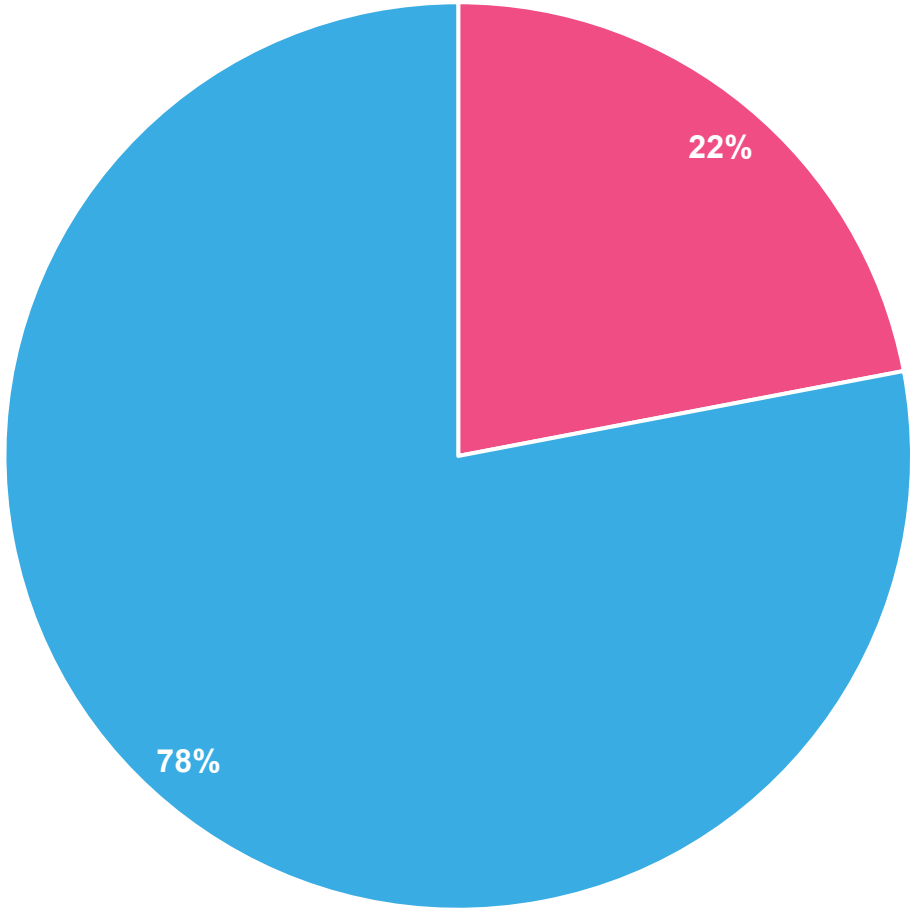
- Overall, figures have remained relatively stable between 2025 and 2026.
- The slight increase in SPLWs employed directly by PCNs coupled with the slight decrease in VCFSE employment may indicate a gradual shift toward PCN-based employment and a reduced role for the voluntary sector as an employer of SPLWs.

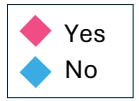


Q. Are you a SPLW Team Lead, SPLW Manager, or Senior SPLW?

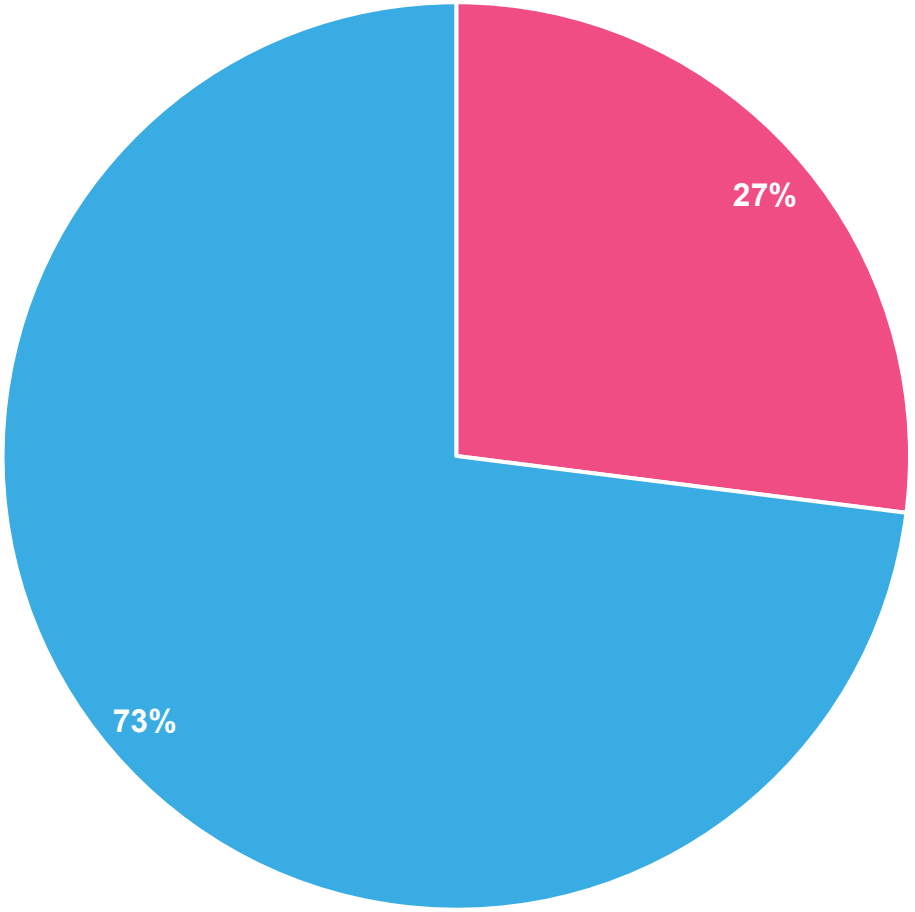
- Around 1 in 5 respondents are a Team Lead, Manager, or Senior Manager; a slight decrease on the 2025 figure.

2026
(n=385)





2025
(n=411)



(n=385)

NORTH WEST ICS	55	14%
Cheshire & Merseyside	37	10%
Greater Manchester	7	2%
Lancashire and South Cumbria	11	3%

MIDLANDS ICS	93	24%
Birmingham and Solihull	4	1%
Black Country	9	2%
Coventry and Warwickshire	6	2%
Derby and Derbyshire	5	1%
Herefordshire and Worcestershire	6	2%
Leicester, Leicestershire and Rutland	16	4%
Lincolnshire	17	4%
Northamptonshire	6	2%
Nottingham and Nottinghamshire	14	4%
Shropshire, Telford and Wrekin	9	2%
Staffordshire and Stoke on Trent	1	<1%

SOUTH WEST ICS	42	11%
Bath and North East Somerset, Swindon and Wiltshire	6	2%
Bristol, North Somerset and South Gloucestershire	5	1%
Cornwall and the Isles of Scilly	5	1%
Devon	7	2%
Dorset	5	1%
Gloucestershire	10	3%
Somerset	4	1%

LONDON ICS	45	12%
North Central London	2	1%
North East London	16	4%
North West London	4	1%
South East London	16	4%
South West London	7	2%

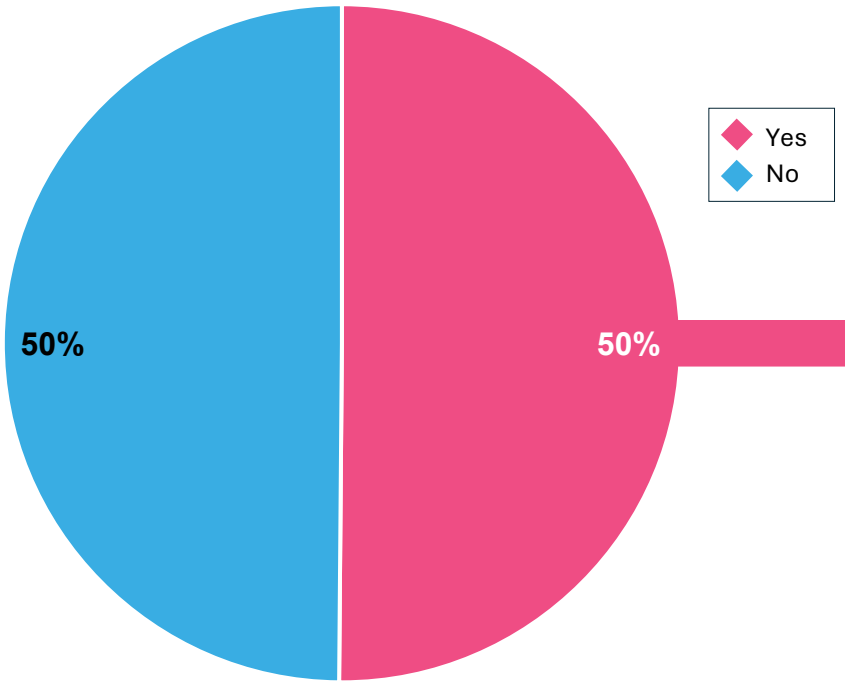
NORTH EAST AND YORSKHIRE ICS	65	17%
Humber and North Yorkshire	12	3%
North East and North Cumbria	31	8%
South Yorkshire	3	1%
West Yorkshire	19	5%

EAST OF ENGLAND ICS	38	10%
Bedfordshire, Luton and Milton Keynes	-	-
Cambridgeshire and Peterborough	10	3%
Herefordshire and West Essex	9	2%
Mid and South Essex	3	1%
Norfolk and Waveney	7	2%
Suffolk and North East Essex	9	2%

SOUTH EAST ICS	47	12%
Buckinghamshire, Oxfordshire and Berkshire West	14	4%
Frimley	-	-
Hampshire and the Isle of Wight	12	3%
Kent and Medway	3	1%
Surrey Heartlands	8	2%
Sussex	10	3%

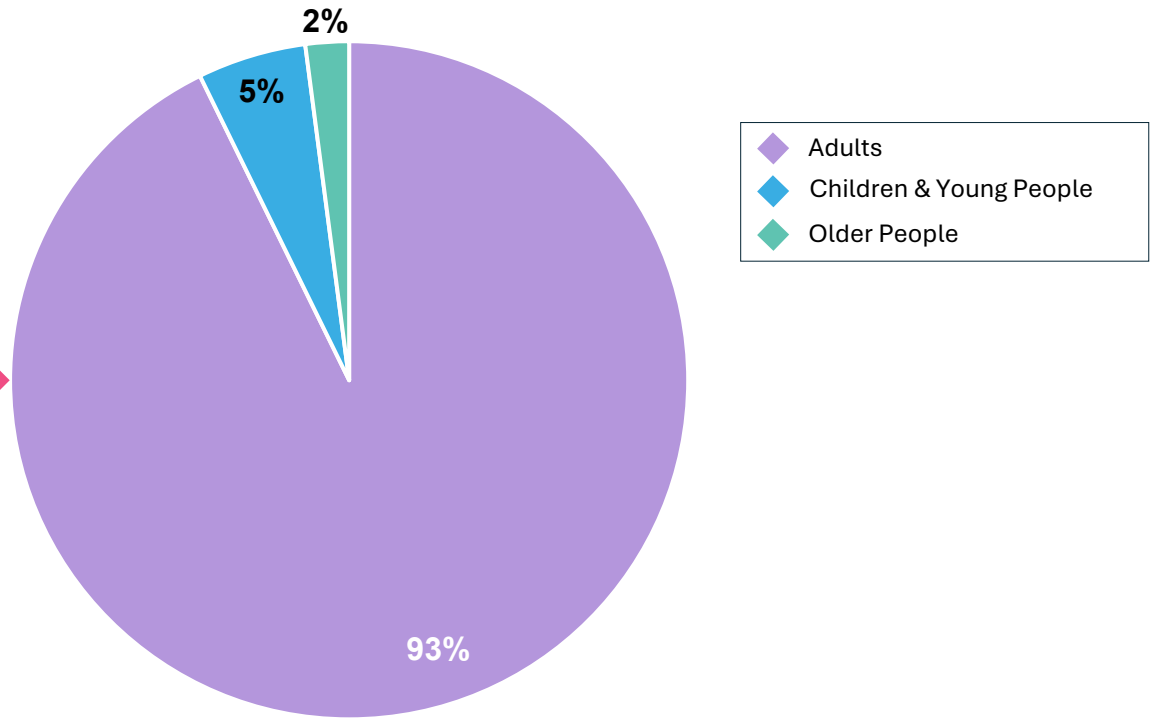
- Services are evenly split, with 50% set up to support a specific age group and 50% not restricted by age.
- Where services are age-specific, they are predominantly adult-focused, with limited provision specifically tailored to children and young people or older populations.

Q. Is your service set up to support only a specific age group? (n=385)



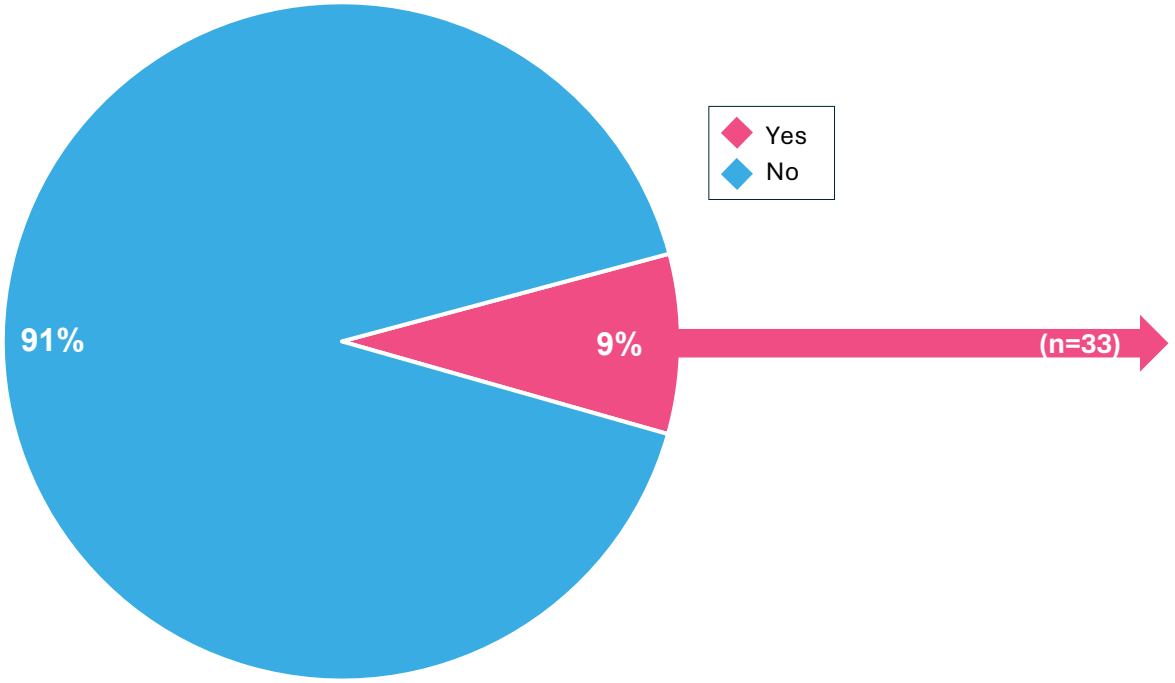
(n=193)

Q. What age group does your service support?



- The vast majority of services are <u>not</u> cohort-specific; only around 1 in 10 SPLWs indicate that their service focuses on a specific cohort.
  - This suggests that social prescribing services tend to be universal, rather than targeted at particular populations.
- Among services that support a specific cohort, mental health is the most common focus, followed by dementia, cancer, and CVD.
  - This suggests that where services are cohort-specific, they tend to prioritise clinical and high-need populations, particularly mental health and long-term conditions.

Q. Is your service set up to support only a specific cohort of patients/clients? (n=385)

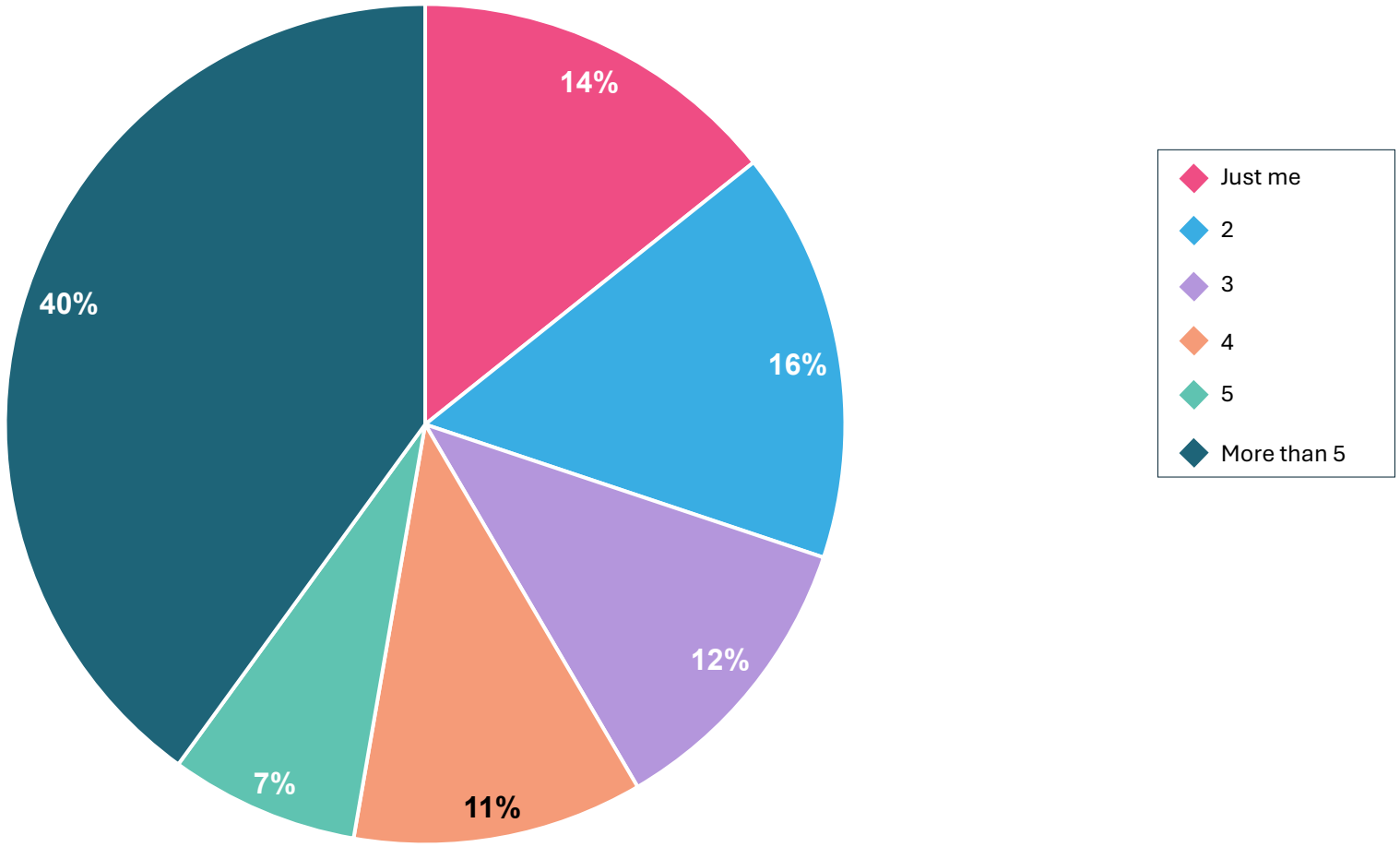


Q. If yes, please select the category below that best describes the eligibility criteria of your service

Cohort	n
Mental health problems	5
Dementia	4
Cancer	3
Cardiovascular disease	3
Long-term conditions	2
On a waiting list for surgery/procedure	2
People facing financial hardship	1
Severe mental illness	1
Chronic respiratory disease	1
Armed forces community	1
Veterans	1
People in social housing	1
Recovery services	1
Sensory	1
Sickle Cell and Thalassemia	1
Students and their dependents 18+	1
Nutrition problems	1
Loneliness & socially isolated	1
Complex medical and social issues	1
All migrants/non-English speakers	1

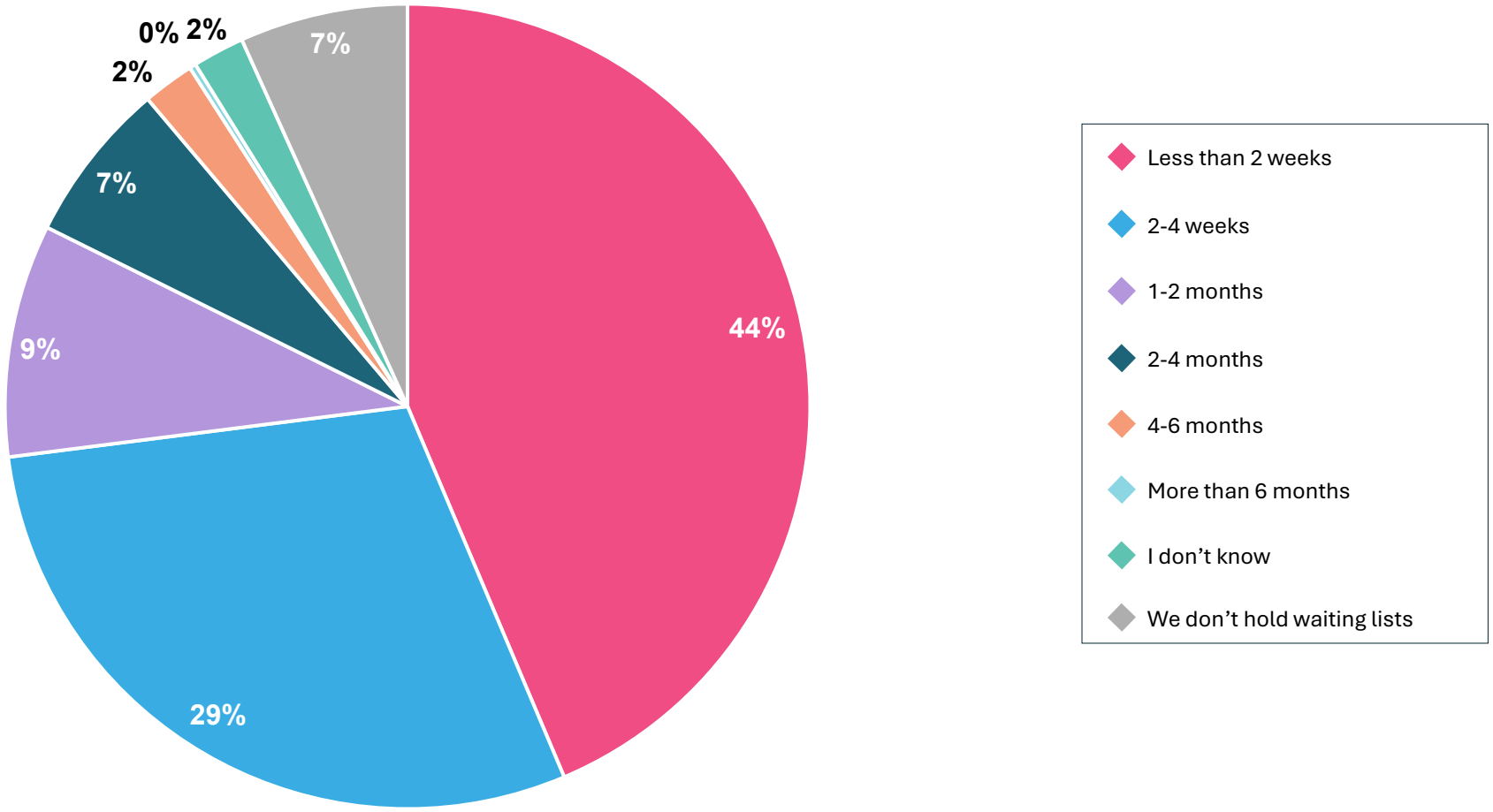
Q. How many SPLWs are employed within your social prescribing service? (n=385)

- Around 2 in 5 SPLWs report teams of more than 5 SPLWs, with most working with at least 1 other SPLW
- A minority (14%) report working as the sole SPLW in their service, which may have implications for aspects such as capacity and peer support.



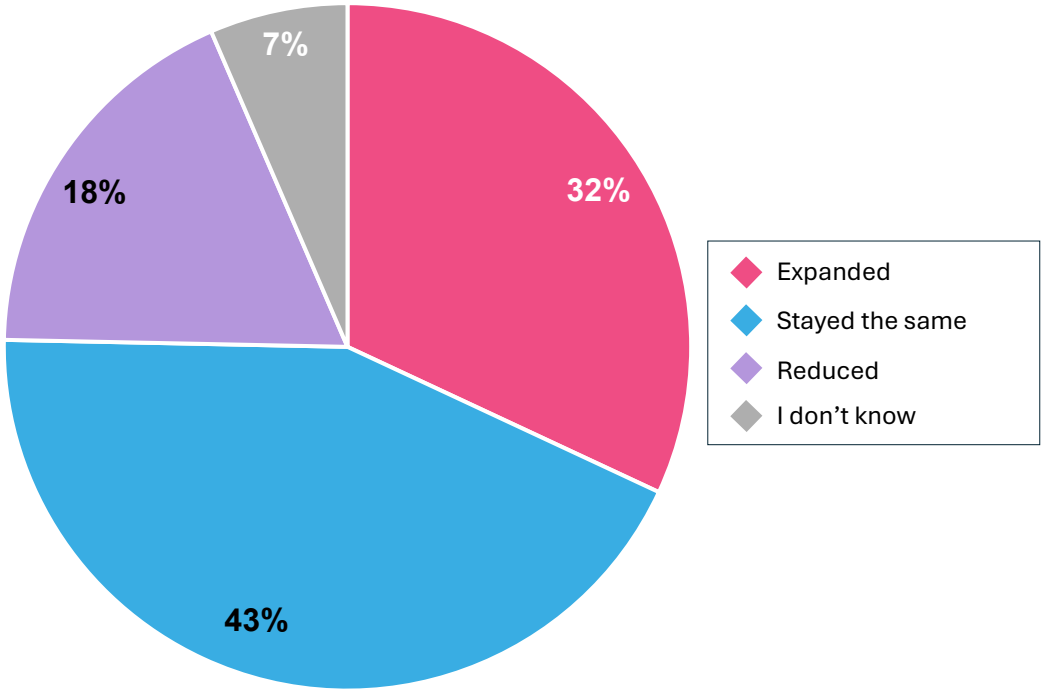
Q. On average, how long do people stay on a waiting list for your service? (n=385)

- SPLWs report that access to their service is generally relatively timely, with almost three-quarters of those referred seen within 4 weeks, although a minority of services experience longer delays, with 16% reporting waits exceeding 1 month.
- Very few report extended waits over 4 months (2%).
- Some services don't operate waiting lists (7%).

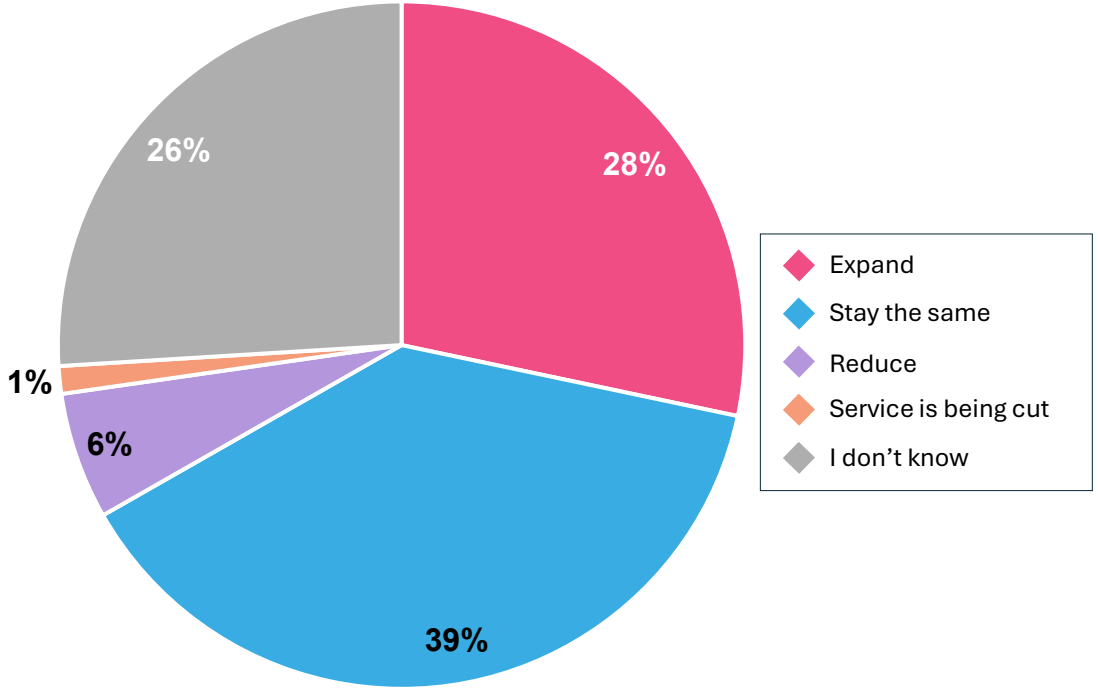


- Over the last year, social prescribing services appear to have remained relatively stable, with potential signs of growth.
- Expectations for the next year point to continued stability with some growth, but the relatively high level of uncertainty suggests future direction remains unclear for many SPLWs/services.

Over the last year, has your social prescribing service…
(n=385)

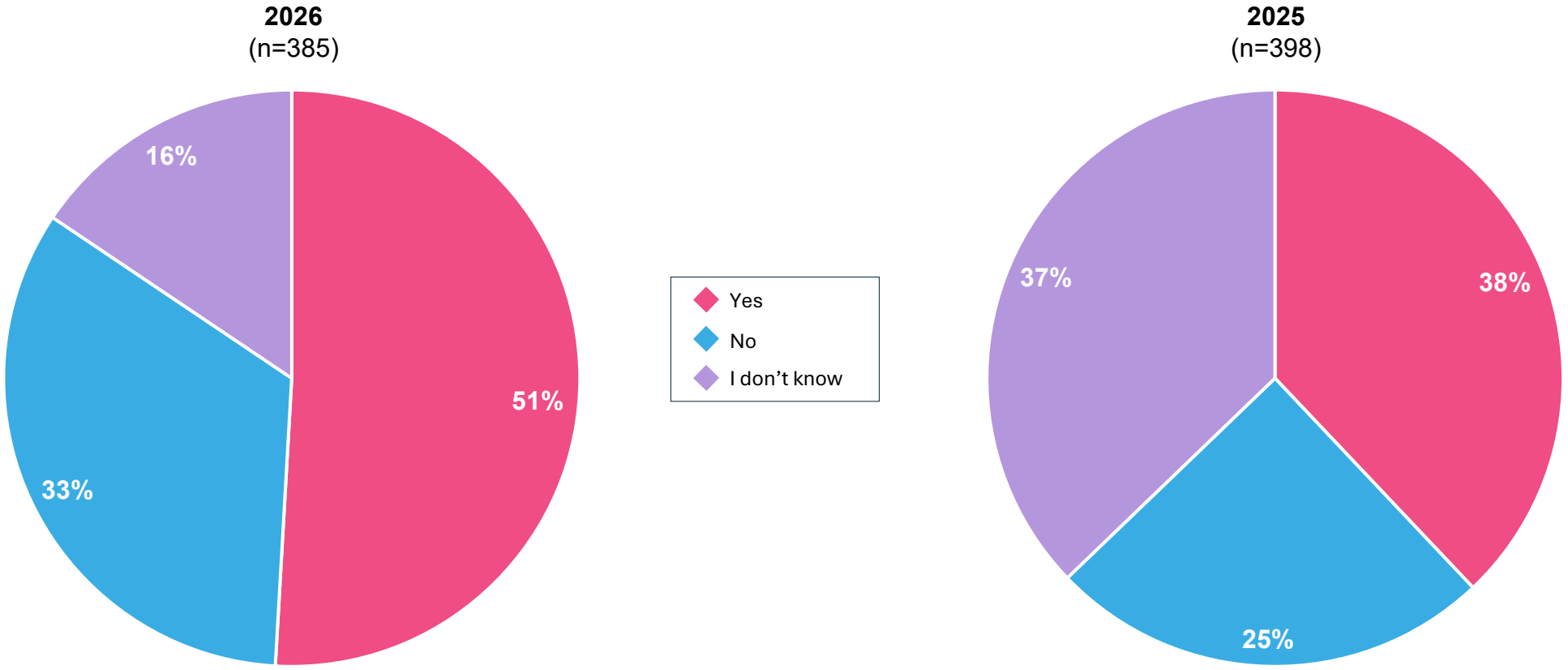


How do you expect your social prescribing service to change over the next year?
(n=385)



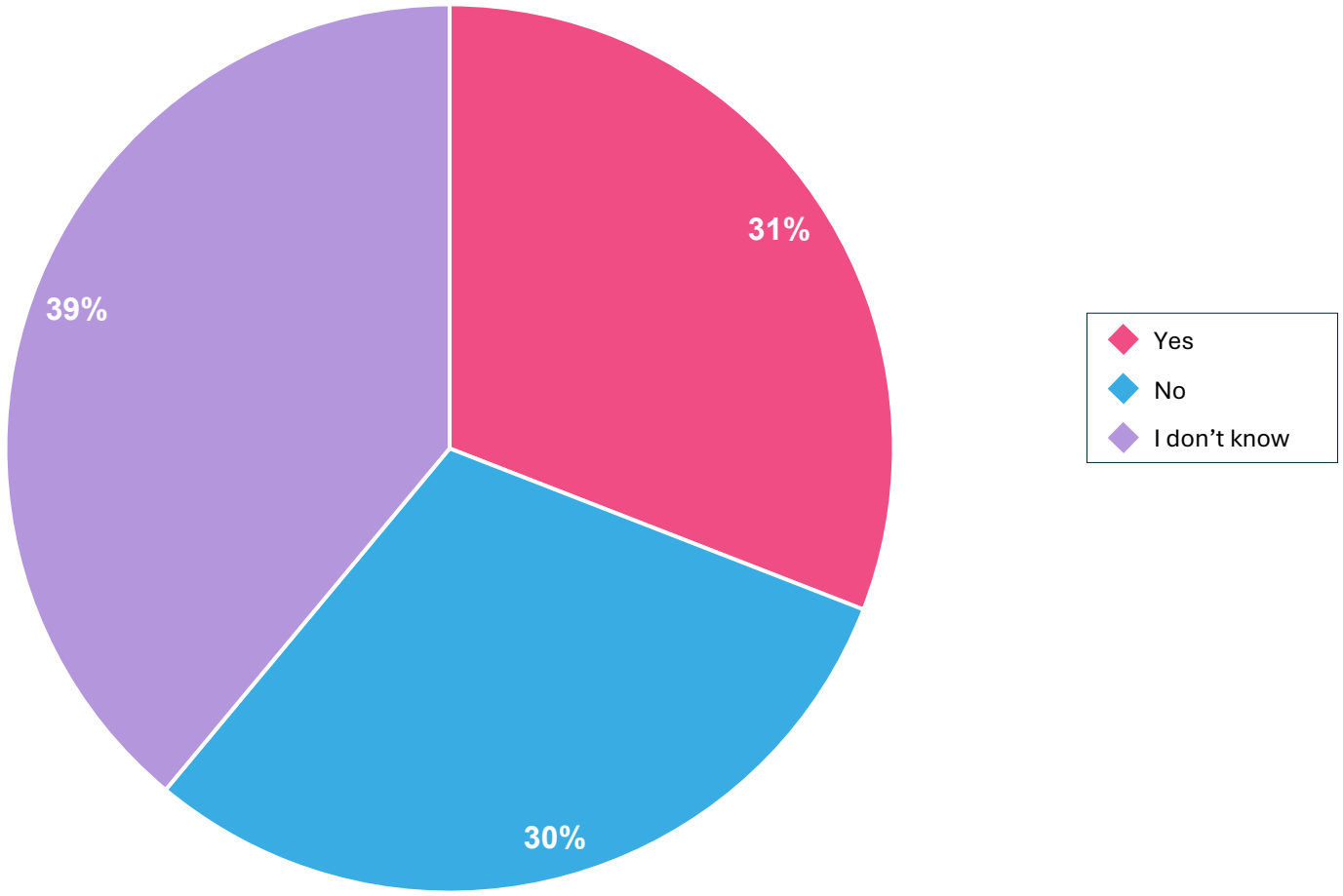
Q. Does your PCN or social prescribing service offer proactive social prescribing (a programme to proactively offer social prescribing to an identified cohort)?

- Half of SPLWs report their service or PCN offering proactive social prescribing.
- *Comparisons with 2025 should be interpreted with caution as there has been a change in both question wording and response options – In 2025, the survey asked 'Does your PCN offer a programme to proactively offer and improve access to social prescribing to an identified cohort with unmet need?' and included a 'Not relevant' response option (which 13 SPLWs reported, and which has been removed from the analysis below).*



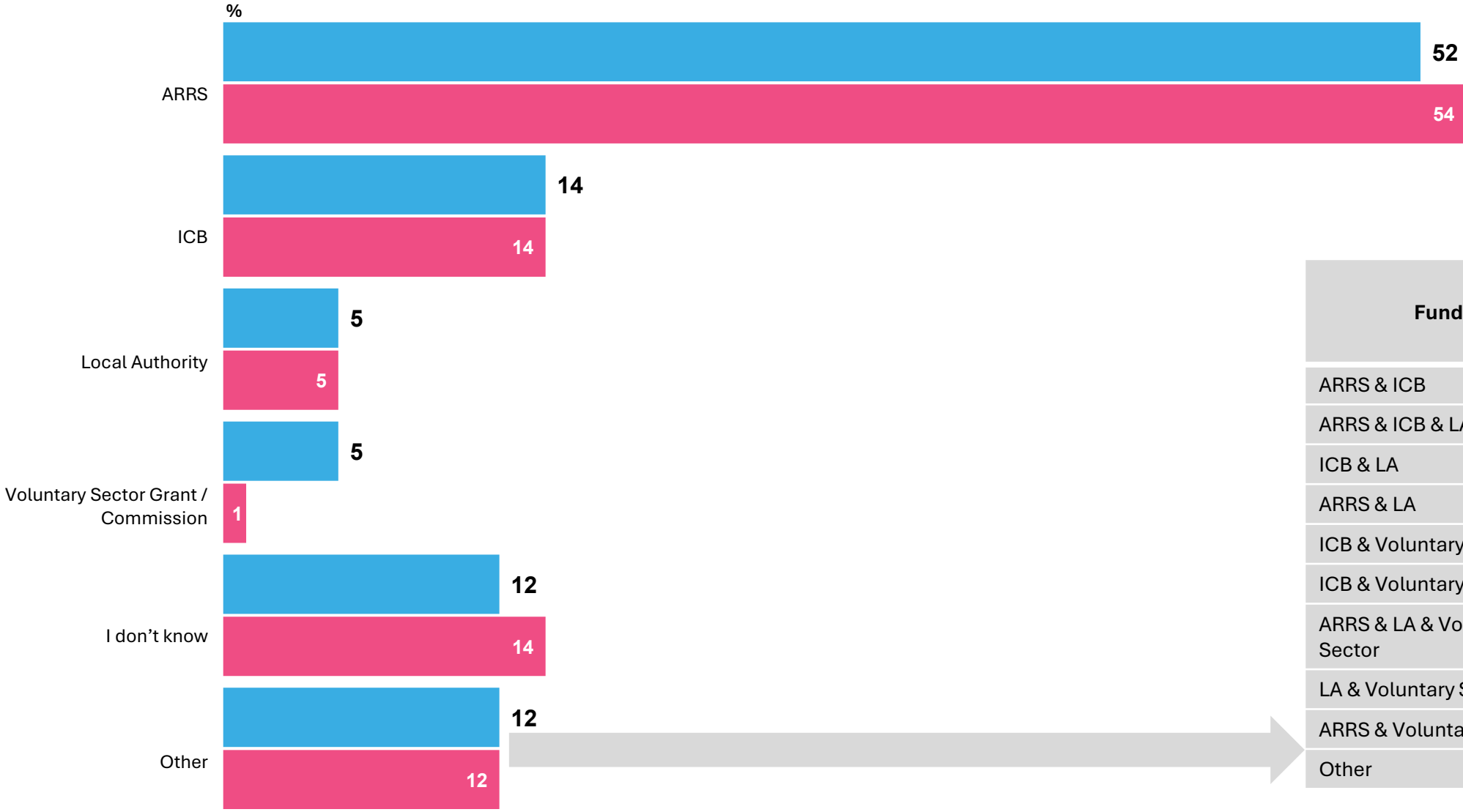
Q. Is your social prescribing service connected to the local Neighbourhood Health offer? (n=385)

- Responses are evenly split, with similar proportions reporting their service is connected to the local Neighbourhood Health offer and reporting that their service isn't.
- A substantial proportion (2 in 5 SPLWs) indicate they don't know, suggesting limited awareness of this.



Q. How is your post funded?

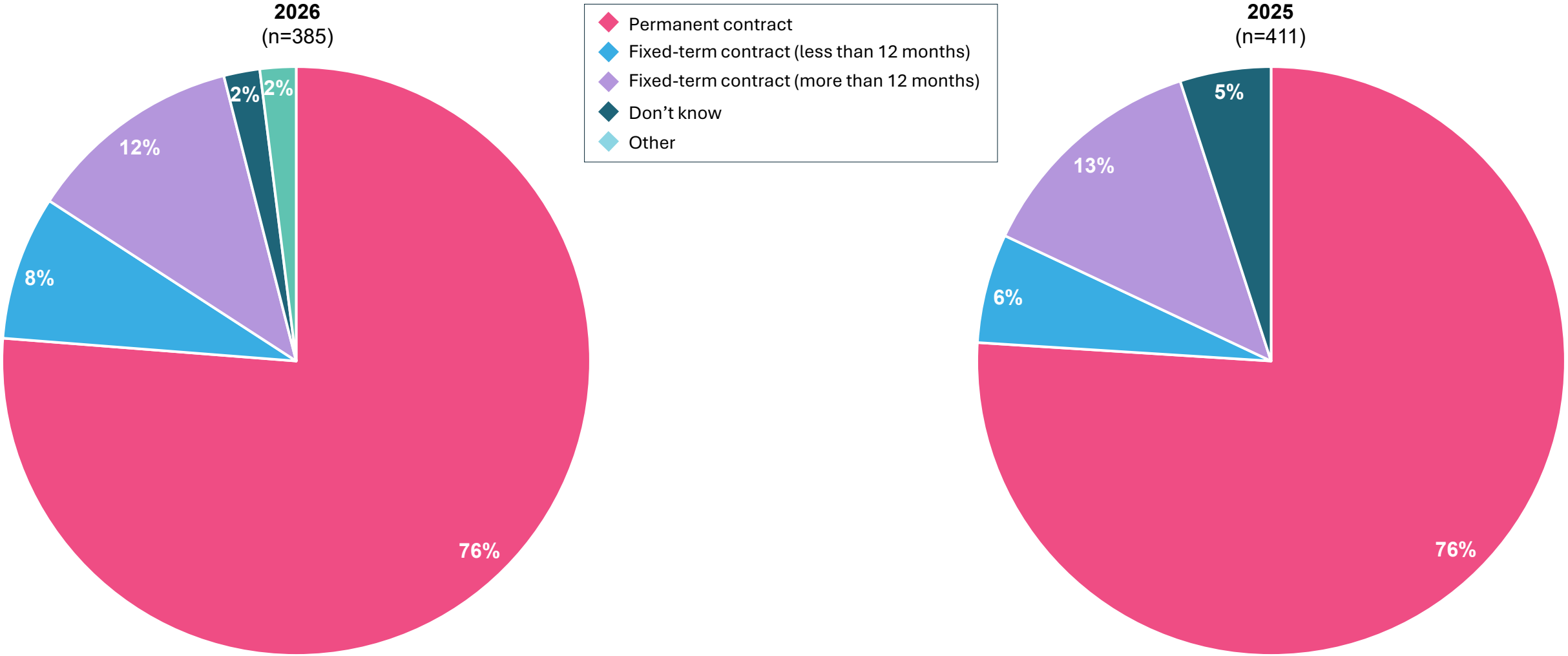
- The majority of SPLW posts are funded through ARRS, either solely or in combination with other sources.
- Mixed funding models are not uncommon, particularly combinations of: ARRS & ICB funding; ARRS, ICB & LA funding; and ICB & LA funding.
- 'Other' sources of funding include GPs, practices, Trusts, and PCNs.
- The funding landscape is relatively unchanged on 2025 figures.



Funders	2026 n=44	2025 n=51
	n	n
ARRS & ICB	9	9
ARRS & ICB & LA	5	1
ICB & LA	4	4
ARRS & LA	2	4
ICB & Voluntary Sector	2	2
ICB & Voluntary Sector & LA	1	0
ARRS & LA & Voluntary Sector	1	0
LA & Voluntary Sector	1	3
ARRS & Voluntary Sector	1	1
Other	18	27

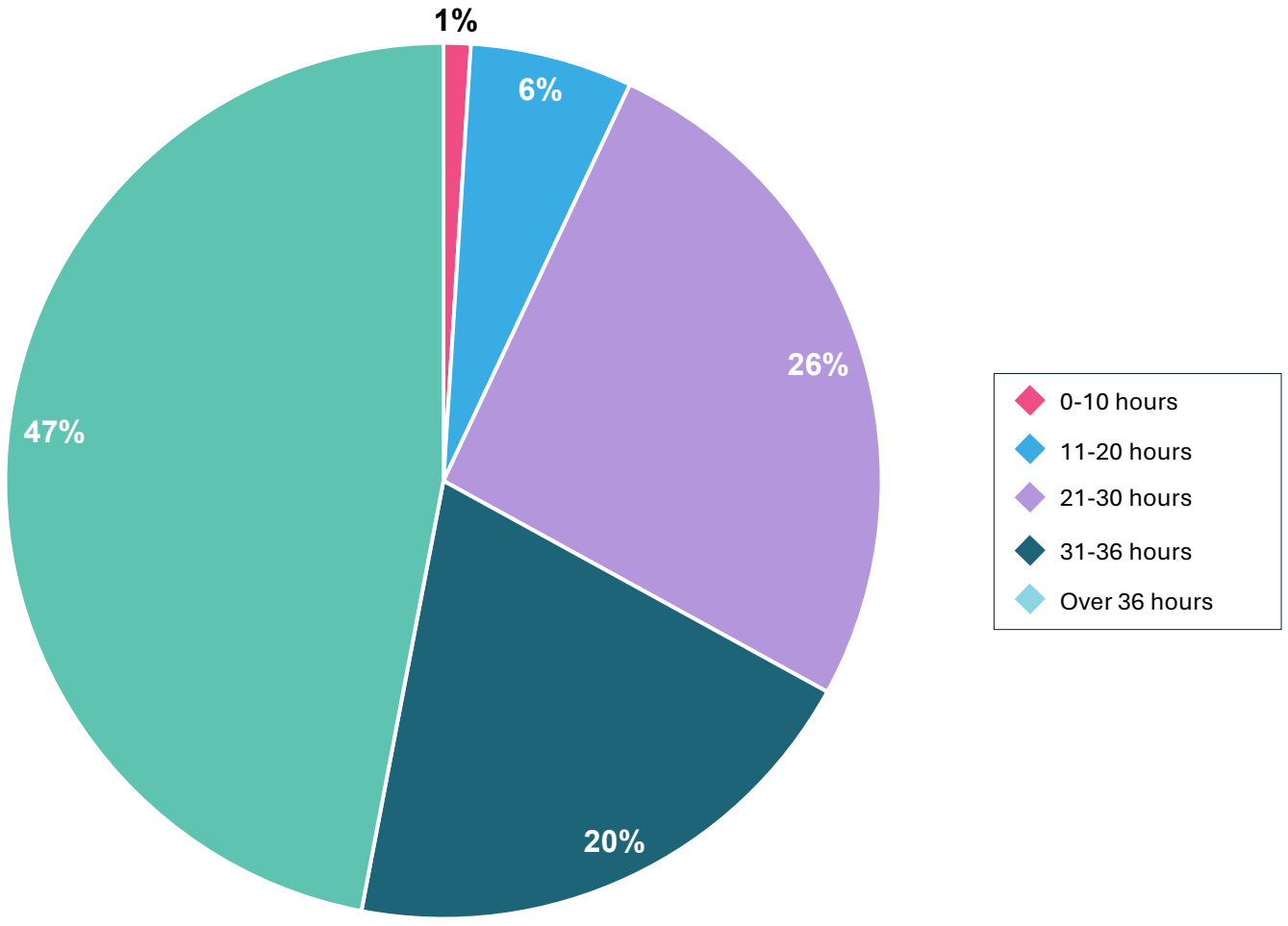
Q. Which of the following best describes your contract type?

- Three-quarters of SPLWs report being on permanent contracts.
- One-fifth of SPLWs report being on fixed term contracts of more or less than 12 months.
- The vast majority of those selecting 'Other' report being on 12-month contracts.
- Respondents' type of contract has remined relatively stable on 2025 figures.



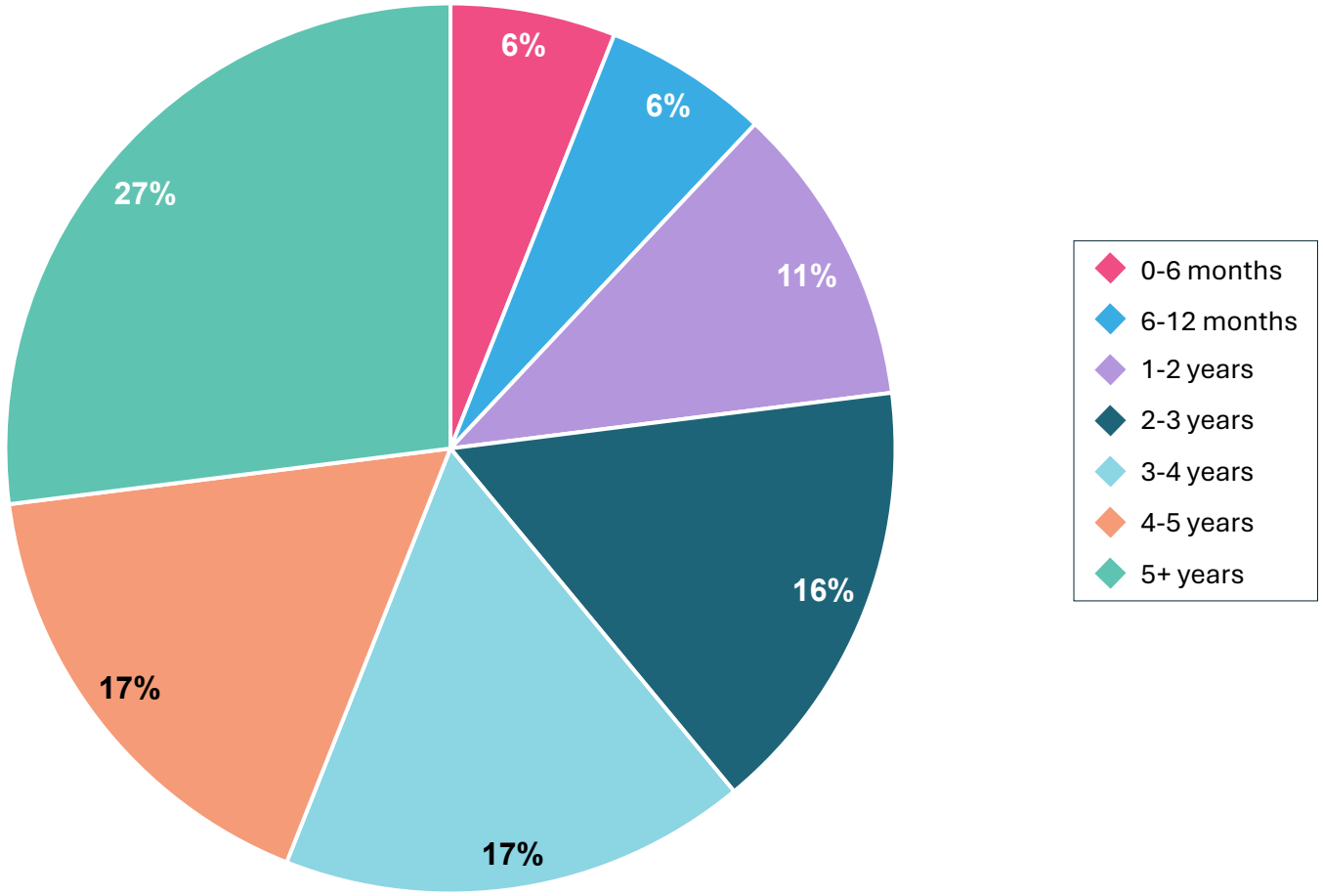
Q. How many hours per week are you employed as a SPLW? (n=385)

- Most SPLWs work full-time or near full-time hours, with almost half reporting working over 36 hours per week.
- A further quarter work mid-range hours (21-30 hours), while fewer work under 20 hours per week.



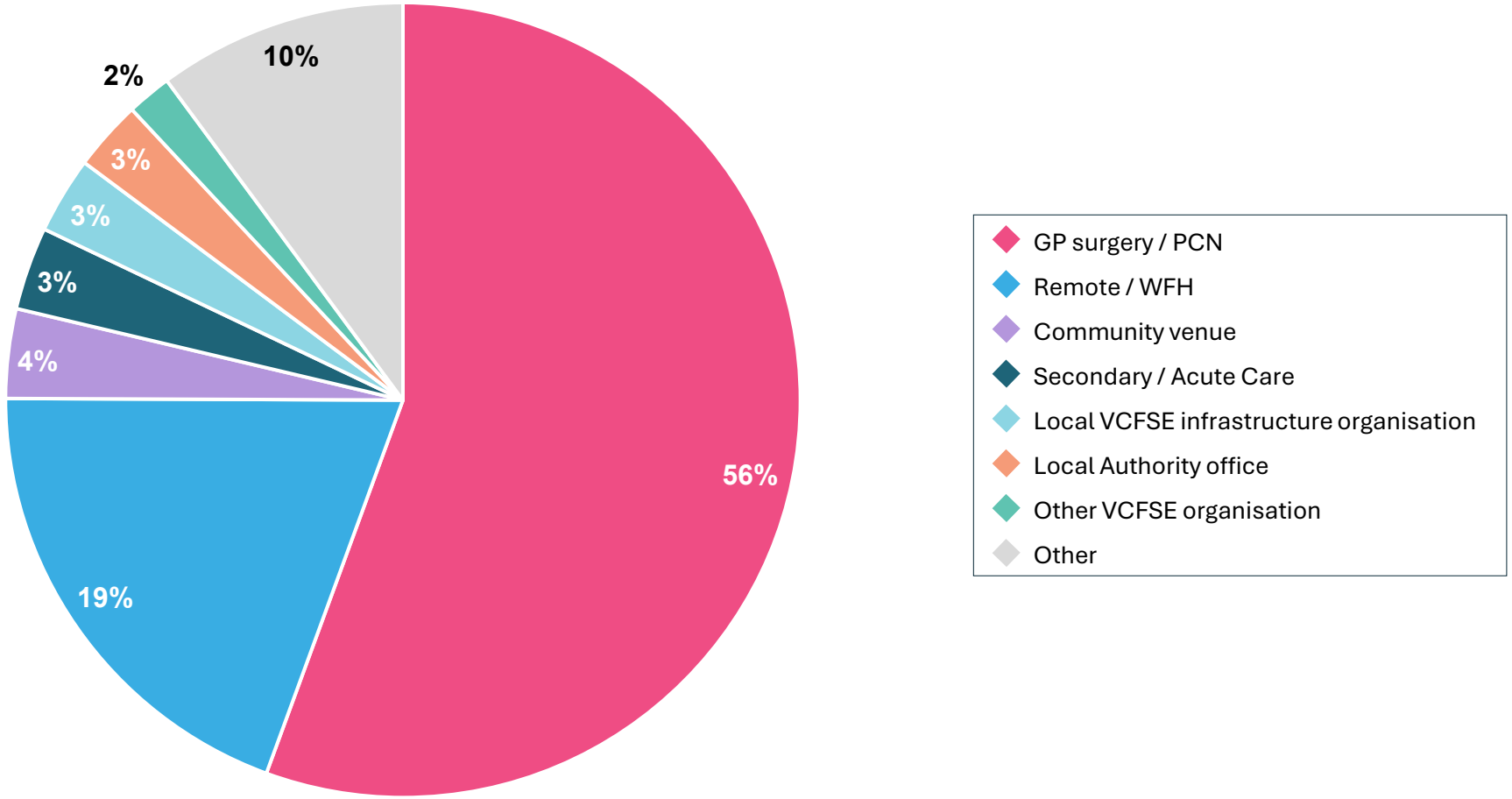
Q. How long have you been employed as a SPLW? (n=385)

- The SPLW workforce is becoming increasingly well established, with over three-quarters of the workforce reporting over 2 years' experience as a SPLW – a quarter report over 5 years experience.



Q. Where are you based in your current role (your main work location)? (n=385)

- The majority of respondents report being based at a GP surgery/PCN.
- Around one-fifth of respondents report working remotely/from home.
- Other includes hybrid, schools, and HMPPS sites.



Day-to-Day Role

Day-to-Day Role - Summary

1. Delivery Model: high volume, relational, short term

- SPLWs report high and variable caseloads (with many reporting caseloads of 300+)
- Support provided is typically between 6 weeks and 6 months, and delivered through multiple contacts (commonly 4-6)
- Day-to-day work is primarily 1:1, referral-focused, via phone and face-to-face delivery
- Outreach, group work, and co-production are less consistent aspects of the SPLW role.

2. Referral & support focus: dominated by high-need demand

- Referrals are overwhelmingly from primary care (GPs/PCNs)
- Onward referrals focus primarily on mental health and practical needs (housing, finances, social care, carers)
- Arts, heritage, and faith activities are referred to less consistently
- In practice, social prescribing is often acting as a frontline response to complex social need.

3. System context: barriers and uneven effectiveness

- Statutory services are constrained by capacity, eligibility/thresholds, and waiting lists
- Community provision is limited by awareness, availability, and referral pathways
- Support referred to is generally perceived as effective:
  - Carers, finance, and age-related services are felt to be most effective
  - Housing, faith-based, and heritage services are viewed as the least effective.

4. Drivers of impact

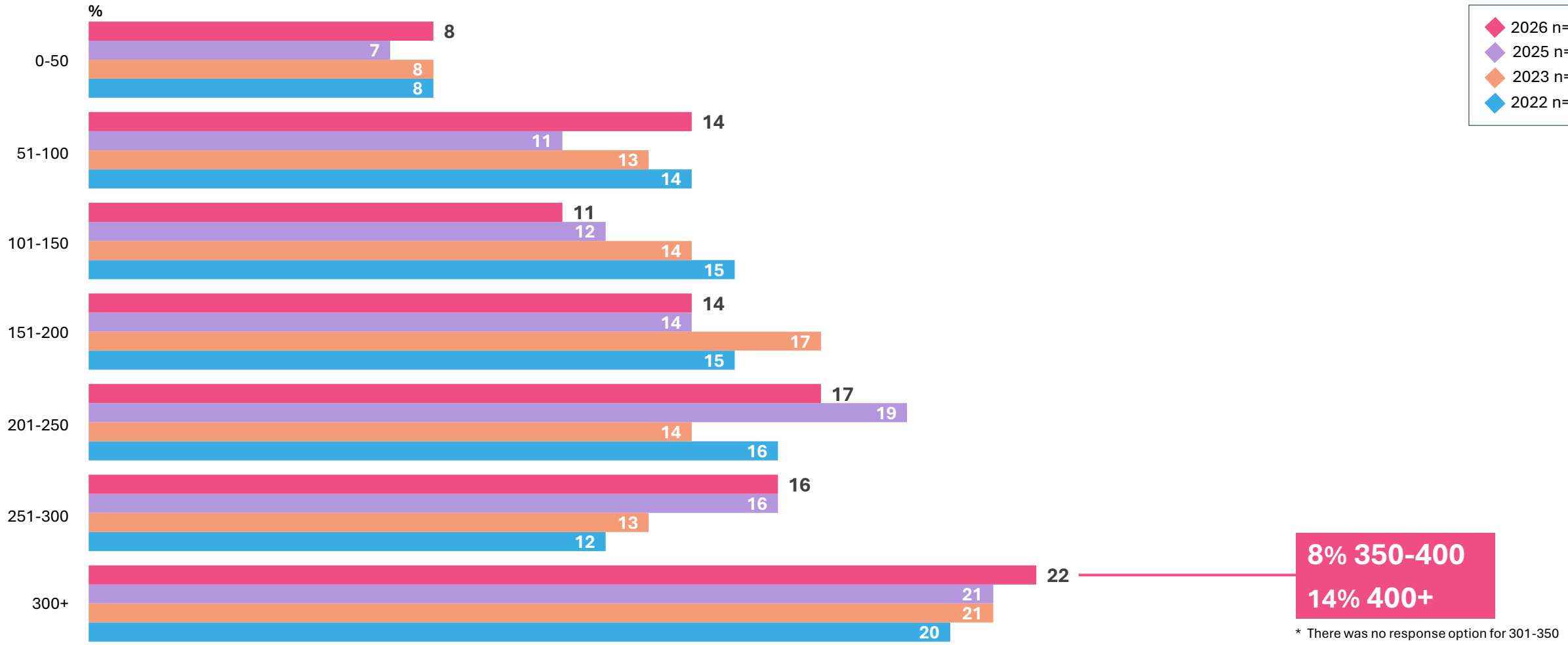
- Outcomes are perceived to be driven by a combination of trusted SPLW relationship, social connection, and regular activity engagement
- Social prescribing is perceived as most effective as a connector to flexible, relational support
- Wider system capacity constrains the impact of social prescribing.

5. What this means for delivery

- Social prescribing is functioning as a high-volume, frontline response to complex social and emotional need
- SPLWs are operating as relational practitioners within overstretched systems
- SPLW delivery is heavily shaped by wider system pressures, particularly in mental health, housing, and financial issues
- Delivery appears to be being drawn toward complex crisis and practical support, at the expense of broader preventative community work.

Q. What is your average caseload over the course of a year?

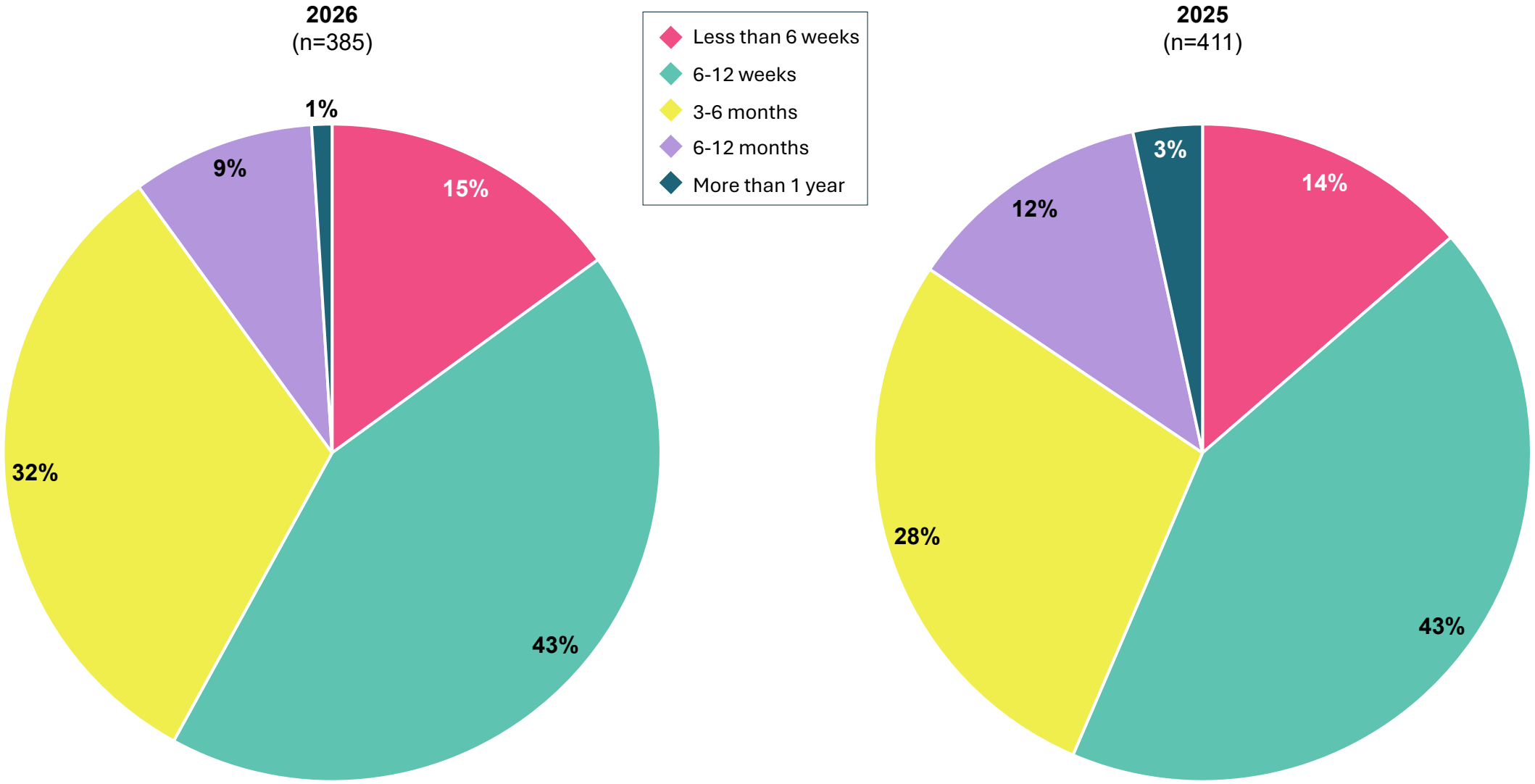
- Caseload distribution has remained largely unchanged year-on-year.
- The proportion of SPLWs with an average of 300+ cases per year remains the highest, with around 1 in 5 respondents reporting this.
- Around 2 in 5 have an average caseload over 250 a year (the maximum safe caseload recommended by NHSE).
- SPLWs employed directly by PCNs are particularly likely to report high caseloads:
  - 45% of PCN SPLWs report a caseload of 250+, compared with 28% of other SPLWs, and 17% of PCN SPLWs report a caseload of 400+, compared with 10% of Other SPLWs.



* There was no response option for 301-350

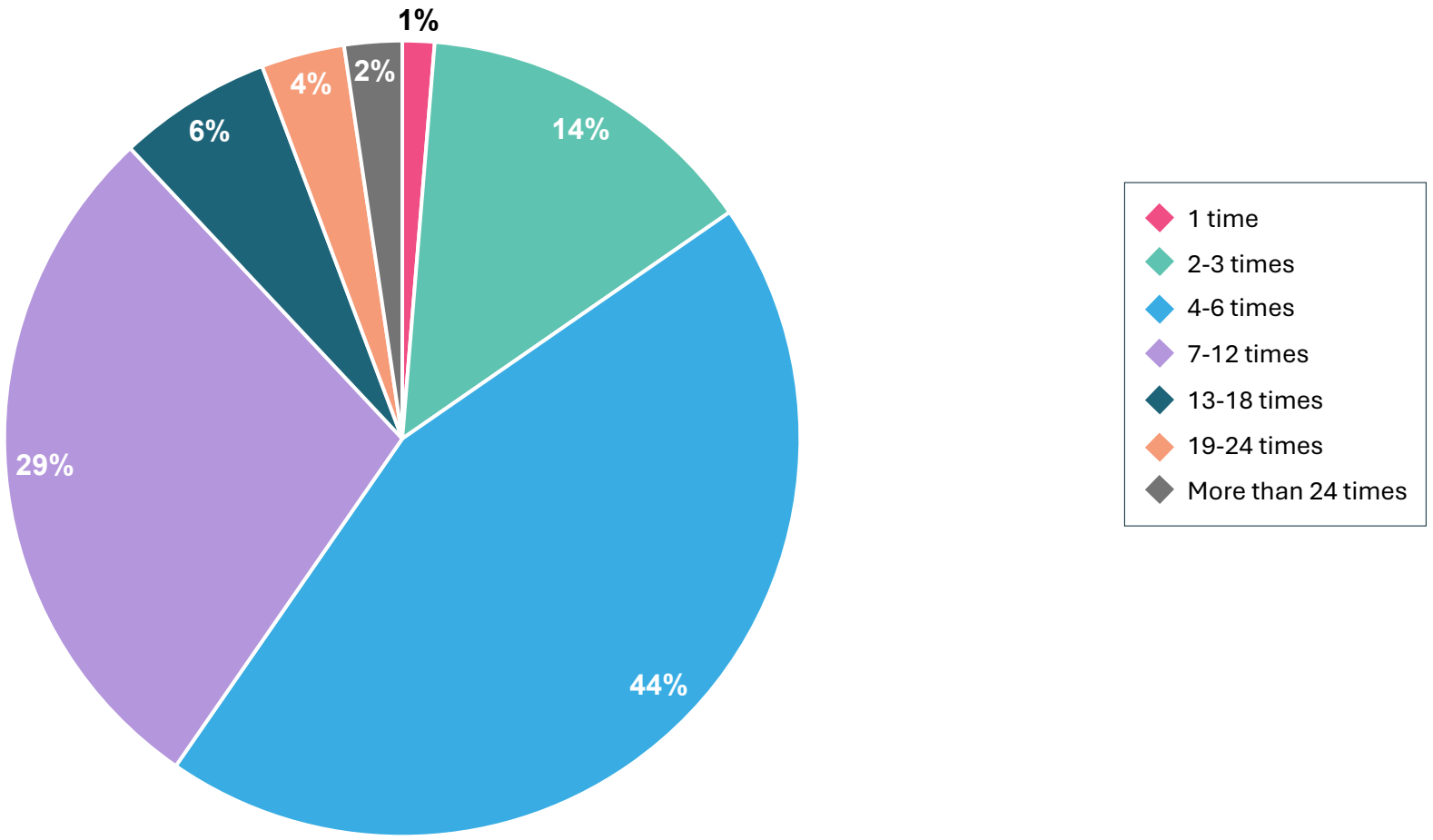
Q. On average, how long do you work with a patient/client?

- Most SPLWs engage with clients for up to 6 months, with the greatest proportion working within a 6-12 week timeframe.
- Long-term cases are less common, and compared with 2025, there has been a slight decrease in SPLWs working with clients for over 6 months (from 15% in 2025 to 10% in 2026).



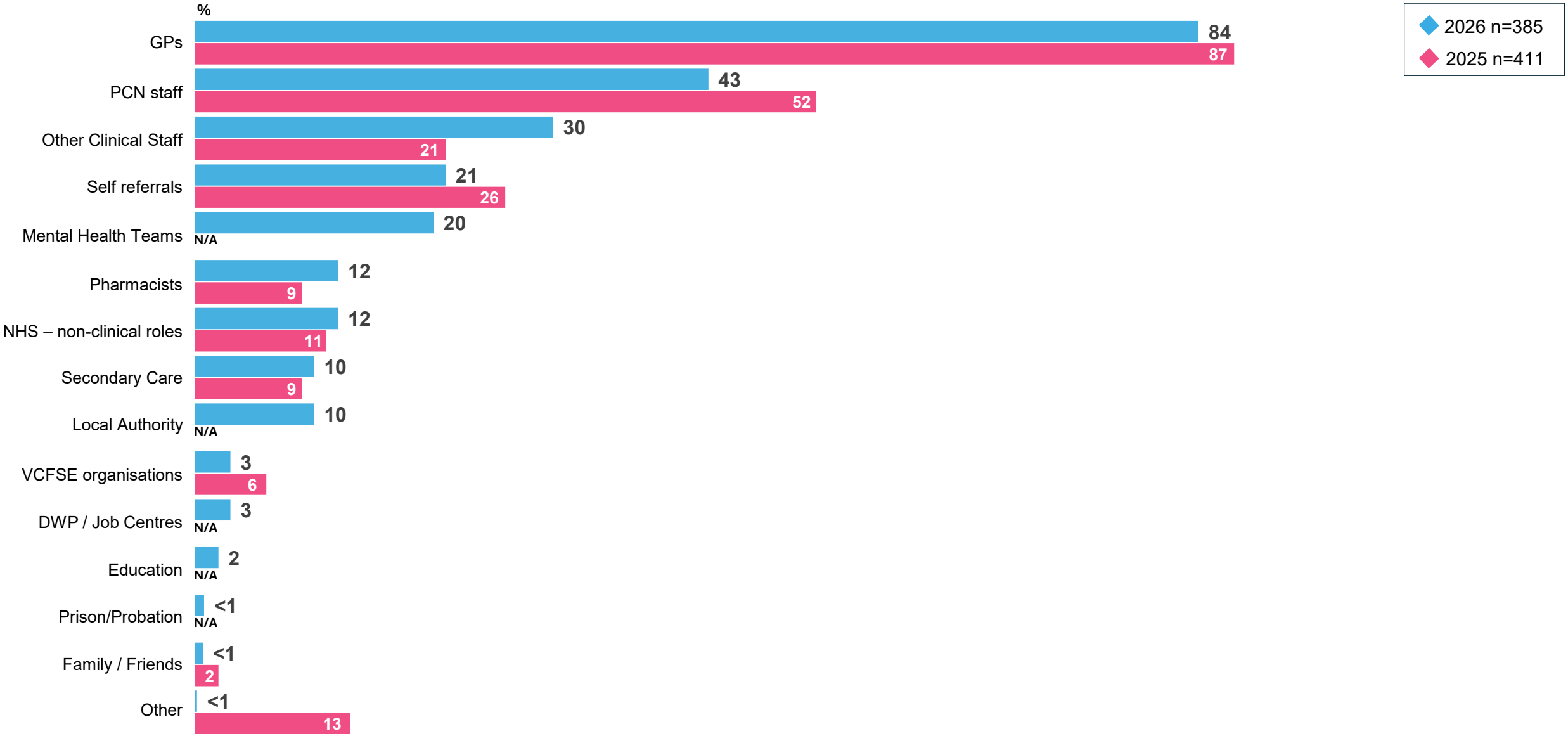
Q. On average, how many times do you have contact with a patient/client? (n=385)

- Most SPLWs have multiple contacts with patients, with the greatest proportion of SPLWs reporting 4-6 interactions, in line with national guidance
- A substantial number of SPLWs report more intensive support, with many reporting an average of 7-12 contacts per patient/client.
- Fewer report very low or very high contact (15% report 1-3 contacts, and 12% report 13+ contacts).



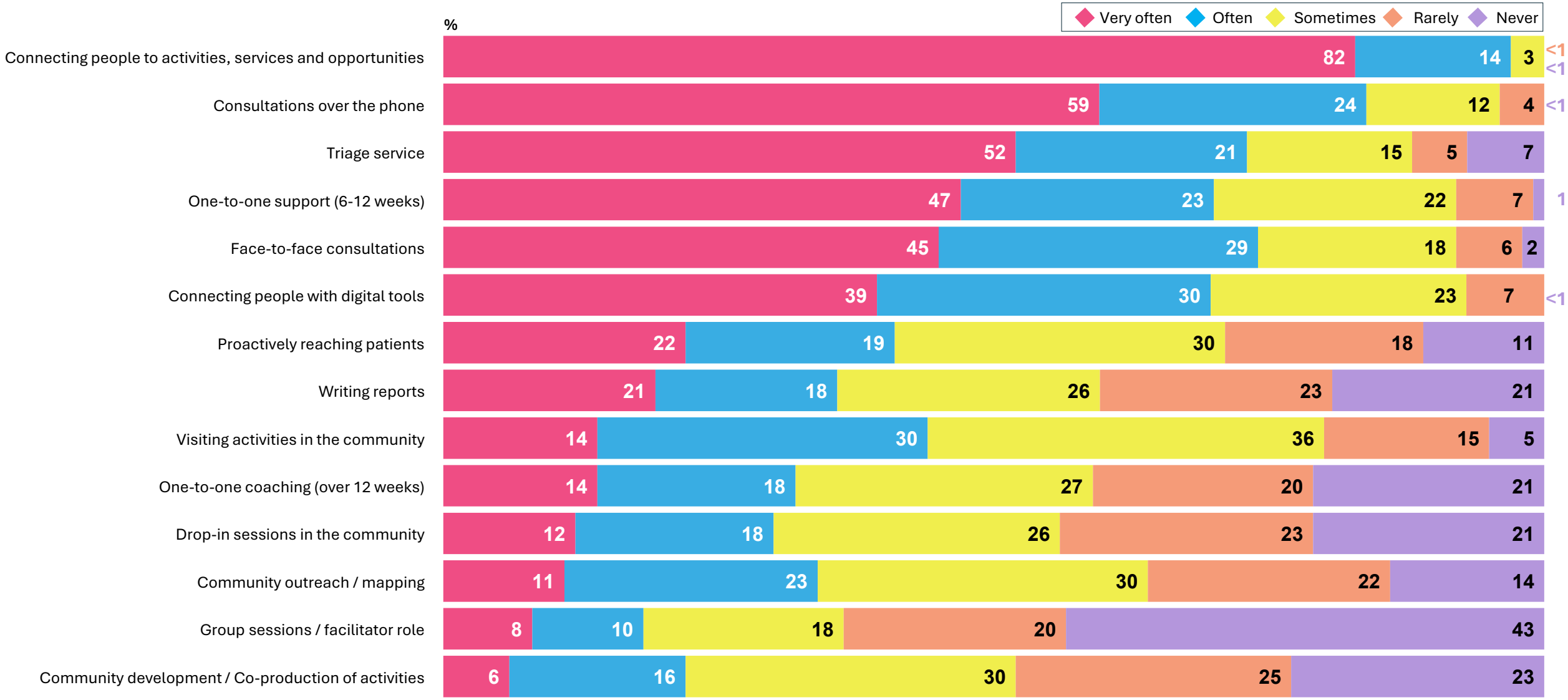
Q. Where do you receive most of your referrals from? Please select at most 3 options.

- As in 2025, the vast majority of SPLWs receive referrals primarily from GPs.
- Around two in five SPLWs cite PCN staff as a key referral pathway into social prescribing, followed by other clinical staff, self referrals, and mental health teams.
- The referral landscape remains similar to 2025; the main changes are a decrease in referrals from PCN staff, and an increase in referrals from other clinical staff.



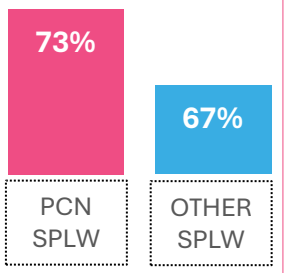
Q. How often do you do the following as a part of your role? (n=385)

- Connecting people to activities, services and opportunities is the most frequently reported task from the list provided (82% of SPLWs report doing this very often).
- Phone consultations and triage are also core aspects of the SPLW role, while one-to-one client support over 6-12 weeks, face-to-face consultations, and connecting people with digital tools are also undertaken frequently.
- Community development/co-production of activities is not a primary focus for most SPLWs (only 22% do this very often/often, while 48% rarely or never do it), and group facilitation is the least frequent task, with more than half of respondents (63%) rarely or never doing it.

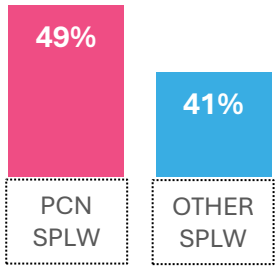


PCN SPLWs are more likely to Very Often/Often

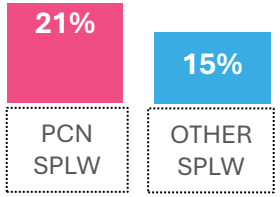
TRIAGE SERVICE



VISIT COMMUNITY ACTIVITIES

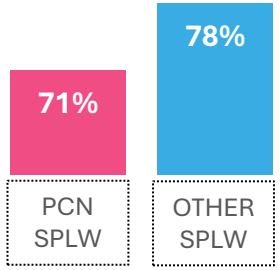


GROUP FACILITATION

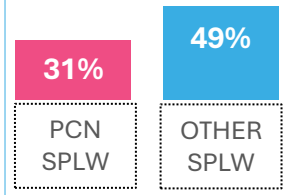


PCN SPLWs are less likely to Very Often/Often

FACE-TO-FACE CONSULTATIONS

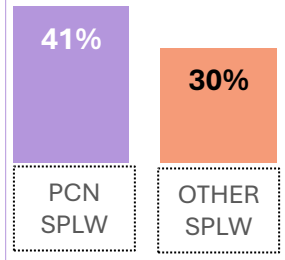


WRITE REPORTS



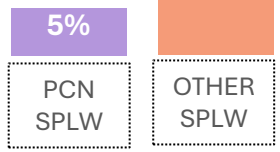
PCN SPLWs are more likely to Rarely/Never

WRITE REPORTS

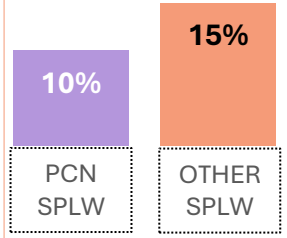


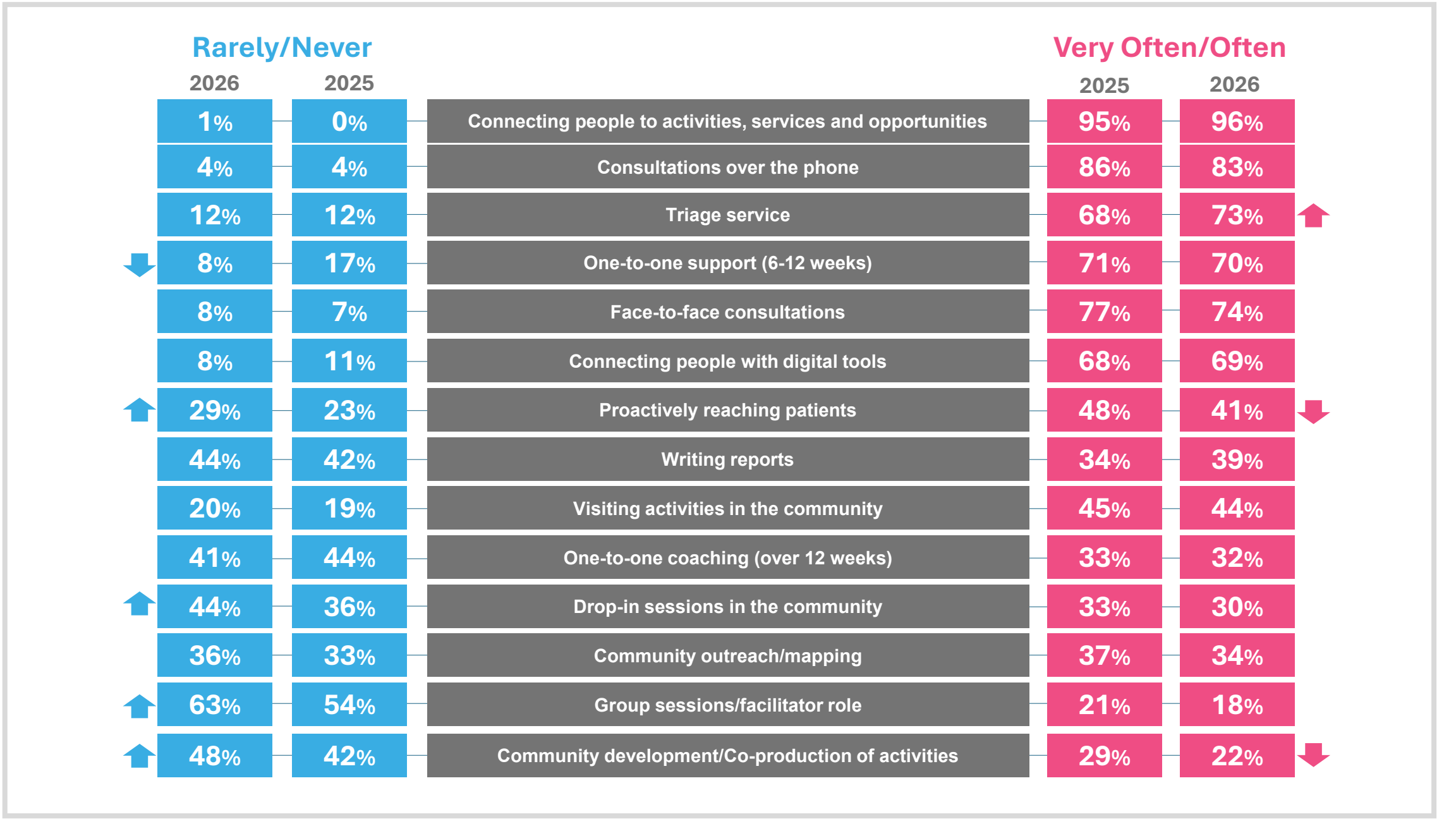
PCN SPLWs are less likely to Rarely/Never

TRIAGE SERVICE



ONE-TO-ONE SUPPORT 6-12 WEEKS

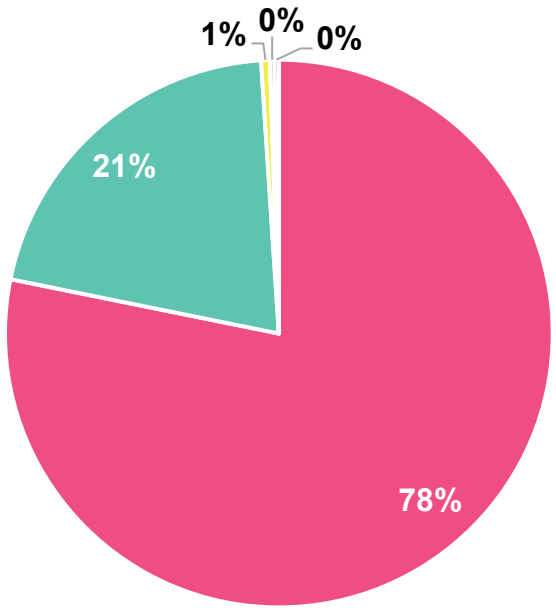



Rarely/Never
2026
2025
Very Often/Often
2025
2026
1%
0%
Connecting people to activities, services and opportunities
95%
96%
4%
4%
Consultations over the phone
86%
83%
12%
12%
Triage service
68%
73%
8%
17%
One-to-one support (6-12 weeks)
71%
70%
8%
7%
Face-to-face consultations
77%
74%
8%
11%
Connecting people with digital tools
68%
69%
29%
23%
Proactively reaching patients
48%
41%
44%
42%
Writing reports
34%
39%
20%
19%
Visiting activities in the community
45%
44%
41%
44%
One-to-one coaching (over 12 weeks)
33%
32%
44%
36%
Drop-in sessions in the community
33%
30%
36%
33%
Community outreach/mapping
37%
34%
63%
54%
Group sessions/facilitator role
21%
18%
48%
42%
Community development/Co-production of activities
29%
22%

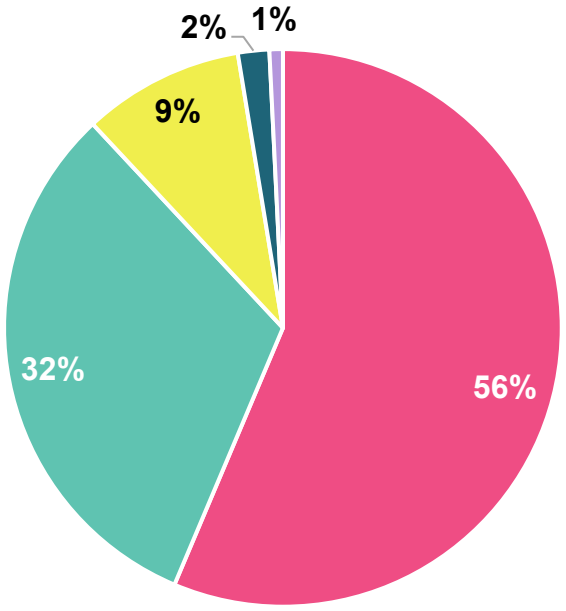
Q. To what extent do you agree with the following statements? (n=385)

- There is strong awareness of local services, with almost all SPLWs agreeing or strongly agreeing that they are aware of local services to connect with and refer on to.
  - The proportion of SPLWs reporting they 'strongly agree' has risen from 70% in 2025 to 78% in 2026.
- Connections with VCFSE infrastructure are more mixed, with a little over half of SPLWs strongly agreeing they are well connected, and a further third agreeing.
- SPLWs generally report strong referral pathways with health and social care professionals.

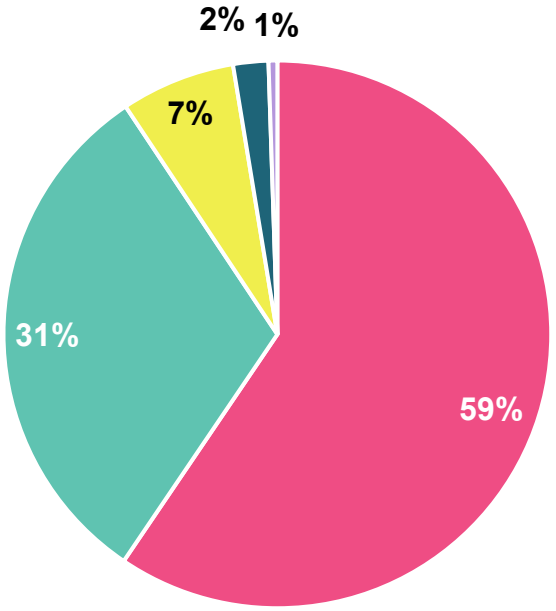
I am aware of local services that I can connect with and refer on to



I am well connected with the local VCFSE infrastructure in my area



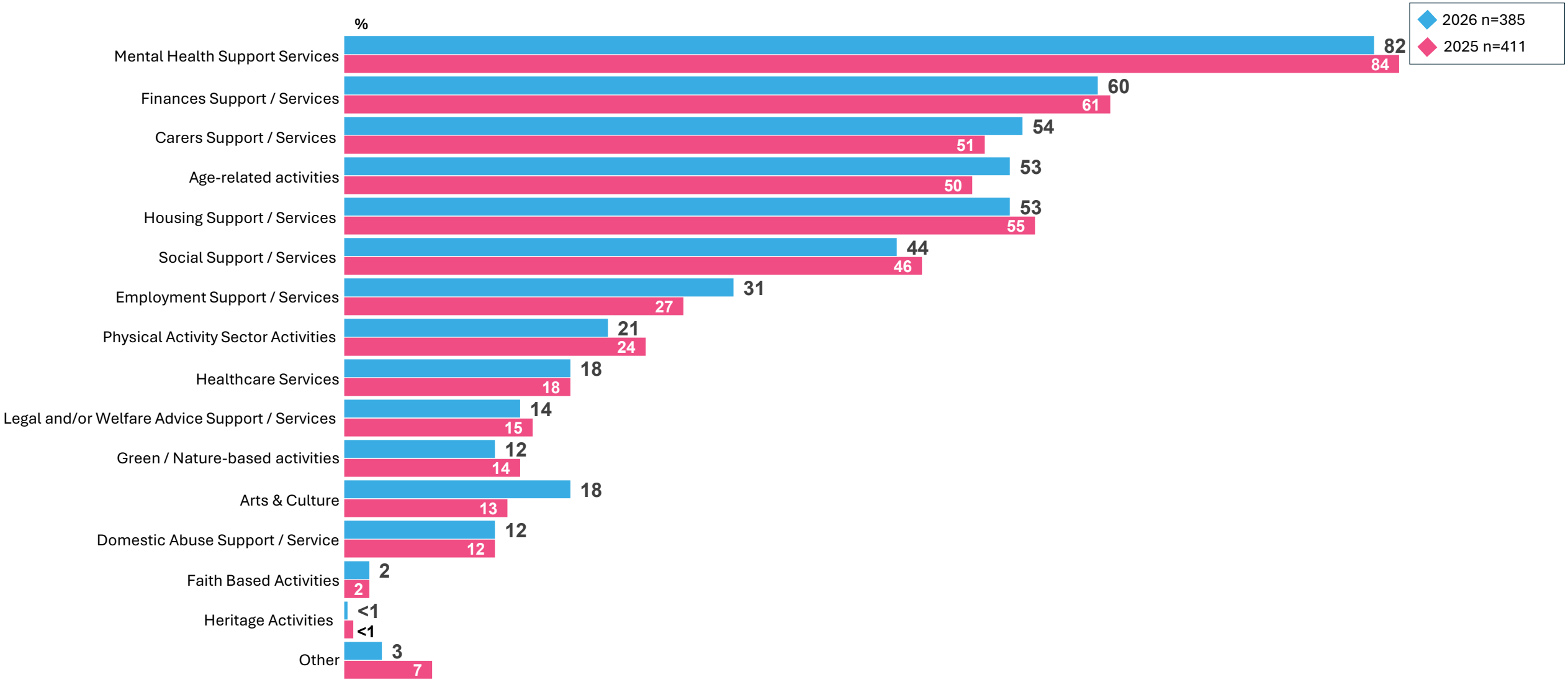
I feel I have developed / am able to develop strong referral pathways with other health and social care professionals



Strongly Agree | Agree | Neither agree nor disagree | Disagree | Strongly Disagree

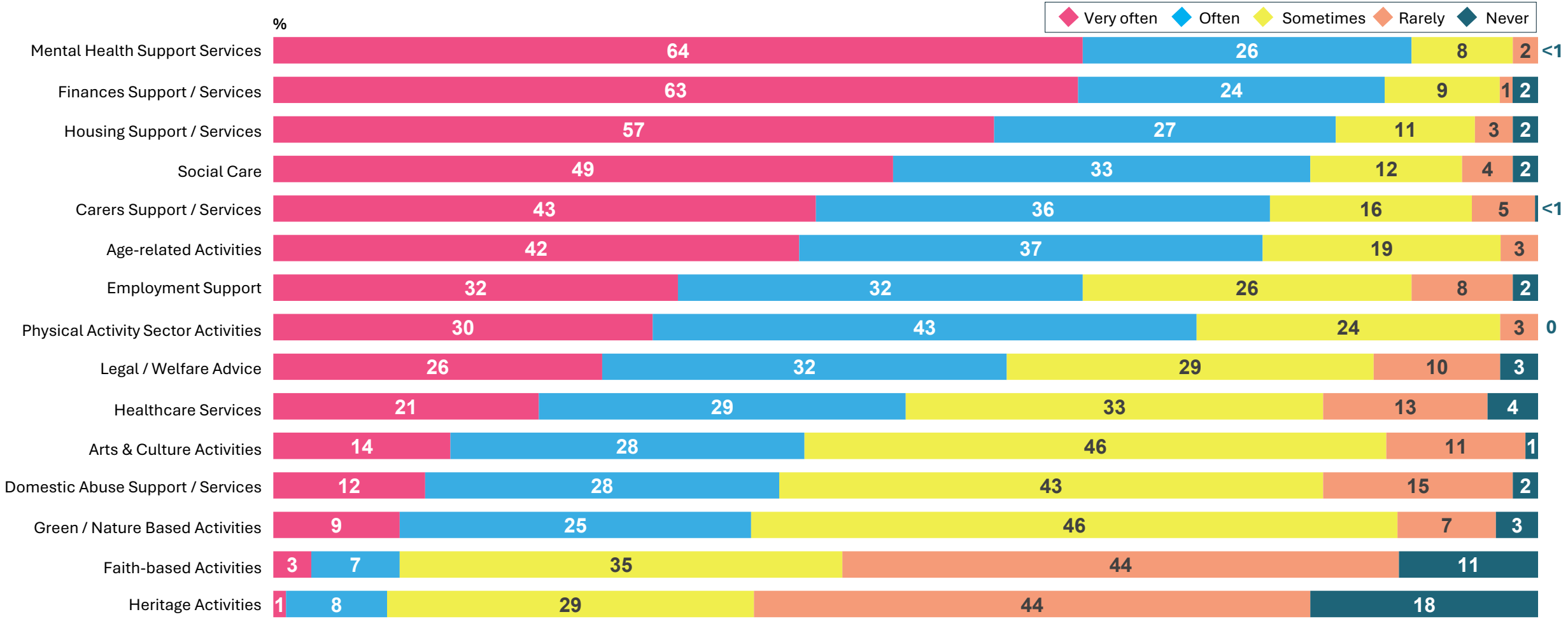
Q. What category of organisations do you make the most referrals to? Please select at most 5 options

- SPLWs most frequently refer people to Mental Health Support Services (4 in 5 SPLWs select this response).
- Support for finances, carers, age-related activities, and housing also feature highly.
- Referrals to faith-based activities, and heritage activities are relatively rare, suggesting lower awareness, demand, or availability of these types of services.
- The categories of organisations SPLWs make the most referrals to is relatively unchanged compared with 2025, but referrals to Arts & Culture has seen a slight increase.



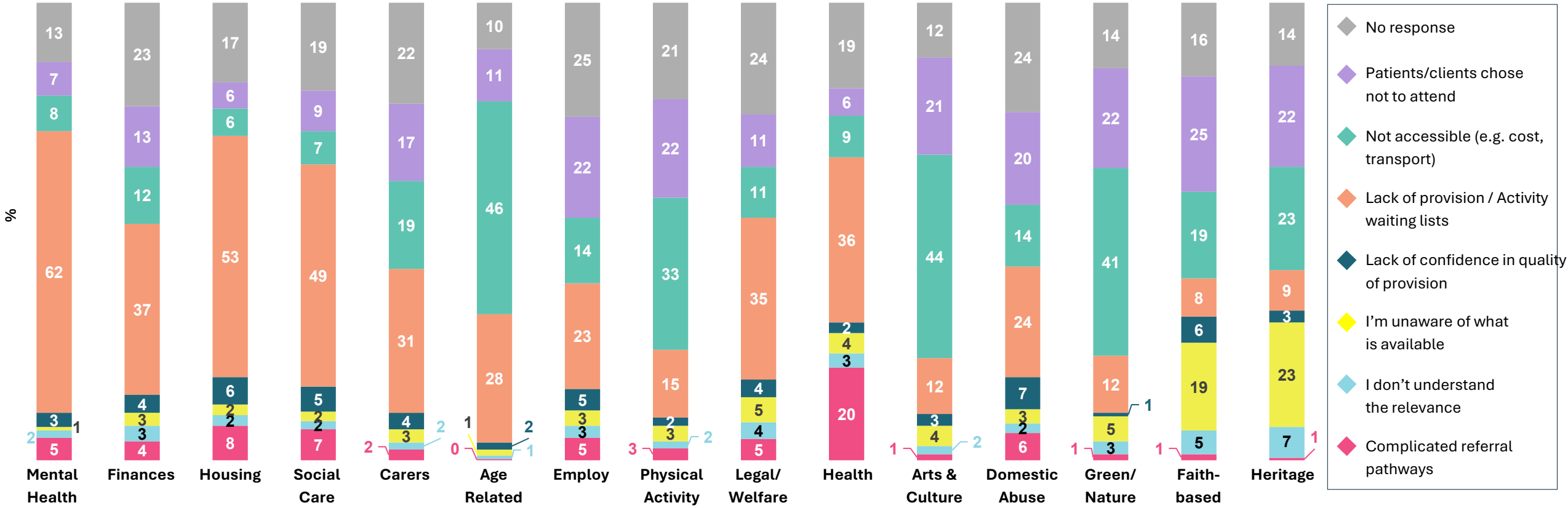
Q. How often do you refer into the following? (n=385)

- Mental Health Support Services are the most referred to type of service from those listed, closely followed by Finances Support/Services.
- Housing Support / Services additionally see high referral rates, while Social Care, Carers Support / Services, Age-related Activities are also well-utilised.
- Faith-based and Heritage Activity referrals have the lowest referral rates – this may indicate lower relevance to most clients, or limited awareness or availability of such services in certain areas.
- Where comparable, types of services referred into has remained relatively stable compared to 2025, with the main differences being:
  - A decrease in SPLWs reporting they Very often/Often refer into Healthcare Services (79% in 2025, compared with 50% in 2026).
  - A decrease in SPLWs reporting they Very often/Often refer into Faith-based Activities (21%, compared with10% in 2026).
  - A decrease in SPLWs reporting they Rarely/Never refer into Green / Nature Based Activities (23% in 2025, compared with 10% in 2026).
  - An increase in SPLWs reporting Rarely/Never refer into Heritage Activities (52% in 2025, compared with 62% in 2026).



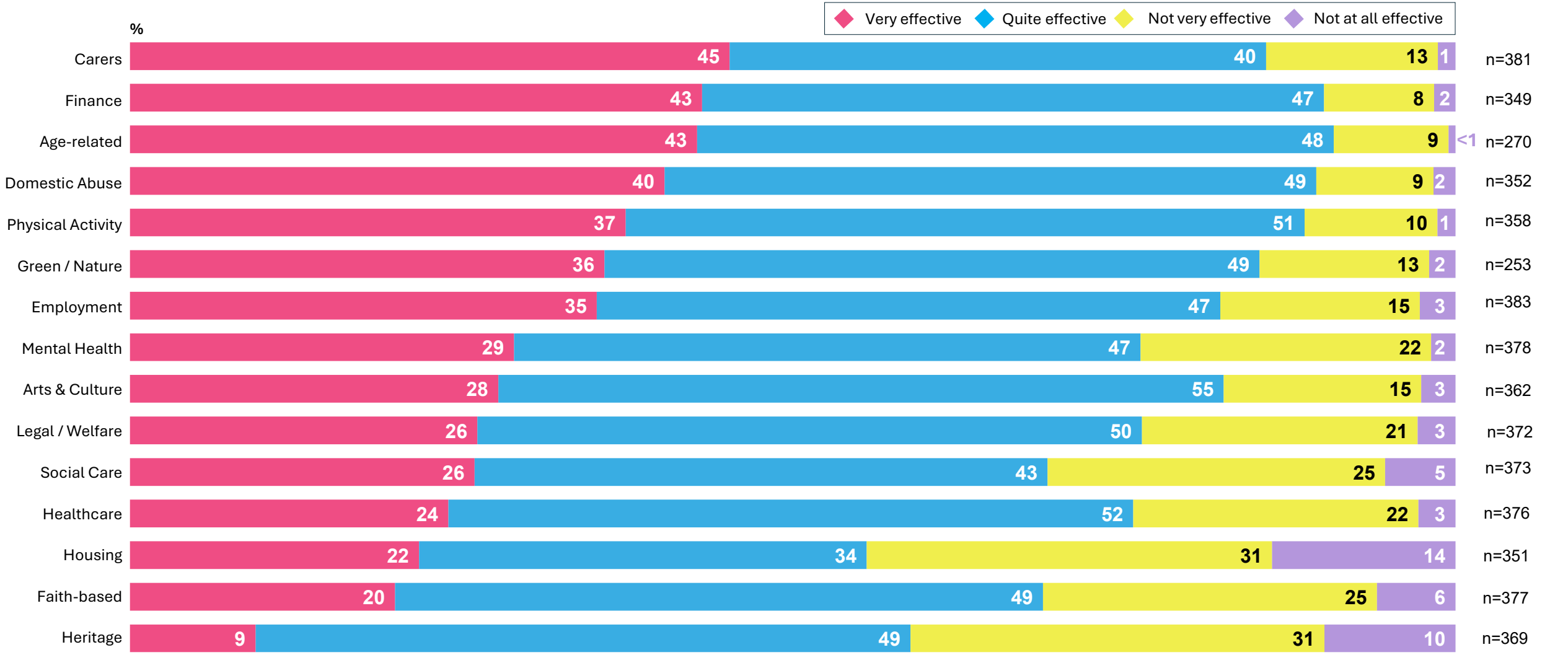
Q: What are the main barriers to referring patients/clients to the following? (n=385)

- Lack of provision/waiting lists is the most cited barrier across almost all types of provision.
  - This is particularly a barrier for: Mental Health Services; Housing; and Social Care. This suggests that demand for these services exceeds supply, causing delays or access issues.
- Age-related services and Arts & Culture Services are particularly affected by accessibility issues (e.g. cost of activity, or lack of transport).
  - This suggests that these constraints may be preventing engagement with these types of service.
- Complicated referral pathways is identified as a particular barrier to Healthcare services, indicating that administrative and procedural barriers may prevent effective referrals.
- A substantial proportion of SPLWs report being unaware of what's available as a barrier, particularly in relation to Heritage and Faith-based support.
  - This suggests a need for better communication and promotion of available services.
- Heritage and Faith-based support share the highest concerns about relevance, while Domestic Abuse has the highest concerns about quality, suggesting scepticism about effectiveness or suitability.
- Across all categories, clients choosing not to attend is a notable barrier, especially for: Faith-based, Heritage, Green/nature, Physical Activity, and Employment Support.
  - This indicates that even when services are available, uptake is not guaranteed, and more efforts may be needed to engage and encourage patients/clients to attend.
- Where comparable, SPLWs views on barriers are relatively in line with 2025.



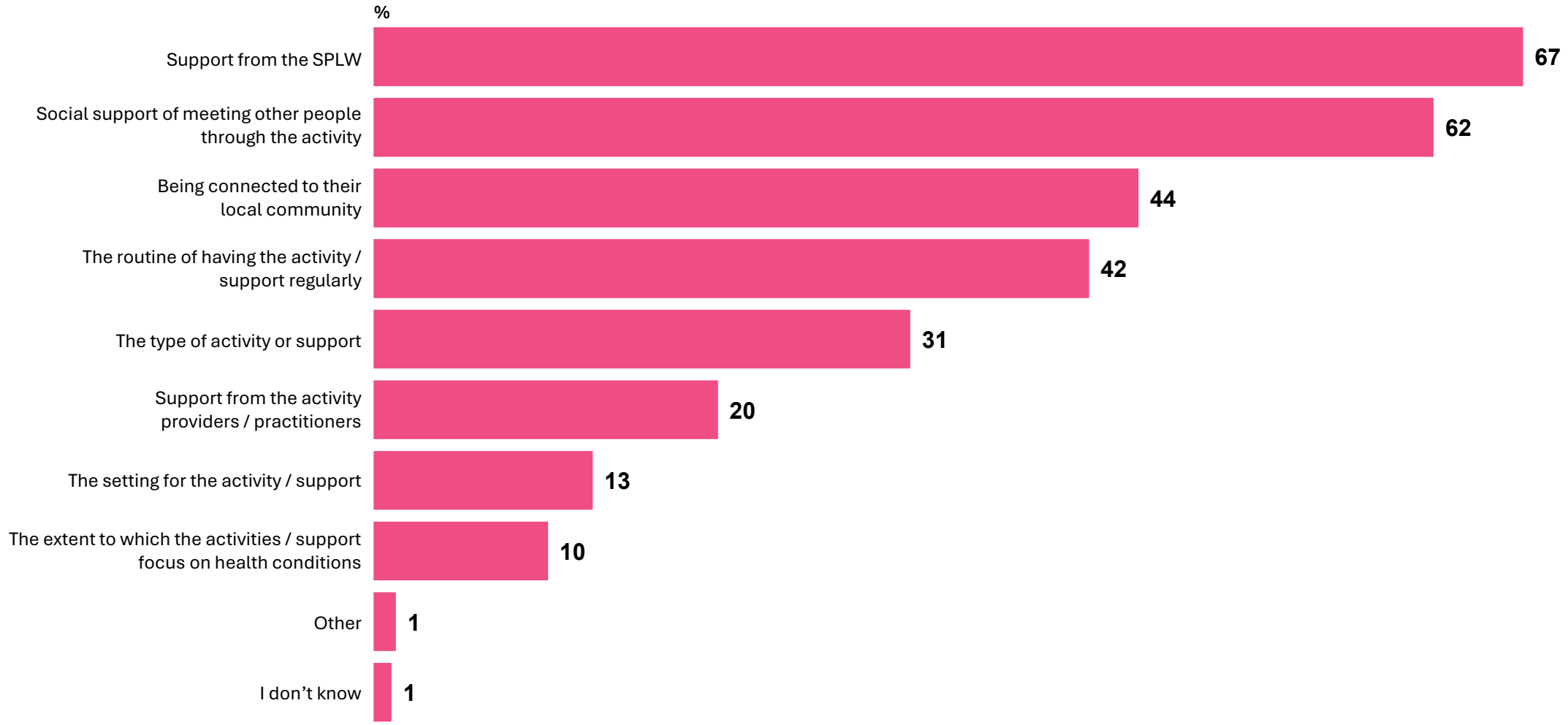
Q. How effective do you feel the following are in supporting your patients/clients? ('not applicable and/or relevant' removed)

- Support referred to is generally perceived as effective, with most support types rated positively, with clear majorities reporting them to be very or quite effective – but reports of 'quite effective' rather than 'very effective' indicates solid, rather than exceptional, impact.
- Carers, finance, and age-related services are felt to be the most effective of the service/support types listed.
- Housing, faith-based, and heritage services are viewed as the least effective, with only 9% of SPLWs rating heritage services as 'very effective'.
- Housing services receives the highest negative rating across all categories, with 44% of SPLWs reporting them to be ineffective.



Q. Based on your observations, which of the following do you think has led to the most positive impact for your patients/clients? Please select at most 3 options (n=385)

- Impact is perceived to be driven primarily by relationships and social connection, with SPLW support at the core:
  - SPLWs view the support they give patients/clients as the strongest driver of impact, highlighting the central role of the link worker relationship.
  - Social connection is also perceived as important – with meeting others and community connection perceived to be key contributors to positive patient/client impact.
  - Consistency and routine are also viewed as playing an important role.
  - Type and quality of activities are considered secondary to the relational and social factors.
  - Fewer SPLWs attribute impact to setting or health condition focus.



Training, Development & Supervision

Training, Development & Supervision - Summary

1. How SPLWs are supported

- Overall, support structures are embedded and valued
- Most SPLWs report receiving regular supervision
- Where present, peer support and informal networks play a key role in day-to-day learning and support
- Some SPLWs report limited access to reflective or clinical supervision.

2. Training & development

- Access to training provision is inconsistent across areas
- While most SPLWs report receiving some training, this is primarily mandatory organisational training
- SPLWs report that caseload pressures limit time available for training, and that training is not always prioritised or supported by management
- Lack of understanding of the SPLW role is viewed as affecting investment in SPLW development
- Practical barriers (e.g. scheduling, availability, lack of tailored content) also serve to reduce accessibility of training
- Priority training gaps emerging from practice focus on supporting high-complexity cases including supporting clients with mental health needs, and navigating complex systems (e.g. benefits, debt, and housing issues).

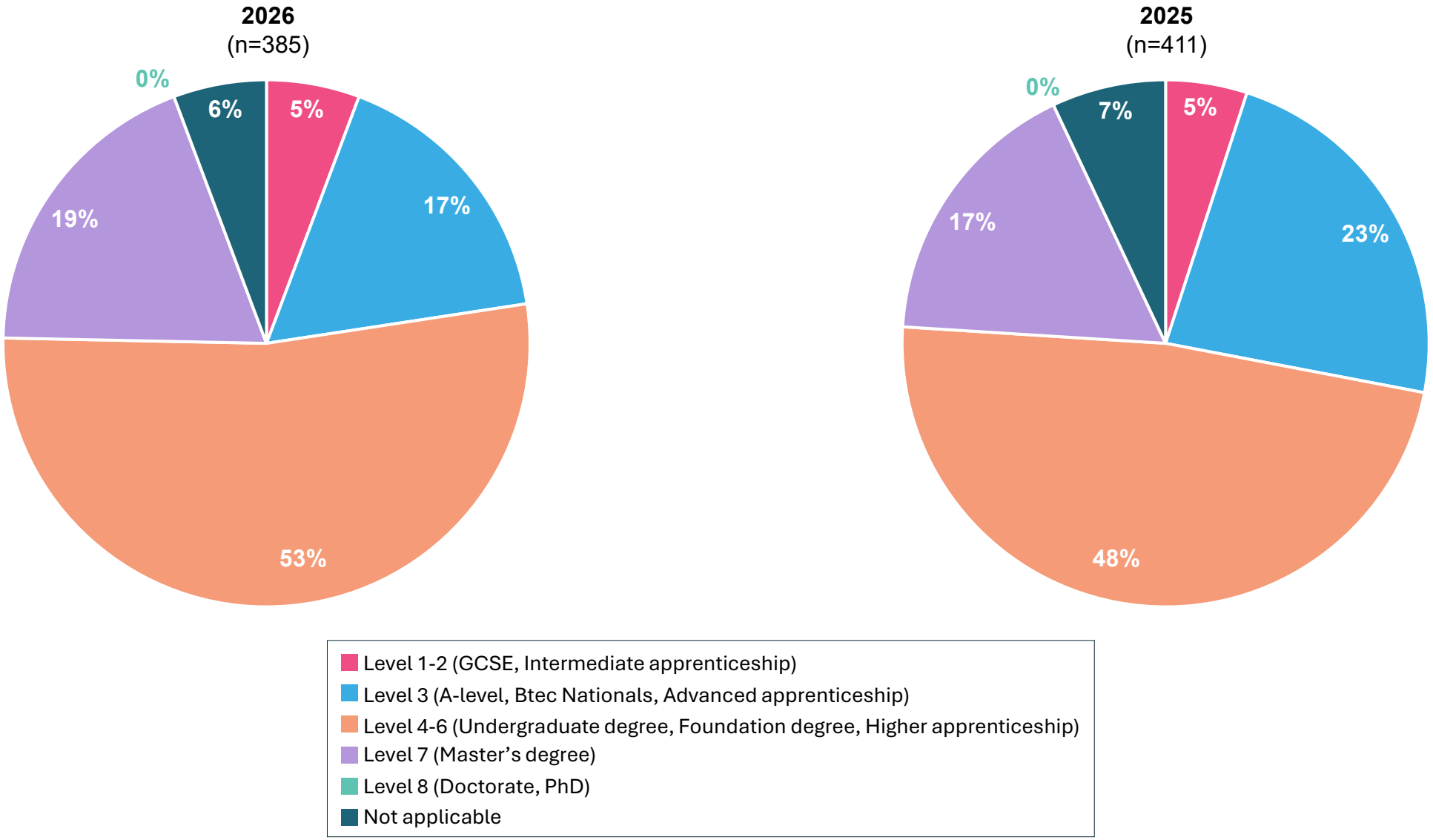
3. Where pressures are emerging

- SPLWs report increasingly supporting clients with complex needs
- Demand includes mental health and wider social issues such as housing and finance issues
- Some SPLWs report requiring additional skills and knowledge to respond effectively, suggesting a gap between role expectations and training provision
- Clear career pathways and progression opportunities remain an apparent gap in workforce development

4. What this means for delivery

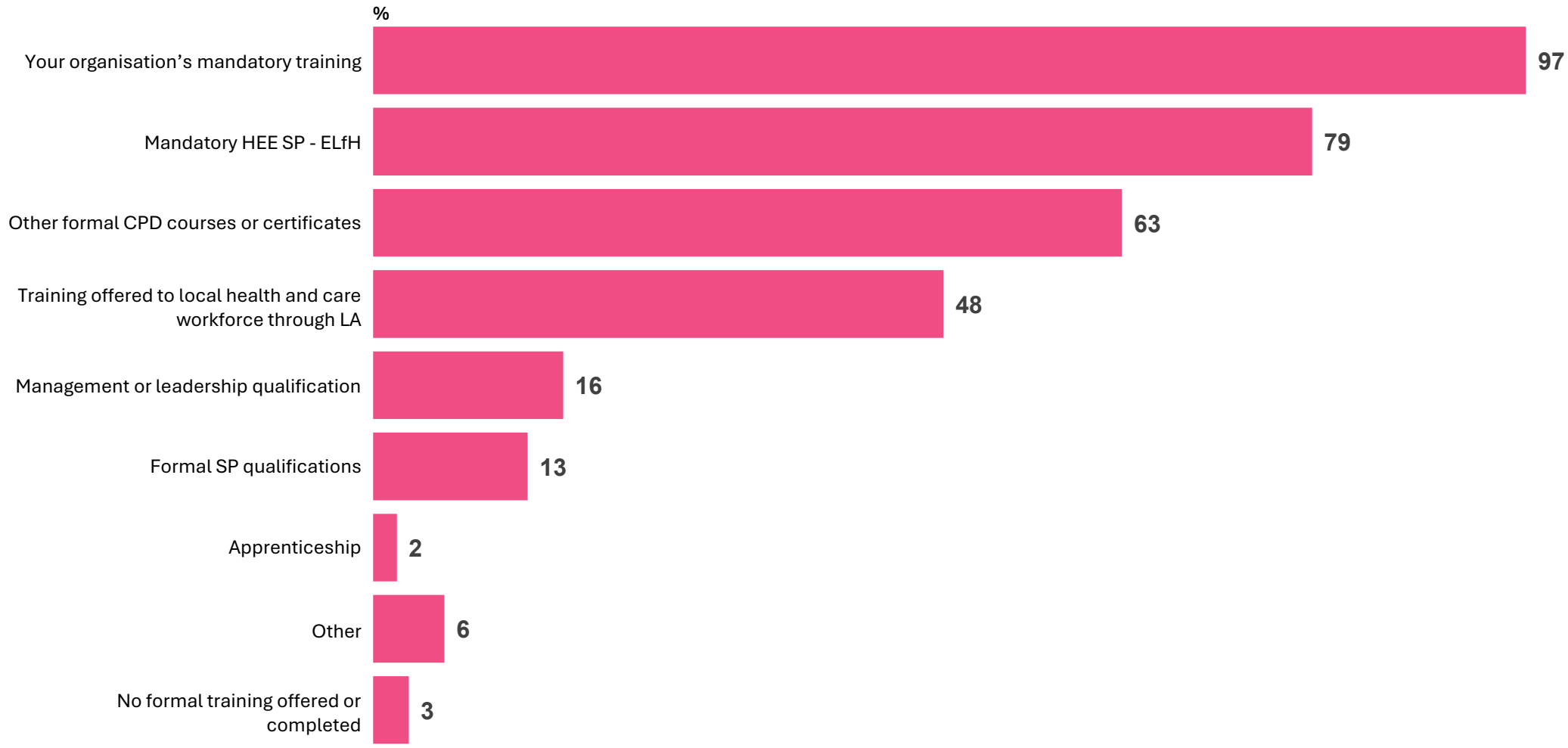
- Limited awareness of career pathways and progression opportunities may contribute to challenges around retention, professional identity, and longer-term workforce sustainability
- Inconsistent training may limit effectiveness in more complex cases
- Strengthening role-specific training and reflective support could improve consistency, impact, and retention
- Aligning training, supervision, and role demands will be key to achieving positive outcomes and sustaining impact.

Q. What is the highest level of training/education you had received before becoming a SPLW?



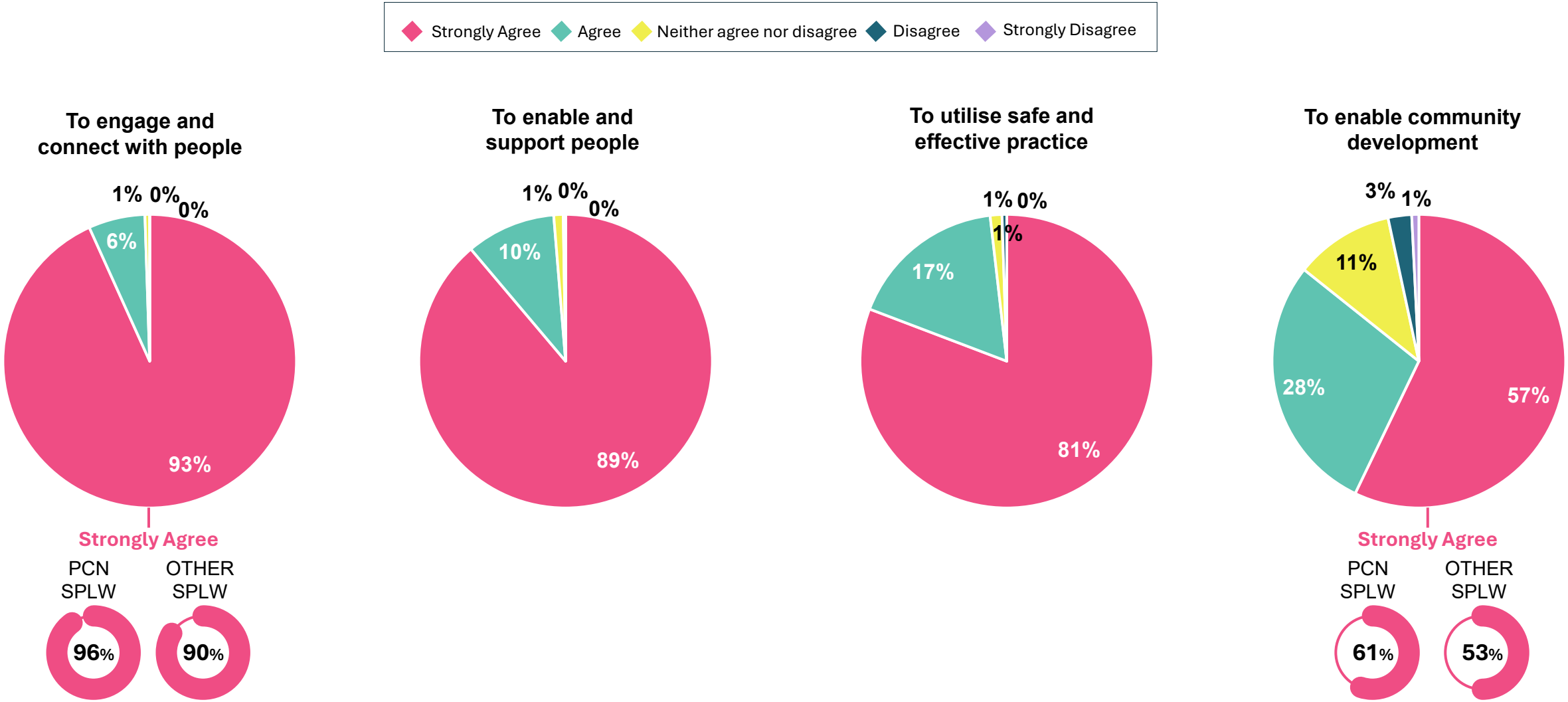
Q. From the following list, which training courses have you completed, or are in the process of completing since starting your role? (n=385)

- The vast majority of SPLWs have completed some form of training since starting their role, with very few reporting no formal training.
- Organisational mandatory training is most common, followed by HEE ELfH training, and other formal CPD.
- Around half of SPLWs report receiving local authority provided training.
- Relatively fewer have completed leadership/management qualifications, formal social prescribing qualifications, or an Apprenticeship.
- These findings suggest training is widespread, but varies in type and depth, and is driven primarily by mandatory organisational training.



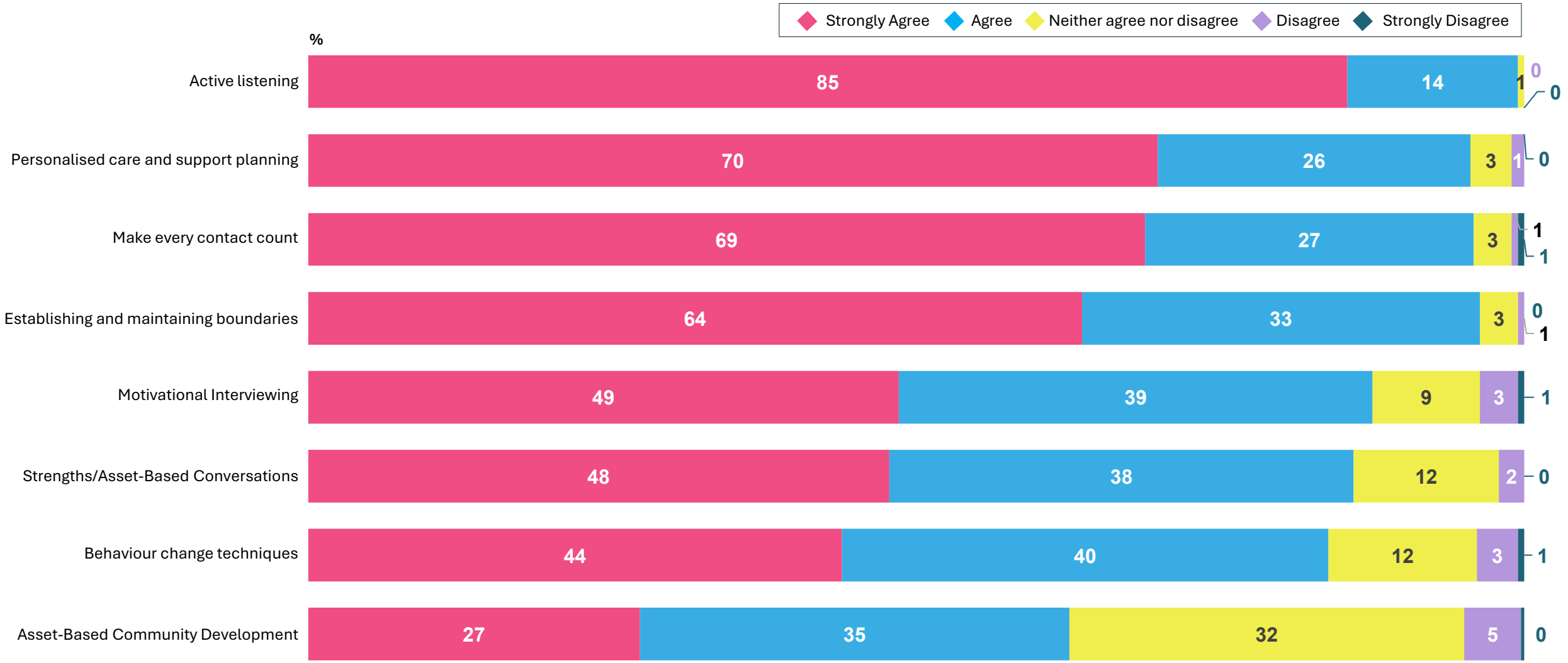
Q. The NHS England Workforce Development Framework sets out 4 core competencies for Social Prescribing Link Workers.
To what extent do you agree with the following statements? Regarding these competencies, I feel confident in my ability (n=385)

- The vast majority of SPLWs report feeling confident in each of the four NHSE core competencies for SPLWs.
- Almost all respondents feel confident in their ability to engage and connect with people, to enable and support people, and to utilise safe and effective practice, while a slightly lower majority report feeling confident in their ability to enable community development.
- SPLWs employed directly by PCNs are more likely than other SPLWs to report feeling confident in relation to engaging and connecting with people, and utilising safe and effective practice.



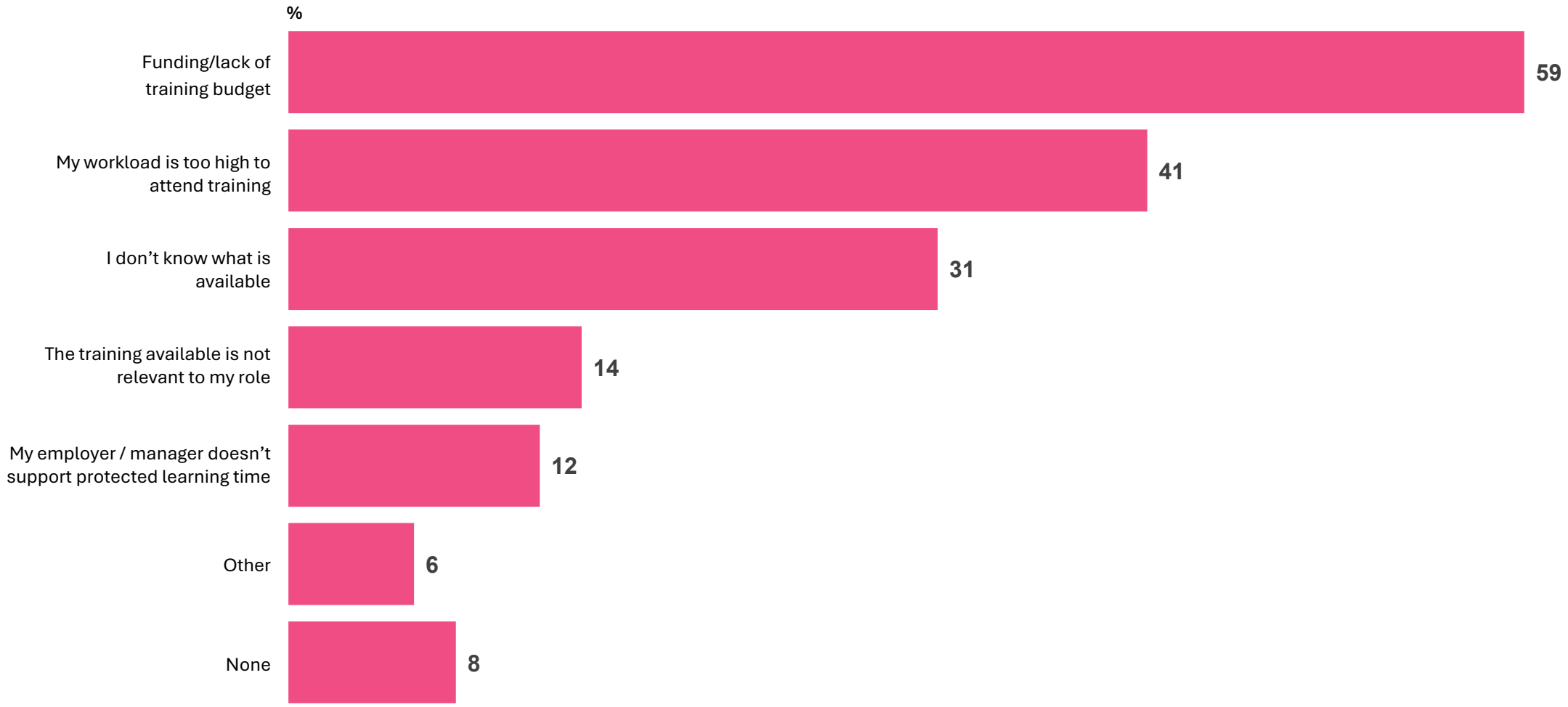
Q. To what extent do you agree with the following statements? I feel confident in the following as part of my practice: (n=385)

- SPWLs report high confidence across most areas of their practice listed, with very low levels of disagreement indicating consistent capability across the SPLW workforce.
- SPWLs have strongest confidence in Active Listening, followed by Personalised care and support planning, Making every contact count, and Establishing and maintaining boundaries.
- SPLWs have slightly lower confidence in Motivational Interviewing, Strengths/Asset-Based Conversations, and Behaviour change techniques.
- The lowest confidence reported is in Asset-Based Community Development, which also has a significant 'neutral' (neither agree nor disagree) group, suggesting more mixed familiarity.



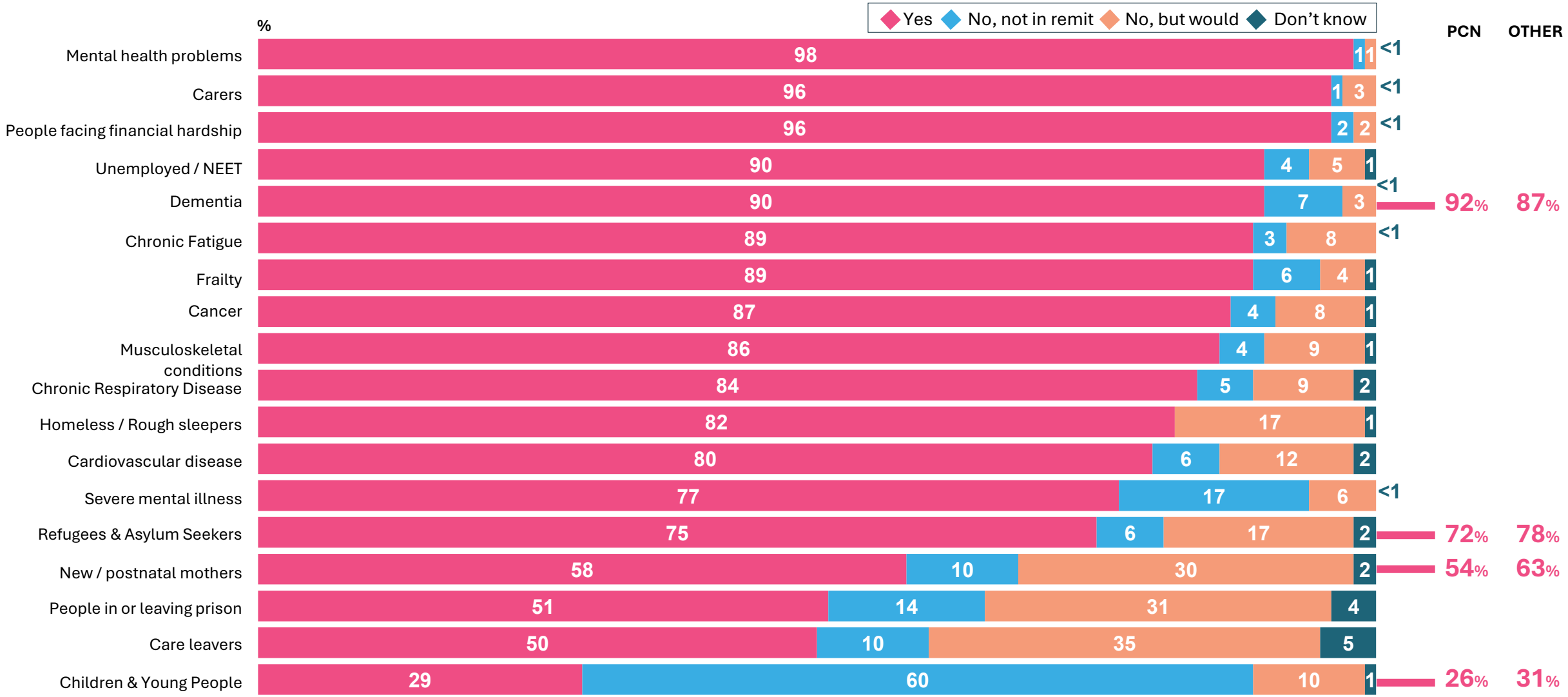
Q. Are there any barriers to undertaking formal training/CPD activities? (n=385)

- Access to training/CPD is constrained primarily by funding, and to some extent by workload.
- Almost a third of SPLWs report being unsure about what training is available acting as a barrier.
- Training not being relevant to the role, and limited employer support are lesser barriers, but still experienced by some SPLWs.
- Other barriers cited include organisational and structural barriers (e.g. limited management understanding of the SPLW role and lack of prioritisation by management), and limited flexibility - e.g. insufficient notice of opportunities given pre-booked appointments, and lack of interpreters).



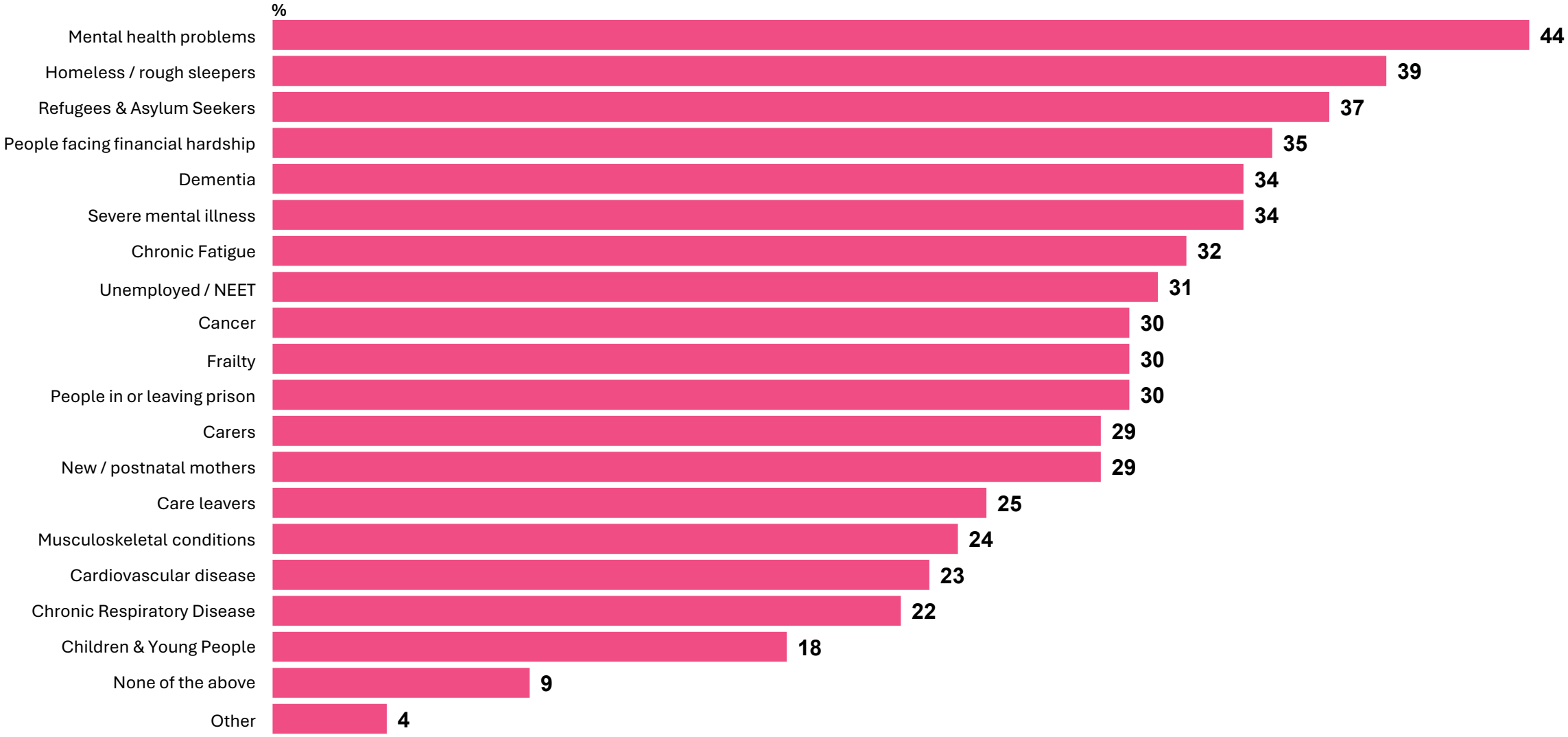
Q. To the best of your knowledge, have you supported any individuals from the following patient/client groups, in your role as a SPLW? (n=385)

- SPLWs report supporting a broad range of population groups, with particularly strong reach in mental health and social need, and more variation in specialist populations:
  - The majority of SPLWs report having supported patients/clients with mental health problems, carers, and people facing financial hardship.
  - People who are unemployed/NEET, as well as dementia, chronic fatigue, and frailty are also among the most commonly supported groups.
  - There is more variation in specialist or less typical groups, such as care leavers, people in or leaving prison, and new/postnatal mothers.
  - The least commonly support group is children and young people, which is likely to reflect remit boundaries.
- PCN SPLWs are more likely that Other SPLWs to have supported Dementia, and less likely to have supported refugees & asylum seekers; new/postnatal mothers; and, children and young people.



Q. Which of the following groups would you like to feel more confident in supporting? (n=385)

- The highest demand for increased confidence is in mental health, with mental health problems topping the list at 44% of SPLWs, and severe mental illness at 34%.
- Complex social needs, such as homelessness), refugees and asylum seekers, and financial hardship, are also a key theme.
- Traditionally underserved groups feature prominently (e.g. Unemployed/NEET, and people in or leaving prison).
- Long-term conditions also show moderate demand – including dementia, chronic fatigue, and cancer.
- Very few SPLWs feel confident across all groups (only 9% selected 'none').
- 'Other' suggestions include neurodiversity, housing issues, and learning disabilities.

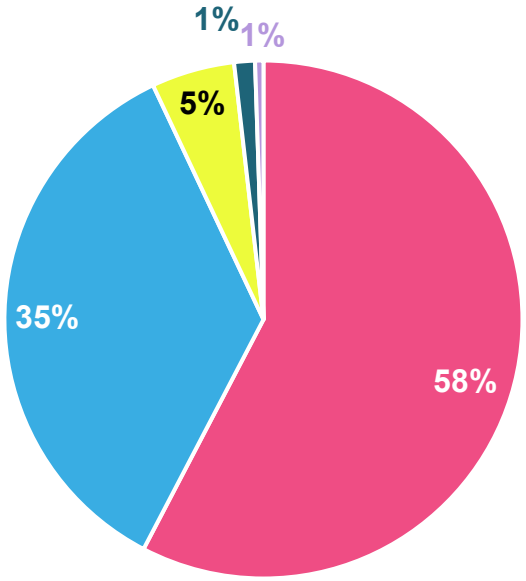


Q. To what extent do you agree with the following statements regarding training and development?

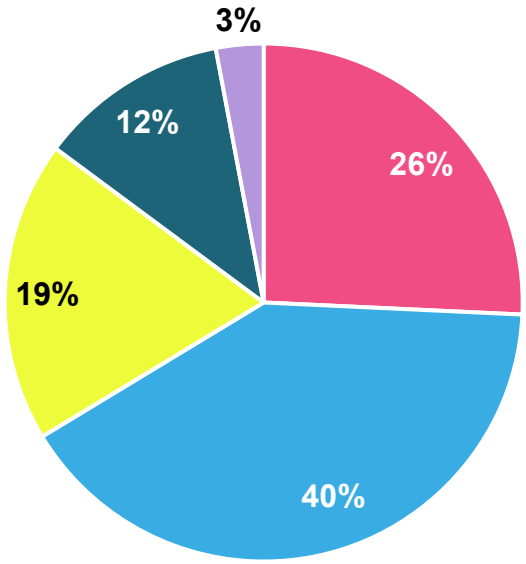
- The vast majority of SPLWs report understanding the scope of their role (93% 'strongly agree' or 'agree', compared with 89% in 2025).
- Two-thirds report being aware of the training and development opportunities in their role (66% 'strongly agree' or 'agree')
- Only one-third report being aware of available career progression opportunities (33% 'strongly agree' or 'agree').

2026 (n=385)

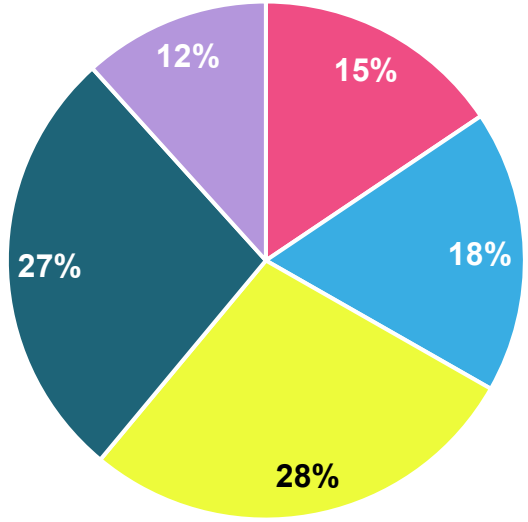
I understand the scope of my role



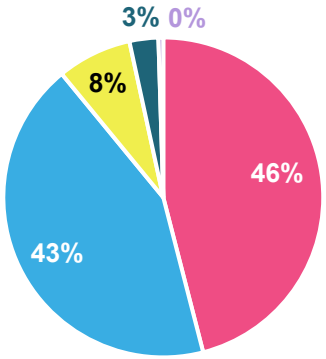
I am aware of the training and development opportunities in my role

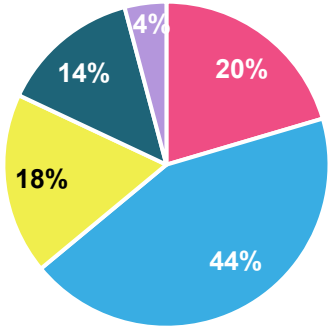


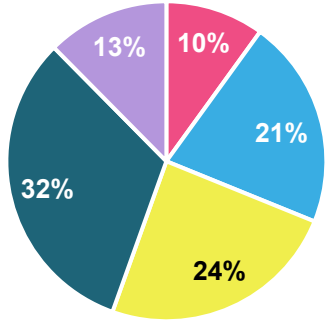
I am aware of the career progression opportunities available to me



2025 (n=411)



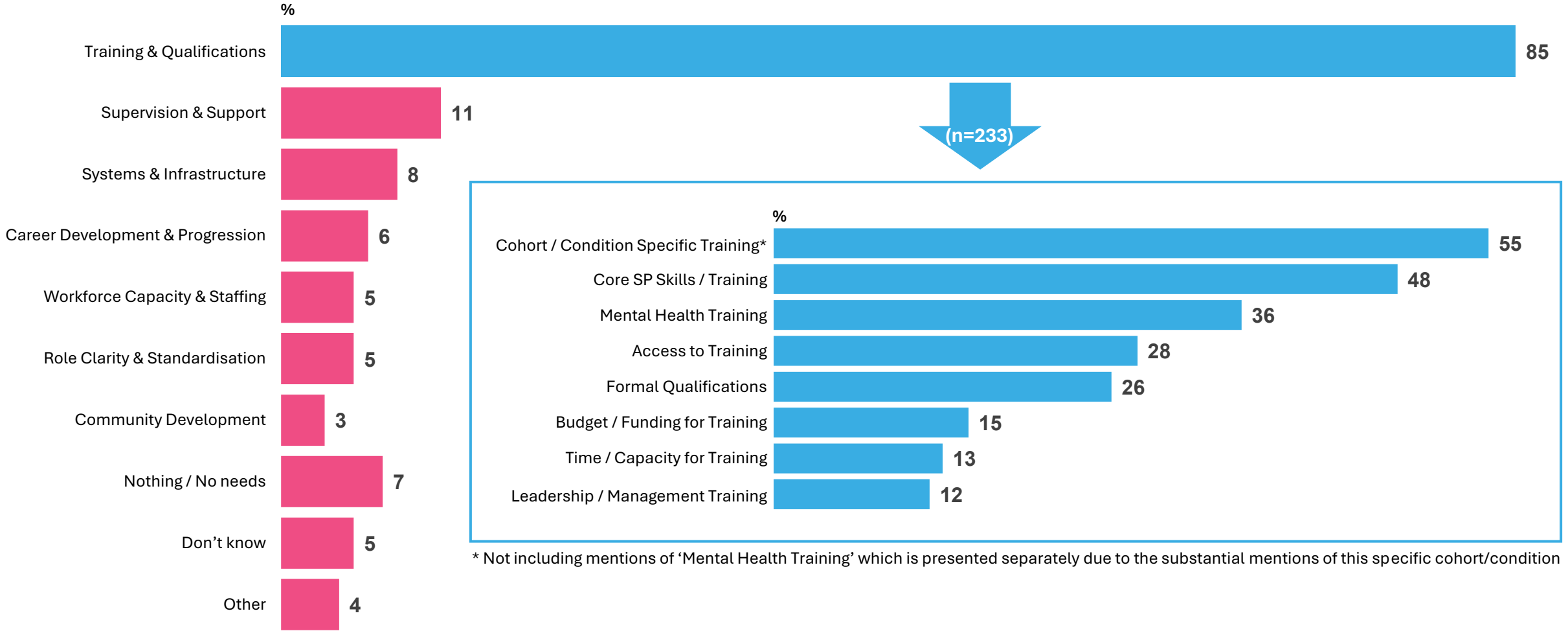




Strongly Agree | Agree | Neither agree nor disagree | Disagree | Strongly Disagree

Q. What additional training, support, or resources would improve your practice? – Open, write in (n=275)

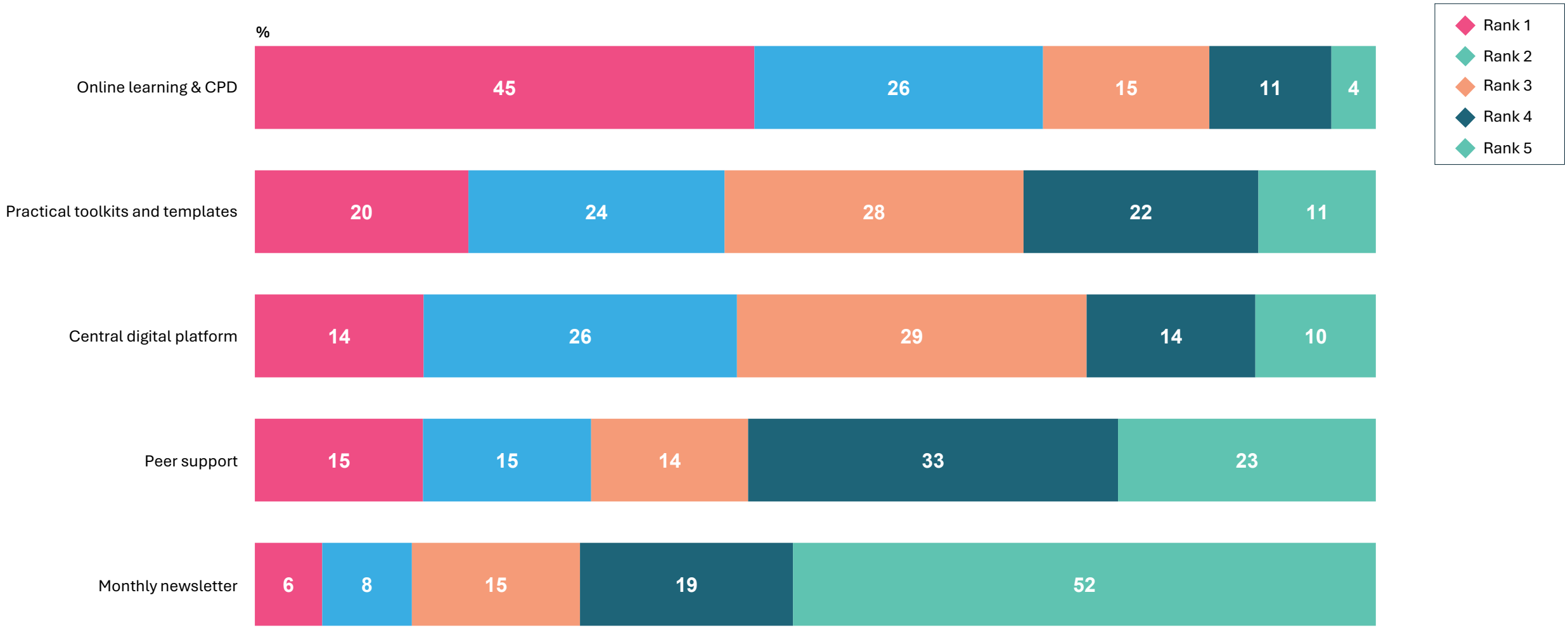
- Overwhelmingly, SPLWs referred to training & qualifications to improve their practice.
- Within this, the majority cited cohort/condition-specific training, followed by core social prescribing/SPLW skills, and Mental Health training.
- Aside from non-specific requests for e.g. 'training to support the cohorts the practice supports' (n=11), the most frequently requested cohort/condition-specific training was Neurodiversity (n=7), followed by Dementia, and Homeless/Housing (both n=5).
- The most frequently mentioned core skills were Motivational Interviewing (n=17) and Coaching (n-=13).



* Not including mentions of 'Mental Health Training' which is presented separately due to the substantial mentions of this specific cohort/condition

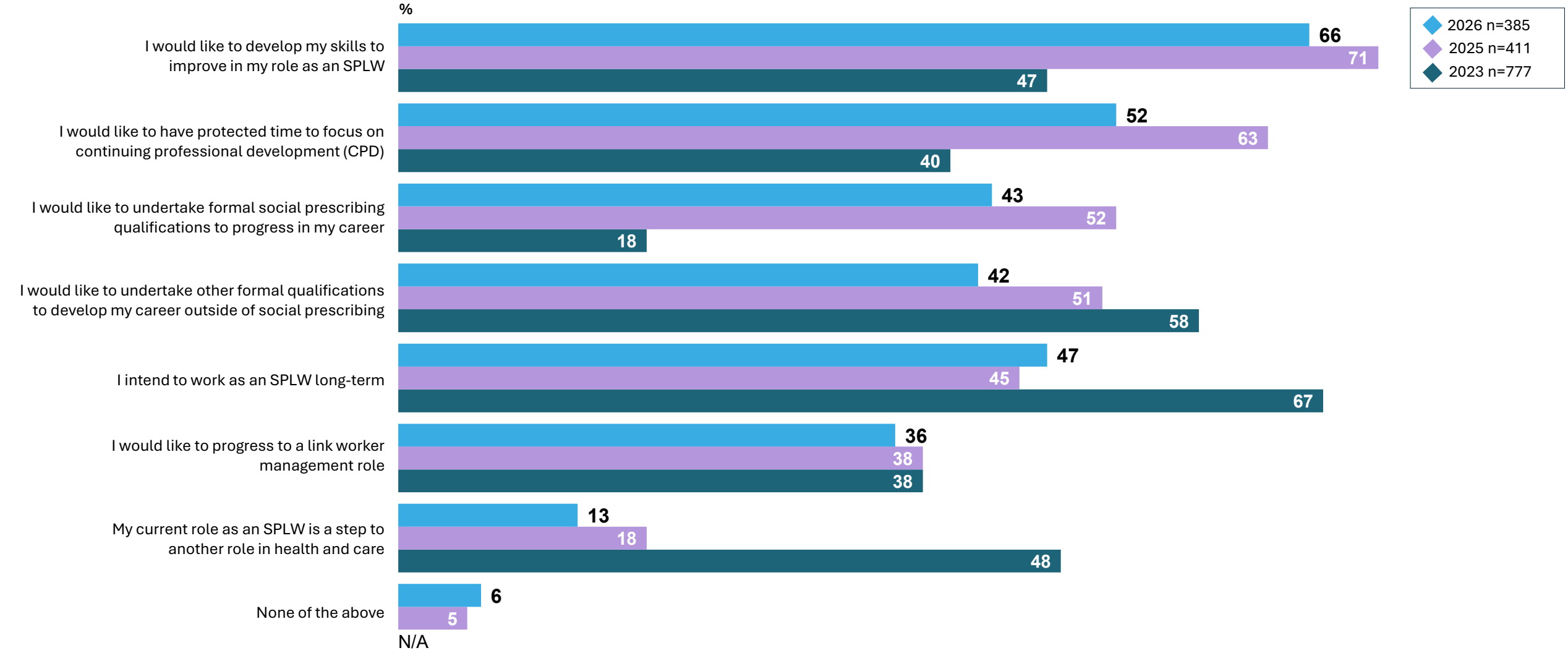
Q. Which types of support or resources from NASP would be most valuable to you? Please rank the following options in order of most to least valuable (n=385)

- SPLWs prioritise practical, skill-based support:
  - Online learning is the top priority, with the highest number of SPLWs ranking it as most valuable.
  - Practical toolkits and templates and a central digital platform are also valued, but typically ranked in the middle, suggesting broad but less urgent demand.
  - Peer support shows mixed preference, with responses spread across rankings, indicating it is considered valuable but not universally prioritised as a method of NASP support.
  - Newsletters are least valued, with over half ranking them lowest.



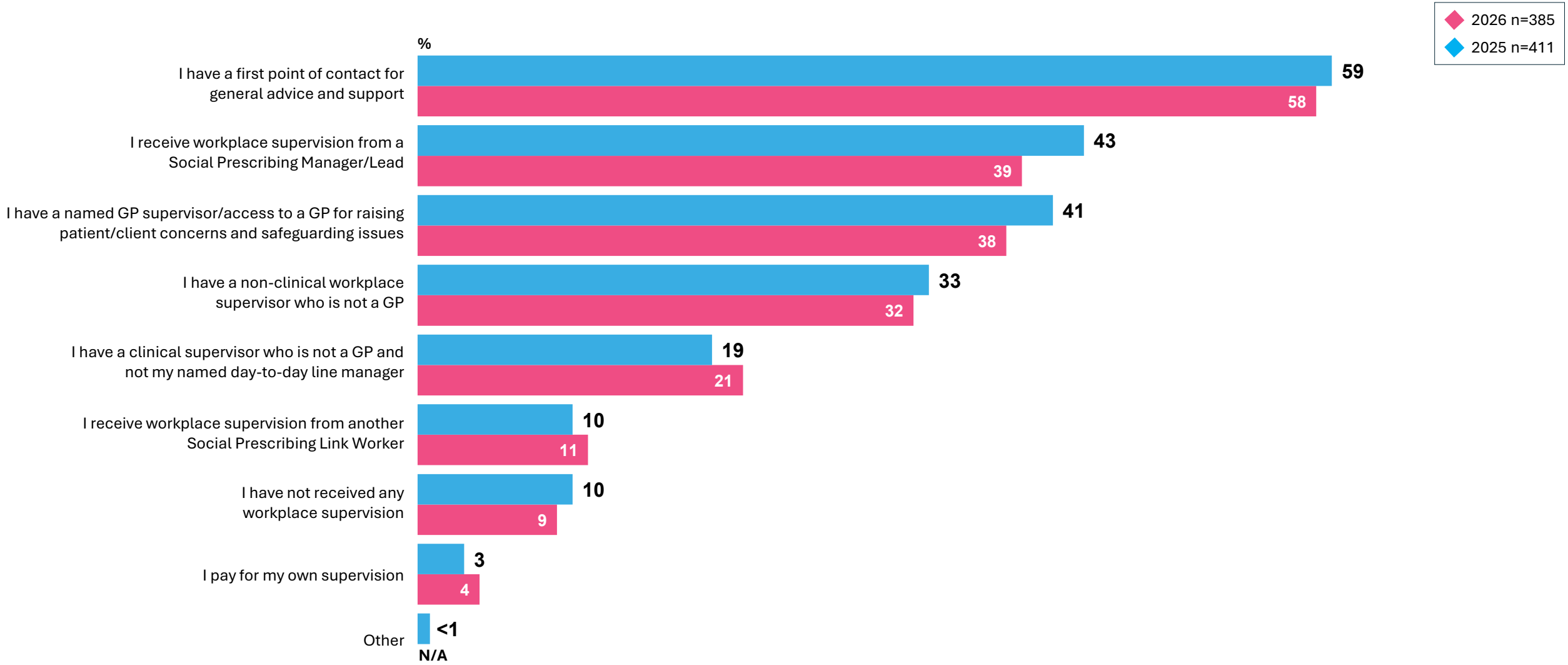
Q. With regards to career progression and professional development, please select all the following statements that apply.

- There is strong appetite for development within role, with the highest responses for developing skills to improve practice and having protected time for CPD.
- A little less than half of SPLWs indicate their intention to work as an SPLW long-term, with few indicating the role is a step to another role in health and care.
- There is significant interest in further qualifications – both within social prescribing and more broadly. But interest has decreased since 2025.
- Career progression ambitions are mixed, with interest in management roles spread more evenly – 39% of those not already in a SPLW Team Lead, SPLW Manager, or Senior SPLWrole, say they would like to progress to one.
- Few SPLWs selected 'none of the above', indicating that the vast majority are invested in professional growth in some capacity.



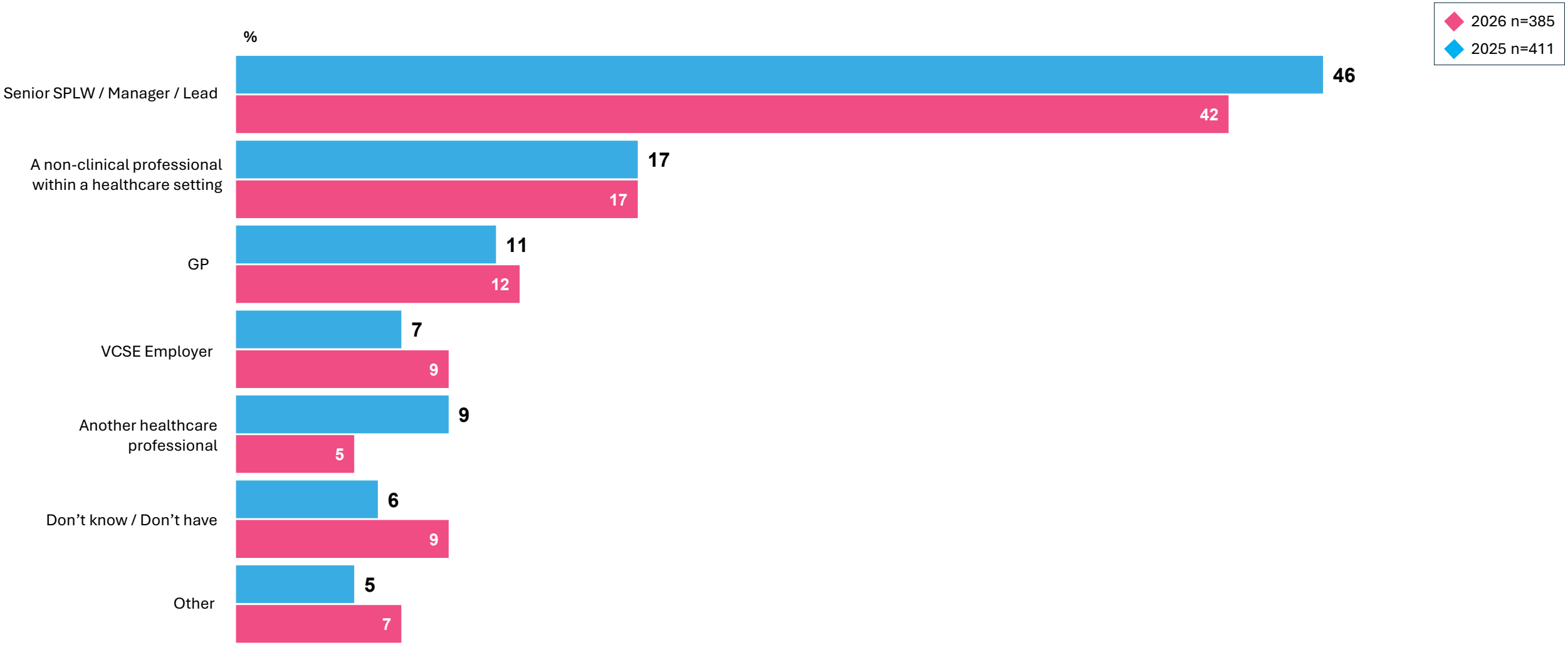
Q. Which forms of supervision do you receive in your role? Please select all that apply

- The most frequently cited forms of supervision are:
  - A general advice/support contact
  - Supervision from a social prescribing manager/lead
  - A named GP supervisor/access to a GP for raising patient/client concerns and safeguarding issues.
- One in ten SPLWs report receiving no workplace supervision – PCN SPLW are more likely than Other SPLW to report not receiving any workplace supervision (13%, compared with 6%).



Q. Who is your primary supervisor?

- There is substantial variation in supervision arrangements, and a mix of clinical and non-clinical supervisory models.
- SPLWs most commonly report being supervised by a Senior SPLW, Manager, or Lead.
- The slight decrease in SPLWs who don't know/don't have a supervisor, coupled with a slight increase in supervision from senior SPLWs/managers/leads and other healthcare professionals suggests some improvement in structures, but a need to strengthen support structures for some SPLWs remains.



Systems & Caseload Management

Systems & Caseload Management - Summary

1. How outcomes are measured

- A wide range of tools are used, including ONS4, (S)WEMWBS, MYCaW, and in-house measures
- Many SPLWs use a combination of quantitative and qualitative tools
- No single standard approach, with variation across individuals and areas
- A small but notable group report using no formal measurement tools.

2. Consistency of data capture

- Outcome data collection is not consistently embedded in practice; recording frequency varies, suggesting it is often *ad hoc* rather than routine
- SPLWs identify a need for more time, clearer processes, and better systems to support consistent data capture.

3. How data is used

- Outcome data is most often used for internal learning and service improvement, and less frequently used to inform funding, investment, or wider system decisions; sharing beyond the social prescribing team is inconsistent.

4. Feedback collection

- Feedback is most commonly gathered from patients/clients, with less consistent collection from carers, referrers, and activity providers
- This suggests a partial view of impact, with gaps in system-wide insight.

5. Systems and infrastructure

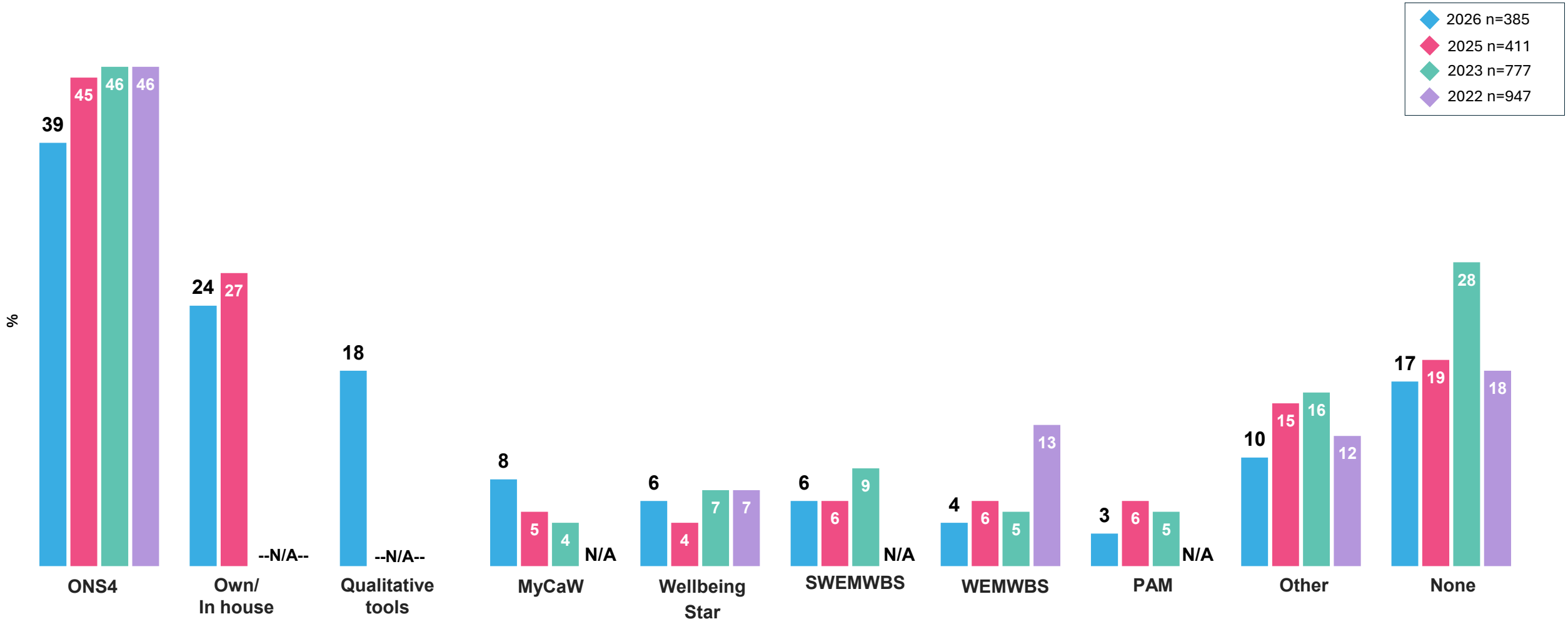
- There remains a fragmented IT landscape, including use of clinical systems, Joy, Elemental, spreadsheets, and in-house CRMs
- Some SPLWs report no dedicated system for tracking referrals
- Variation in systems used likely contributes to inconsistent data capture and use.

6. What this means for delivery

- Lack of standardisation and inconsistent data capture creates data gaps and reduces the ability to fully demonstrate impact and value
- Strengthening data collection tools, processes, and infrastructure will be key to moving from data collection to meaningful insight and influence.

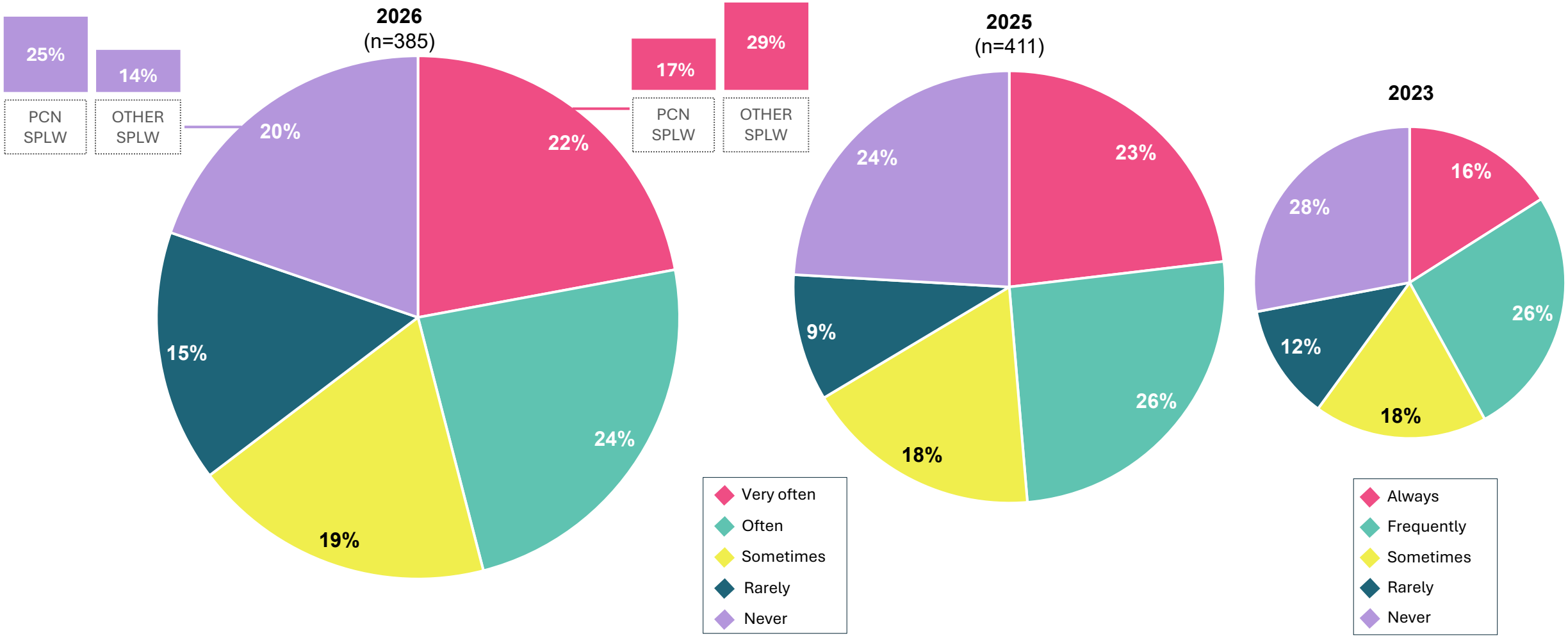
Q. Which tools do you use to measure social prescribing outcomes?

- ONS4 remains the most commonly used tool to record outcomes, but has use has declined over time.
- A quarter report using their own/in-house tool, and almost a fifth report using 'qualitative tools (e.g. open-ended questions)'
- Over the years there has been a slight increase in use of MyCaW and a decrease in use of WEMWBS and SWEMWBS.
- A notable minority (17%) still report not using any tools to measure outcomes.



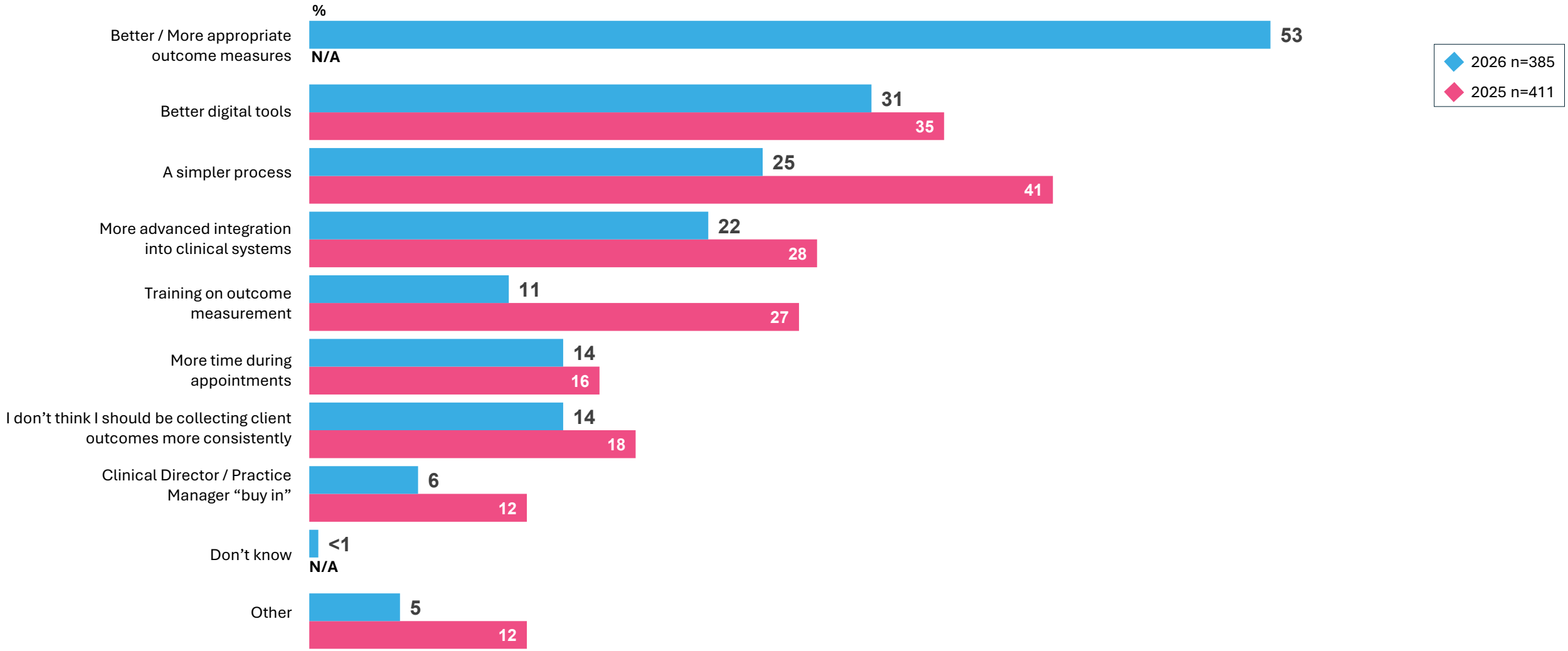
Q. Overall, how often do you record patient and/or client outcome measures (e.g. ONS4)?

- A little under half of respondents indicate that they record social prescribing outcomes 'very often' or 'often' (46%), while a 20% report that they 'never' record outcomes.
- While the majority of SPLWs (54%) still report recording outcomes only 'sometimes', 'rarely', or 'never', indicating ongoing inconsistency in outcome recording, the decrease in SPLWs reporting 'never' (from 28% in 2023 to 20% in 2026) suggests a gradual shift towards more consistent recording.
- PCN SPLWs are more likely than other SPLWs to say they 'never' record outcomes (25% compared with 14%) and less likely to say they record outcomes 'very often' (17%, compared with 29%).



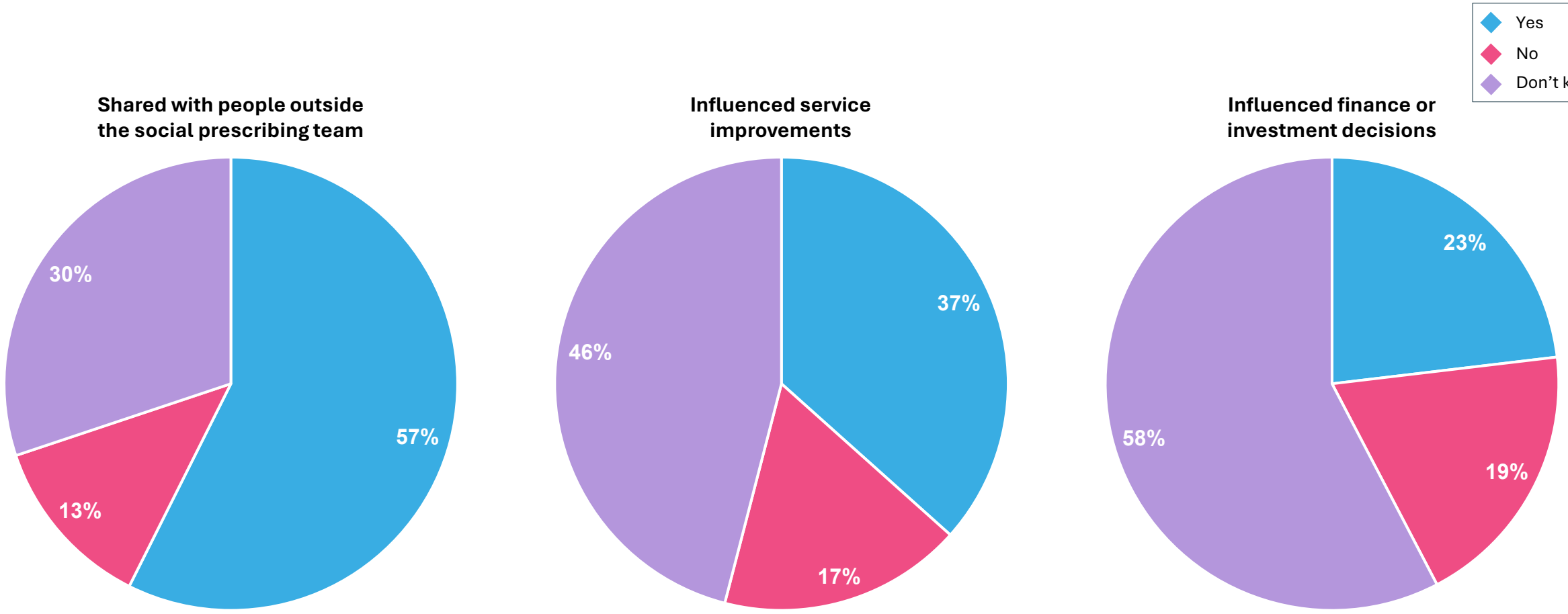
Q. What do you need to enable you to capture patient/client outcomes more consistently? Please select at most 3 options

- 'Better/More appropriate outcome measures' is by far the most commonly selected response needed to more consistently capture client outcomes reported by just over half of SPLWs.
- Almost a third of SPLWs selected 'better digital tools', a quarter 'a simpler process', and approximately a fifth 'more advanced integration into clinical systems'.
- Compared with 2025, there has been a substantial decrease in the proportion of SPLWs reporting:
  - 'A simpler process' (from 41% to 25%)
  - 'Training on outcome measurement' (from 27% to 11%)
  - 'Clinical Director/Practice Manager "buy in" (from 12% to 6%).



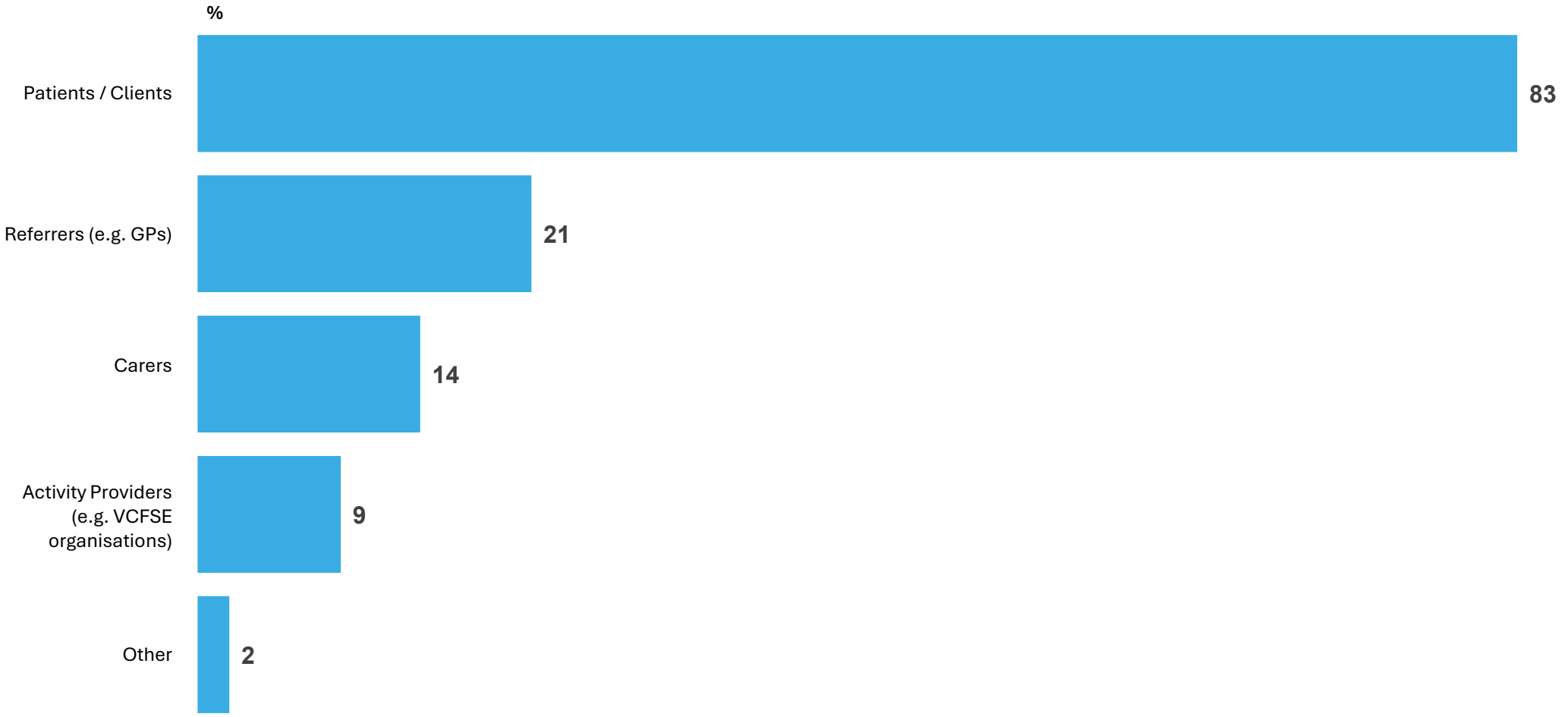
Q. Has outcome data been used in any of the following ways? (n=385)

- While outcome data is being used across services, its application remains inconsistent and not well understood by SPLWs.
- Most SPLWs report that data is shared beyond their team, however, a substantial proportion indicate they 'don't know', highlighting limited visibility of how data is used outwith teams.
- Outcome data appears to inform service improvements for some, with around two in five reporting this use. Nevertheless, high levels of uncertainty and a notable minority reporting no use of data in this regard suggests that data is not consistently translated into service development.
- Use of outcome data to inform finance or investment decisions is more limited. Around a quarter report such use, while the majority of SPLWs remain unsure, and one in five indicate outcome data is not used in this manner, suggesting that use of outcome data is not yet routinely embedded in financial decision-making processes.
- Compared with 2025, there has been an increase in the proportion of SPLWs reporting use of data in financial decisions, and reduced uncertainty, however, the simultaneous rise in SPLWs reporting no use reinforces that use of data in finance/investment decisions remains uneven.
    - In 2025, 14% reported data had been used to influence financial decisions, and 12% that it hadn't while 74% reported not knowing if data had been used in this way.



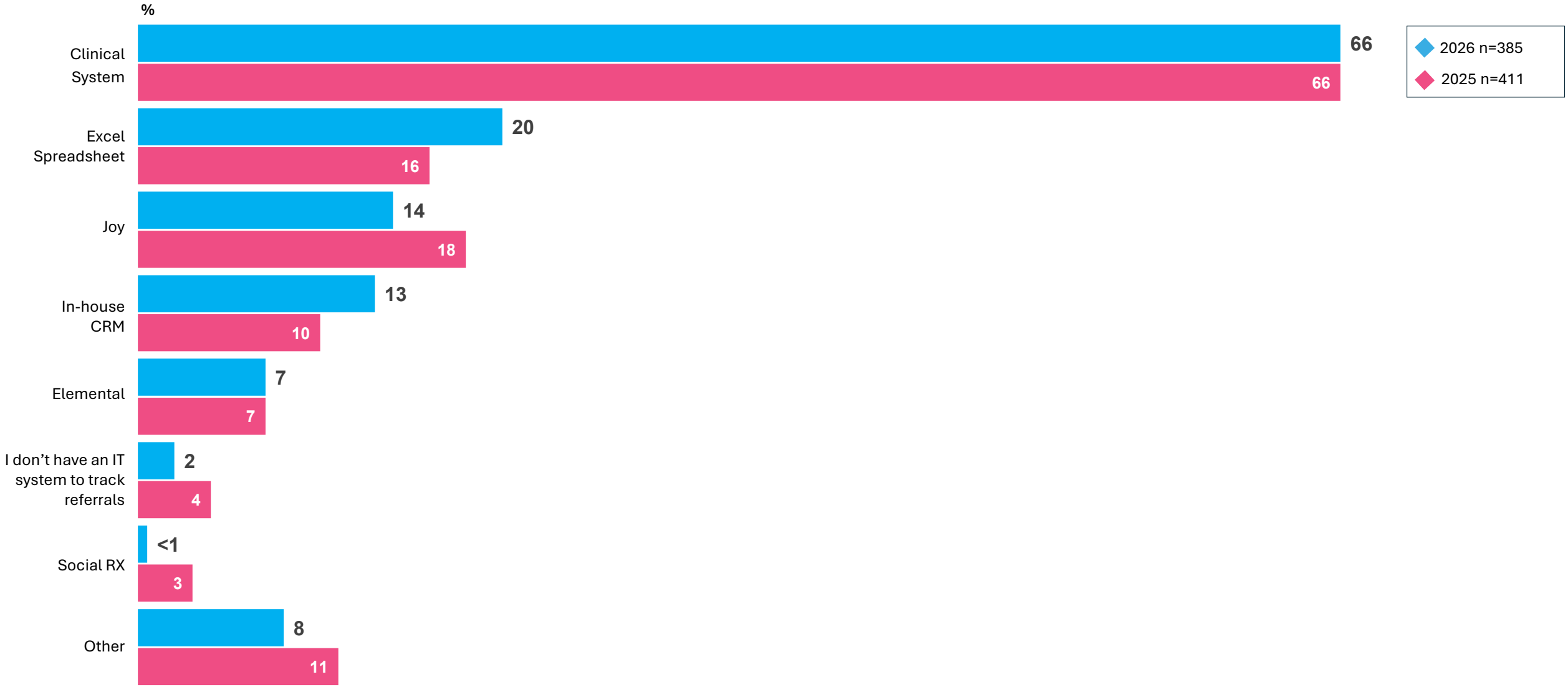
Q. Do you have systems/processes in place for collecting feedback from…? (n=385)

- Overall, feedback systems capture a partial view of impact, focused on end users rather than the full pathway:
  - Feedback collection is heavily concentrated on patients/clients; around 4 in 5 SPLWs reporting collection from this group.
  - Referrers and carers are less consistently included, limiting visibility of the wider support journey.
  - Very limited feedback is collected from activity providers, despite their central role in delivery.
- The findings suggest missed opportunities for system-wide learning, particularly around referral quality, service fit, and delivery experience.
- Strengthening feedback from providers, referrers, and carers would enable a more holistic understanding of impact, while more balanced feedback loops could improve service design, partnership working, and patient/client outcomes.



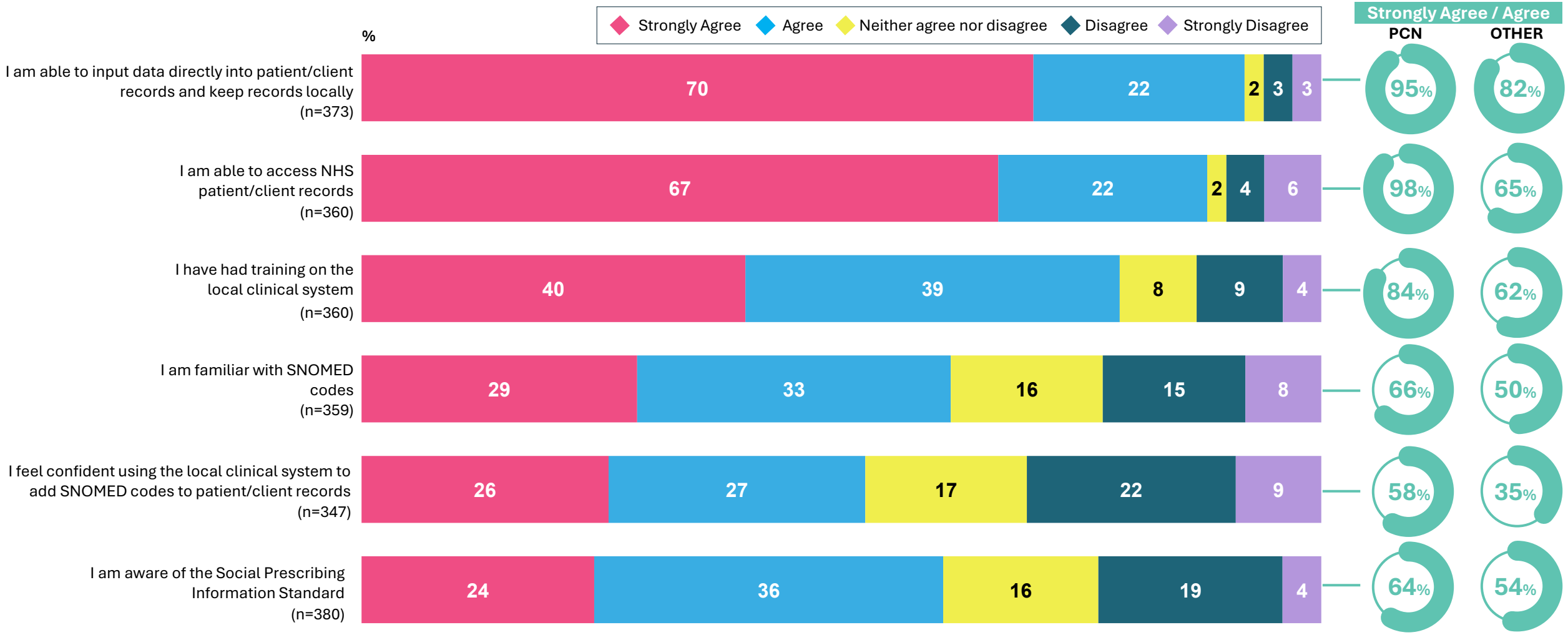
Q. What IT system do you use to track and/or monitor your referrals?

- In line with 2025, two thirds of SPLWs use clinical systems like EMIS or SystmOne to track referrals.
- There has been a slight increase in SPLWs reporting use of Excel spreadsheets and in-house CRMs, and a slight decrease in use of Joy, and reports of not having an IT system to track referrals.
- 'Other' responses include Charity Log and RiO, as well as DCRS, Theseus, Upshot, Simply Connect, AIDE, Medicus, PharmOutcomes, ECINs, and SharePoint.



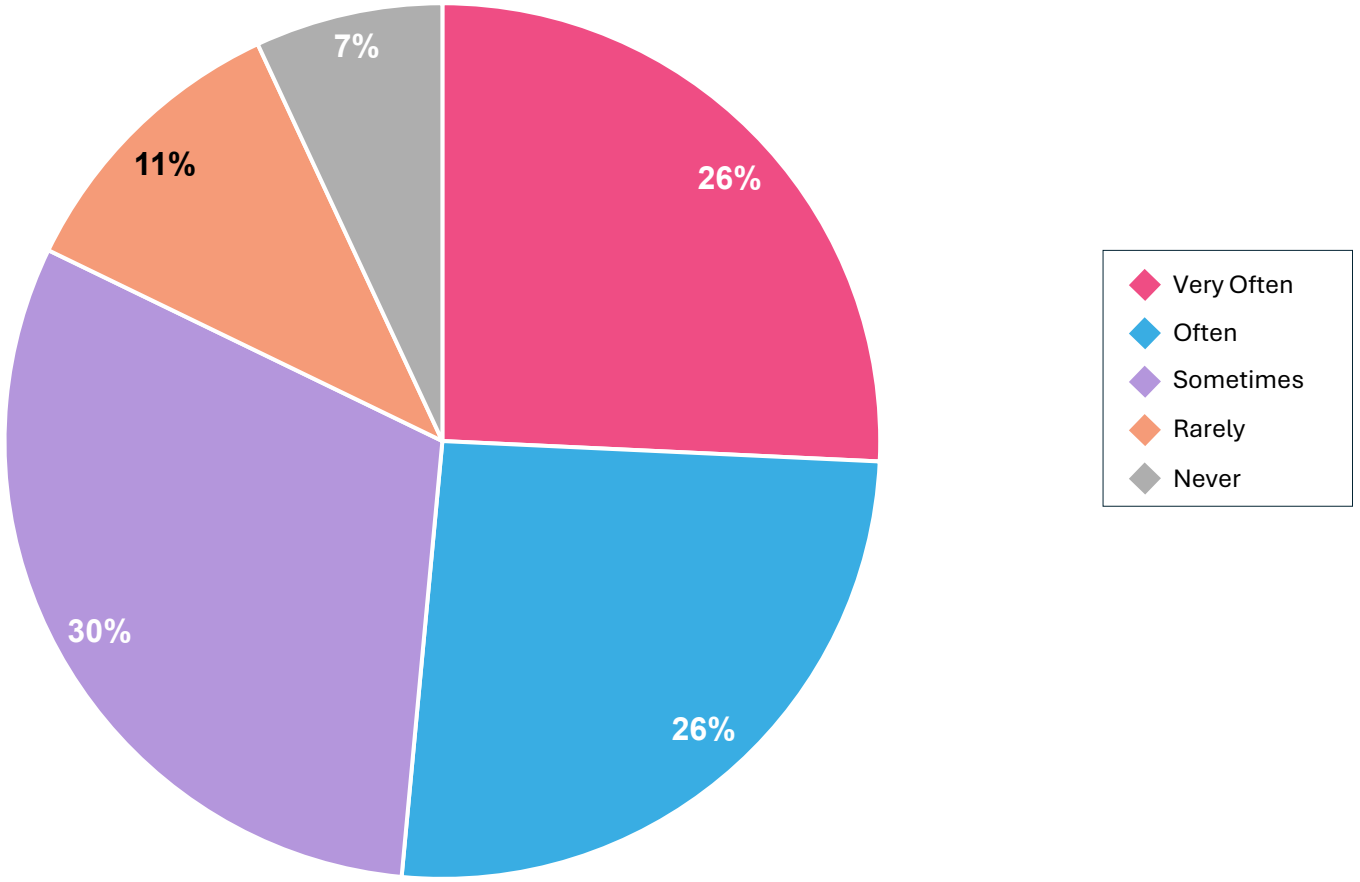
Q. To what extent do you agree with the following statements?

- While access to patient records/clinical systems and data entry are strong, there is a clear gap between system access and confident, standardised data use, suggesting that SPLWs can use systems operationally, but may not be fully equipped to use them consistently or in line with standards.
- Most SPLWs indicate being able to access records and input data directly into patient records, and a clear majority report having received training on local clinical systems.
- However, despite training, confidence and familiarity with SNOMED codes are mixed, with a notable minority lacking confidence in adding SNOMED codes to records.
- Awareness of the Social Prescribing Information Standard is inconsistent, with a sizeable proportion of SPLWs neutral or disagreeing they are aware of it.
- Across all statements, agreement is stronger among PCN SPLWs that Other SPLWs.



Q. Do you track onward referrals to external organisations? (n=385)

- While a little over half of SPLWs report tracking referrals ‘often’ or ‘very often’, a sizeable proportion only track ‘sometimes’ or ‘rarely’, and a small group never tracking onward referrals.
- This variation likely reflects differences in systems and infrastructure, time and workload pressures, and variable expectations or guidance.



Further Information

Further Information - Summary

1. Workforce Experience

- SPWLs feel highly motivated and impactful in their roles
- Most SPLWs are engaged in MDT working, though integration varies
- Strongest satisfaction among PCN-employed SPLWs
- Day-to-day experience remains positive, but not uniform.

2. Integration & recognition

- SPLWs generally feel valued by clinicians and primary care teams
- A notable minority report lack of clarity about the SPLW role among colleagues.

3. Workforce pressures

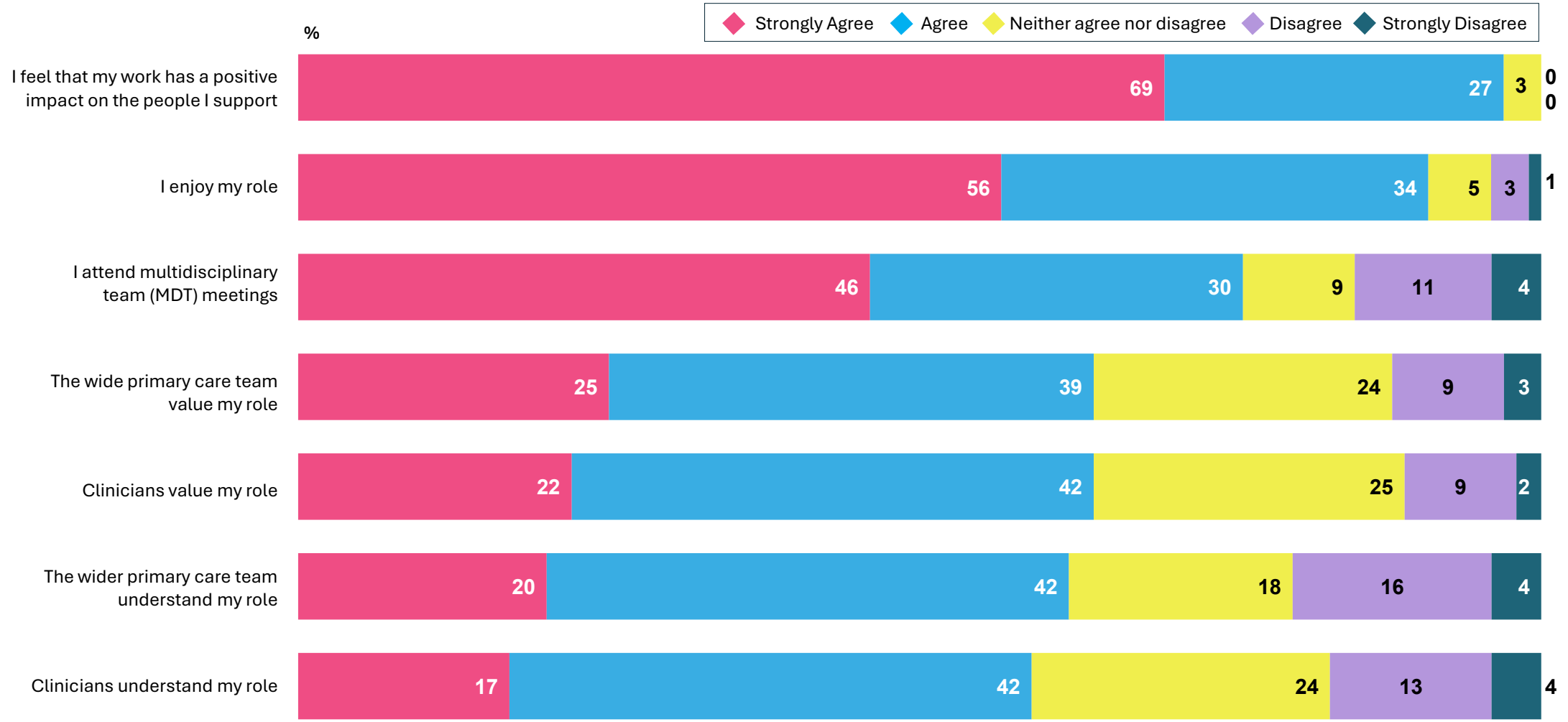
- Around 4 in 10 SPLWs have/are considering leaving (consistent with 2025)
- Key drivers: Career progression & Low pay

4. What drives the workforce/retention

- SPLWs are highly motivated and committed to their impact
- Retention challenges are driven primarily by system factors rather than the role itself
- Workforce sustainability depends on clearer progression, stronger support, and better integration into primary care teams.

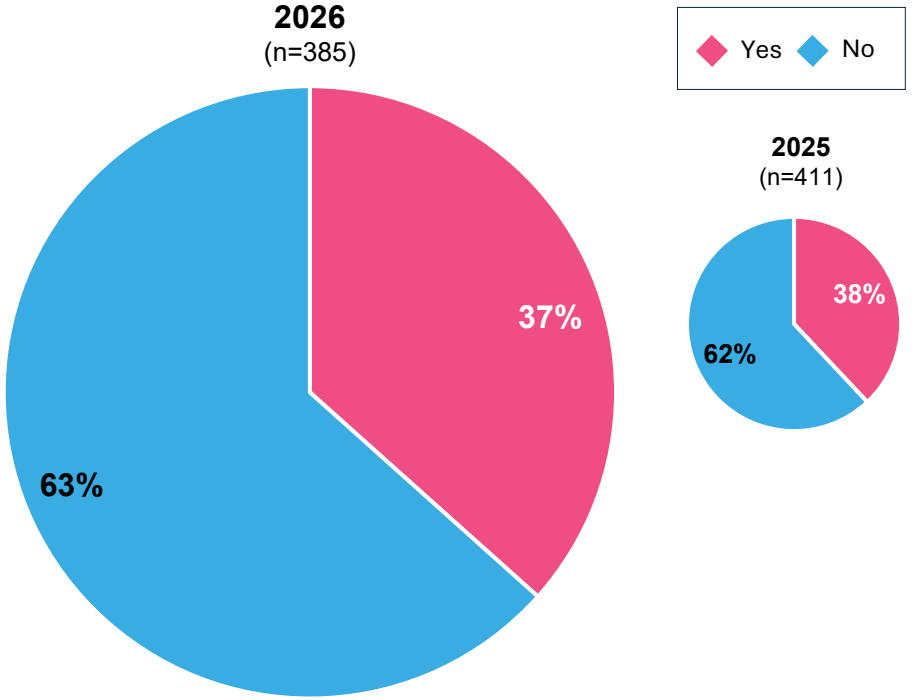
Q. To what extent do you agree or disagree with the following statements? (n=385)

- SPLWs have a strong sense of impact and job satisfaction:
  - 96% 'strongly agree' or 'agree' their work has a positive impact, and 90% that they enjoy their role.
  - SPLWs employed directly by PCNs are more likely than Other SPLWs to 'strongly agree' they enjoy their role – 60% compared with 51%.
    - In 2025, 53% of PCN SPLWs reported this, compared with 62% of Other SPLWs.
- Most SPLWs attend MDT meetings, but some remain less integrated into cross-team working.
- Most SPLWs feel valued by clinicians and primary care teams, though not consistently.
- Understanding of the role is more mixed: A notable minority report that clinicians and wider teams do not fully understand the SPLW role.

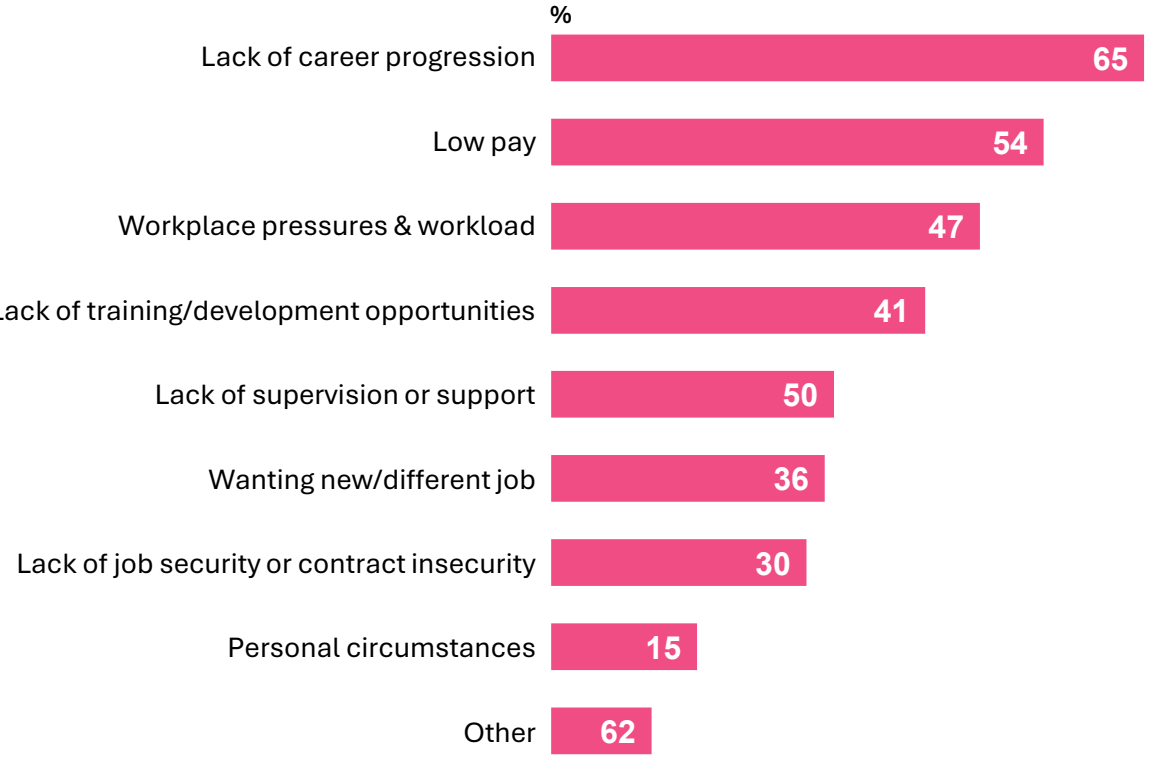


- Nearly 4 in 10 SPLWs report that they have considered or might consider resigning in the next year; this is line with 2025 survey findings.
- Lack of career progression is the most commonly cited reason for considering resigning.
- Low pay is also identified as a contributing factor, along with workplaces pressures & workload.
- Additional themes from 'Other' include:
  - Feelings of isolation in role/lack of integration into practice
  - Ambiguity in job description/boundaries of SPLW role
  - Micromanagement, poor PCN leadership, perceived focus on numbers and data over patient care, and low team morale
  - Reduction of face-to-face work/too much telephone-based work
  - Lack of transport for patients to be able to access available provision.

Q. Have you considered or might you consider resigning in the next year?



Q. If yes, what is the reason you are considering resigning? (n=141)



Optional Questions

Optional Questions - Summary

1. The most enjoyable aspects of the SPLW role revolve around:

- Making a difference in people's lives
- Building meaningful relationships
- Autonomy, variety, and flexibility of the role
- Contributing to community and system impact
- Experiencing personal and professional growth.

2. Key challenges of the SPLW role include:

- Referral and service gaps
- Systemic and organisational challenges
- Funding insecurity and lack of resources
- Client and caseload management
- Workplace support and integration.

3. Changes SPLWs would make to their role relate to:

- Training, development & career progression
- Support & supervision
- Tools & resources
- Role understanding and integration
- Workload & time management
- Job security
- Pay and benefits
- Community engagement & outreach work
- Autonomy and flexibility
- Service accessibility

Q. What do you enjoy most in your role as a SPLW?

MAKING A DIFFERENCE TO PEOPLE'S LIVES

- Helping people overcome challenges, improve wellbeing, and create positive life change
- Supporting and empowering individuals, especially those who are vulnerable or socially isolated
- Seeing tangible improvements in people's lives – e.g. reduced stress and increased confidence

BUILDING MEANINGFUL RELATIONSHIPS

- Developing strong, meaningful connections with patients, carers & wider community
- Having the time to actively listen and support people holistically
- Working 1:1 with patients and seeing their journey of progress

ROLE AUTONOMY, FLEXIBILITY & VARIETY

- No two days are the same, making the job engaging and dynamic
- Opportunity to work independently whilst also being part of a team
- Freedom to manage caseloads and structure work based on patient needs

CONTRIBUTING TO COMMUNITY & SYSTEM IMPACT

- Connecting people to services they weren't aware
- Supporting social change and influencing the healthcare system to adopt holistic approaches
- Joint working, in particular engaging with voluntary and community sector organisations to improve service provision
- Supporting efforts to address wider determinants of health

EXPERIENCING PERSONAL & PROFESSIONAL GROWTH

- Developing new skills such as active listening, problem solving, and creative thinking
- Feeling valued and recognised by patients and colleagues
- Opportunities for professional development and shaping the SPLW role
- Manging social prescribing teams, training SPLWs, and supporting new SPLWs

MAKING A DIFFERENCE

"Being able to make a positive and sometimes life changing impact to people lives; connect people to their community again, and others who feel the same as them, have things in common, get people more help that they weren't aware was there for them, benefit checks to get them entitlements they didn't know about. Get other medical support for them. Help people make friends/look after themselves better. Make them feel that they count"

"I love helping people for what they need and connecting them to the support they need. Sometimes patients 'fall through the gaps' due to socioeconomic and biopsychosocial issues which restricts them from accessing the support they need, I feel this is where social prescribing really supports these individuals, especially since we are person-centred and can adjust support to the individual"

"I find it very rewarding seeing patients' journey and really believe in Social Prescribing as a model in primary care. Most issues we see in clinic cannot be treated by medication alone. I like the health coaching element helping people to feel in control of their situation"

"Being able to use my decades worth of experience in the social and voluntary care setting to help people overcome the anxieties related to poor mental health, low mood and depression"

"Being able to help people by enabling them, giving them the courage or confidence to make a change or try something new to better their lives. Sometimes its just sign posting to a service they may not have been aware of"

"The opportunity to make a difference to someone's life. When a patient comes to me with a worry or a concern, being able to help them dismantle that worry and work out a way forward is priceless"

"Empowering people to be able to take control and make their own decisions and choices, and sharing skills and knowledge, as well as tips and tricks to be able to more effectively navigate systems"

"I genuinely enjoy seeing the positive changes people make in their lives, especially when they begin to feel more empowered and confident in their own abilities"

"I love watching people go from shy/worried/unsure to a confident person who knows what they are doing"

"I enjoy helping encourage clients to make positive changes and seeing the difference this makes on their overall mental and physical wellbeing"

"Seeing people make progress in areas that they did not think progress was possible"

"Benefits to the clients we work with, sometimes these can be life changing or life saving"

"Helping people who are stuck in their lives move forward and improve their health and wellbeing"

"Helping people to engage with their own care and enable them to seek solutions for themselves"

"Supporting a patient to achieve their personal goal, however big or small. To them it is huge"

"What I enjoy most in my role is supporting patients with what matters to them and helping them to receive the support/advice they need"

BUILDING RELATIONSHIPS

"Spending time getting to know patient and what matters most to them to then be able to support them with reaching their goals"

"Providing a space for them to speak openly without feeling rushed"

"Giving people the time and space to be able to discuss what is impacting their life and working together to find solutions"

"Giving people the time to tell their story and feel heard and understood – this feels like a privilege and is valued by the patients and referrers"

"Patients sharing their life stories and what matters to them and building a rapport"

"I enjoy getting to know my patients in a person centred way, to understand fully what is going on for them, and being able to have meaningful interactions for longer than 10 minutes"

"What I value most in my role as a SPLW is the opportunity to work directly with patients and build meaningful, trusting relationships"

"1:1 support with patients, being able to give them time and space to focus on themselves"

"Giving people the time to truly talk about what matters to them. Showing people that they are valued. Working with people effectively and not just 'tick boxing'"

"I enjoy meeting new people and listening to their life stories which builds trust so that I can try to help them"

"Working with people in a holistic, nurturing, encouraging and agency building way"

"I love meeting different people and listening to them and having that time to do so"

"Being able to be there to listen to what matters to them the most and then planning together what would help them the most"

"Being able to treat people as an individual"

"I love working with people in an extremely person centred role and giving people time that they deserve"

"Being able to give people time & support them in the way they choose to bring opportunities for other support, activity & social connection"

AUTONOMY, FLEXIBILITY & VARIETY

"As a Senior, I enjoy how varied the role is – the combination of supporting the team with their more complex cases and gaining more understanding of and involvement in how the service can develop as a whole"

"I love the flexibility of my role, being able to meet people in the community and work from and manage my own caseload is amazing"

"I currently manage SPLWs for 2 PCNs and a team of community-based social prescribers. I enjoy the variety this involves"

"Flexibility of role/intervention – not having to discharge patients after x DNAs – i.e. the ability to engage patients in person-centred, patient-led intervention"

"The variety of referrals and patients you speak to and support"

"It varies every day and there is a good mix of different people to work with and different needs"

"The variety of each day, flexibility in my role, I manage my own diary and am able to make as many or few contacts as necessary dependent on various factors"

"Working with such a wide variety of clients and issues"

"The diversity of the role and the amount of time I can spend with patients – no time restrictions"

"Being able to spend time and listen with patients NO CLOCK WATCHING"

"Offering support to people from all kinds of situations, the flexibility I have over my workload allows me to cater to the patients effectively based on their needs"

"Having the flexibility to manage my own caseload and flexibility to be both surgery based and to work from home"

"The freedom and different types of referral"

"Difference in each day. Helping to support people of different ages and backgrounds"

"Autonomy to give bespoke support"

"Autonomy to control my own appointments, freedom to attend groups with my patients"

COMMUNITY & SYSTEM IMPACT

"Tackling health inequalities and working with the PCN to identify shortfalls in healthcare provision"

"Connecting people to their communities"

"I like to think that I am giving something back to the community through my work"

"Improving my local community"

"Tackling social problems and issues"

"Setting new services up where there is a need in the community"

"Contributing to my community"

"I also enjoy strengthening links between the practice and community organisations, as it creates better long-term outcomes for patients"

"Developing systems and models that support large numbers of people to increase their health and wellbeing"

"I enjoy working in the community and being part of that community. I add value to my community by being a trusted person who is out and about every day"

PERSONAL & PROFESSIONAL GROWTH

“ Seeing the differences is so rewarding. It's a privilege to be an SPLW!”

“ Supporting individuals who are often the most vulnerable is incredibly rewarding, and being part of their journey, no matter how small the step, it feels like a real privilege”

“ When a patient tells me I have helped them, usually just through a conversation rather than signposting ”

“ Getting positive feedback from patients about how much they value the support offered/time and space to talk through their situation ”

“ I bring positiveness in people and supporting them makes me feel proud ”

“ It is very rewarding to see those that are making positive changes in their lives”

“ I can work across different areas and learn new skills ”

“ Having lovely feedback from clinicians and practice staff about the difference I've made”

“ Seeing people get through their difficulties is a great reward for me ”

“ Hearing positive feedback from patients can be massively rewarding, having the feeling of making an impact in someone's life is always lovely”

“ Patients are so grateful for my support and feedback is so positive that I feel I have made a big difference/influence on their lives – very rewarding ”

“ I enjoy the after-effects – patients telling me that they don't know what they would have done/where they would have gone if I hadn't been there to guide them ”

“ Rewards of a successful outcome for patients ”

“ I enjoy the rewarding factor of seeing the people I work with and how much happier they become when they have put routine and structure into their week”

“ The positive feedback from patients about how much I have helped them and the rewarding feeling this provides”

Q. What are the main challenges you encounter as a SPLW?

REFERRAL & SERVICE GAPS

- Inappropriate or incorrect referrals, incl. referrals outwith SP scope/for issues like mental health
- A lack of mental health services, housing support, and accessible community activities creating barriers for those in need
- Long waiting lists for community services

SYSTEMIC & ORGANISATIONAL CHALLENGES

- Lack of understanding and recognition of SPLW role, particularly among GP practices and management, leading to role misinterpretation and undervaluation
- Issues with communication and partnership working, especially with local authorities and statutory services
- Inconsistent support from management and PCNs
- Administrative overload
- Inadequate data collection/outcome recording and community mapping

FUNDING & RESOURCES

- Uncertainty around funding, with short-term contracts and no guaranteed future funding for social prescribing services
- Limited access to resources, such as transport and meeting space
- Lack of funding to meet the needs of the client base in the course of the role

CLIENT & CASELOAD MANAGEMENT

- High caseloads and a growing number of referrals making it difficult to give adequate time and support to each patient/client
- Stress from high workloads
- Clients' unrealistic expectations and reluctance to engage with services
- Managing clients with complex needs, or who require ongoing, intensive support, including those involving mental health issues or requiring long-term care

WORKPLACE SUPPORT & INTEGRATION

- Inadequate clinical supervision and peer support
- Disconnect between SPLWs and clinical staff, with a sense of professional isolation and a lack of integration
- Insufficient training & development opportunities

REFERRAL & SERVICE GAPS

"Long waiting lists for services we're expected to refer into, left holding patients and sometimes offering support that is beyond your role"

"Letting those most isolated down due to lack of free befriending services, (my caseload is predominately elderly who are unable to access services outside of their homes), and then seeing their faces when you tell them but there are places that will charge"

"GPs referring complex cases that are not in our remit. Asking us to see someone urgently. We are not an emergency service"

"Insufficient capacity in NHS talking therapies services - long waiting times. The crazily complex referral processes for ADHD diagnoses and medication titration – onerous paperwork greatly adds to the patients' trauma and even when they do eventually receive a diagnosis, they often have to wait again for medication. Lack of capacity in social care and complexity of the system makes it very difficult to navigate for patients and their families. Housing: nightmare! Trying to support patients and families in overcrowded accommodation, who have often been waiting to be rehoused for 10+ years. Feeling helpless to do anything apart from writing supporting letters to Housing and offer emotional support while patients are waiting."

"Other services not supporting the individual appropriately and passing it back to SPLWs when it isn't appropriate referral to us"

"Due to the funding being cut for the VCSE sector, a lot of support that was previously available to public is not longer available. e.g. getting a support worker allocated for someone who is struggling with mental health and struggles with daily tasks. Or an elderly patient who is isolated, struggles with mobility and would like someone to take them out for a few hours in the day."

"There isn't always support available for the resident and there has been a lack of funding for voluntary organisations in the borough, so I feel the offers are less than they were years ago. People are struggling with debt and housing issues and that can feel a bit like a losing battle."

"Lack of resources/linking into services that are not adequately resourced to be effective quickly, e.g. Autism specialist services having multiple year long wait lists, but the only provisions they offer are for people who are more impacted by their Autism than many of the patients I see"

"Holding patients because the long-term MH services are not there to support them. Exhausting"

"Inappropriate referrals - still not a mental health service, but still juggling and holding patients with significant mental health needs who struggle to access secondary care (how can we get past the 'reply within 7 days' letter?!)"

"Lack of access to a wide variety of services or activities. Not just for us to refer to, but those that are affordable. The majority of our area is rural and there just isn't the infrastructure to access activities. A lot of the support services have lost funding so we often have no domestic abuse support services available. There are also incredible long waiting lists for mental health support and those who self harm who have attempted to end their lives have little to no follow up support"

SYSTEMIC & ORGANISATIONAL CHALLENGES

"One of the biggest challenges in my role as a SPLW is the ongoing lack of understanding about what the role actually involves. Clinicians and management often have limited awareness of the holistic, community-based nature of social prescribing, which can lead to unrealistic expectations or the role being shaped to fit a traditional medical model. This becomes especially difficult when pressured into short, 15-minute appointment slots that don't allow for the depth of conversation or relationship-building that the work requires.... There is also a wider organisational misunderstanding of how essential community presence is, building relationships with local groups, services, and residents is a core part of effective social prescribing, yet it's not always valued or prioritised.

"The lack of meaningful data or appropriate systems to capture the true impact of social prescribing can make it difficult to evidence outcomes, advocate for the role, or demonstrate the long-term benefits for patients and the wider system"

"Primary care's main focus is clinical and not holistic, short term not long-term vision"

"Too much concentration on getting through patients. Number of contacts recorded and brought up in supervisions with discussions on whether the amount of telephone appointments completed has 'met targets'"

"Not being fully understood or valued by some senior staff despite excellent patient feedback"

"A feeling that some surgeries don't actually like primary care networks and don't really want to be part of them, 'the staff are your problem not ours'"

"Having to rely on clinical colleagues when needing to make referrals as our role isn't viewed as professional"

"Lack of interest from clinical directors and managers. Only have interest in shiny new ideas. Zero focus on population needs and more about what gets them most recognition"

"The pressures of quality over quantity. The role since I started has massively changed; fewer home and community visits, the stopping of green social prescribing, and being more desk bound to do phone calls, less networking opportunities and visibility in the community. I do not think this reflects the core of what social prescribing should be"

"Overload/overwhelm due to the range of service development strands and projects I am involved in. Services changing constantly and constantly needing to update resources. My patch being huge the whole of a county is too much to keep connected with"

"Lack of integration with the other ARRS role. Not valuable to GP staff. Seen instead as 'dumping ground' for complex/difficult patients which in itself should be seen outside of social prescriber role. Used as the clearly the 'missing support' for services that are lacking, e.g. mental health support workers"

FUNDING & RESOURCES

Lack of funding - most of my adult SPLW team have just been made redundant, meaning I'm left with 1 FTE SPLW to work with adults (excluding frailty) so we have to cap referrals and won't be able to do proactive work anymore

Funding – I have to provide countless reports on data and value achieved from SPLW service, which always demonstrates clear and positive outcomes for both the patient and the GP practices, yet clinical directors each time refuse to increase SPLW resources despite evidence showing we are understaffed in comparison to caseload sizes and referral numbers far exceeding safe guidance amounts per 1WTE. It's exceptionally demoralising and I feel as non-clinical members of PCNs we are bottom of the pile when it comes to resourcing and funding staffing

The move from being a PCN SP to Neighbourhood SP role. The area will increase in size, the expectation increase and all with no funding or investment in the role that will be seen as the first point of contact

Lack of funding for patients and new ideas

Lack of funding for transport support to get people to and from places

Travelling around to meet people. Very rarely do I have space to see people in one place. Time consuming and I could see more people if I wasn't travelling around

There is a lack of office space for us all to be together and we need space in order to do confidential phone calls which the office space we have doesn't allow for which means you can be lone working a lot and it is effort to engage as a team

Accessing the computer systems for the NHS!

Funding issues – risk of losing role at any point

Not knowing whether our contracts are going to be renewed (we are on a yearly temporary contract every year)

Although I have permanent contract, been informed if ARRS funding doesn't continue I will lose my job – no job security – this happens on a yearly basis around March/April time until they know ARRS funding continues for the next year

Not having a permanent contract and risk of redundancy due to whether there is funding

Not given a laptop but expected to work from home with my own laptop and phone. Requested repeatedly

CLIENT & CASELOAD MANAGEMENT

"We know that some referral pathways eg for housing and mental health support that there are long waiting lists and we don't have much faith that the patient will receive the support they need which can be frustrating

"I cannot build houses or reduce rents or create jobs when there are not or provide free care time or make neurodivergent people who do not want to be around other people go out and cannot fund charities with limited resources that cannot operate effectively as their funding stops every year or so. The idea that an overworked social worker in a PCN can address the social issues/social determinants of health is completely flawed. Social determinants are addressed a government and societal level, a social prescriber can provide conversations about those needs and motivational interviewing, health coaching, overview of what is available in the community, emotional support and psycho-education (many have psychotherapy, psychology and social workers qualifications if remunerated well)"

"People coming with issues that can't be solved or expecting that an SPLW can solve their overcrowding issue for example. The level of chronic illness they might be suffering with that is having a long-lasting impact on their quality of life

"I find it stressful when I am unable to think of anything I can suggest to support a client whilst knowing there will be something I have forgotten or not aware of"

"That I can't fix children & young people's problems. It is really hard to hear some of the hardships the young people I support face, but even if I can make a small difference, it makes my job worthwhile

"Holding patients because the long-term MH services are not there to support them. Exhausting. Referrals are becoming more and more complex, more linked to mental health and a huge rise in domestic abuse situations. 1 in 3 of my referrals this year have been related to domestic abuse

"The most challenging aspect of the role is managing increasing demand alongside the complexity of cases. Many patients present with layered social and emotional needs, and while that is meaningful work, it can be difficult when time and resources are limited

"Very complex patients with multiple needs, frustration in accessing other statutory services, and they are discharged back to SPLW for support, when not appropriate

"Housing and finances have a huge impact on patients existing health conditions. Working with families that are being impacted by poor quality housing (mould and damp) is very challenging because our support is very limited. Supporting people who are homeless and have learning difficulties. Supporting mature adults to get back into work or career change

"When we can't find a solution or onward organisations"

"Housing is a massive issue with no answers in our area which affects a high proportion of our pts and has no answers at all. Extent of deprivation in our area and the impact of this on people's health and motivation

"Complexity of cases working in 1 of most socio-economically deprived areas in Manchester, and lack of recognition from senior management of additional need from a large of cohort of patients including asylum seekers, refugees, and non-English speakers

WORKPLACE SUPPORT & INTEGRATION

“ Lack of clinical supervision - desperately needed for the wellbeing of SPs ”

“Lack of supervision, especially as deal with complex and emotionally charged cases”

“ Remote working can feel isolating at times - there is a lack of office space for us all to be together and we need space in order to do confidential phone calls which the office space we have doesn't allow for which means you can be lone working a lot and it is effort to engage as a team ”

“ No SPLW specific supervision- get monthly GP supervision offered however this seems not really appropriate – would like to be supervised by someone who does my role or e.g mental health professional ”

“ Lone working, not always knowing where to go for advice ”

“ Management not engaging with staff and not understanding the SPLW role”

“ I see that buy-in, despite many and varied attempts to promote SP, within Primary Care is still low ”

“ Lack of adequate support from roles above social prescribing, lack of understanding from clinical and non-clinical colleagues about the process of change and realistic outcomes ”

“No reflective supervisions, and I am waking up in the night worrying about patients and unable to switch off”

“ Maintaining motivation (due to 'luminous' role) – very isolated e.g. in a surgery but not 'part of'... and challenge of 'encouraging' colleagues to visit local community centre to see where we refer many patients to – 3 minutes walk – disinterested/busy & definite feeling that SPLW's have 'lower' status than other ARRS colleagues ”

“ I do not have supervision which I think would help to talk through some more difficult situations and/or help my confidence”

“Lack of appropriate supervision. Lack of clear understanding of the role, and the intensity of role. Lack of recognition of emotional strain in role, and lack of support/therapy for this. No team to work with, no peer support”

“ PCNs not providing supervision. I arranged this myself.... ”

“Feeling tolerated rather than welcomed within practice. The importance of our work hugely under-estimated, and our ability to contribute significantly to some projects at a higher level often overlooked”

Q. If you could change three things about your role what would they be?

TRAINING, DEVELOPMENT & CAREER PROGRESSION
- More training opportunities, including specific conditions & mental health
- Career progression courses
- Clear pathways and opportunities for career advancement

SUPPORT & SUPERVISION
- Better support from management
- Clinical supervision
- More frequent team meetings

TOOLS & RESOURCES
- Access to better resources and tools such as patient/client records, data capture systems, and appropriate workspace
- Access to funding for use in role

ROLE UNDERSTANDING & INTEGRATION
- Better understanding and acknowledgement of SPLW role from PCNs and other professionals
- Improve patient/client understanding

WORKLOAD & TIME MANAGEMENT
- Reduced workloads
- More SPLW
- More time to spend with patients/clients
- Fewer admin tasks

JOB SECURITY
- Longer term contracts
- More stable funding

PAY & BENEFITS
- Improved pay and benefits
- Pay to reflect the responsibilities and emotional labour involved in SPLW role

COMMUNITY ENGAGEMENT & OUTREACH
- More opportunities to engage with the community, including more time for coproduction, service development, outreach, and networking

AUTONOMY & FLEXIBILITY
- More autonomy in role, including control over schedules, and ability to make decisions about patient/client care

SERVICE ACCESSIBILITY
- More services
- Reduced waiting times

TRAINING, DEVELOPMENT & CAREER PROGRESSION

"More CPD time as there is a lot of stuff we have to cover as SPLW. Having protected time to engage in CPD would support our roles I think due to the vast amount of different support/connections we offer"

"More structured, development opportunities and access to recognised qualifications"

"For all SPs to undertake professional boundary training"

"Development opportunities. There is nowhere for me to go in my role and I am beginning to feel stagnant"

"More career progression and opportunities to train while working"

"Any form of progression"

"More training to support patients in-house"

"Have professionally recognised training available and career pathways"

"Better/clearer pathways for career progression"

"Qualifications in related subjects eg CBT"

"Access to a meaningful management course leading to professional qualification and career progression"

"More opportunities to progress as I love my role, but money is tight now"

"More training opportunities and caseload flexibility to accommodate this"

"Better opportunity to progress to senior, team lead, manager"

"For higher level accreditation to SPLW than a Level 3"

"Career progression beyond becoming a Manager. More formal training to achieve this and enhance my practice"

"More progression in the role (I am in a career slump with zero progression to the point where I have had to make up and request a role based on additional workings I am doing)"

"Progression and development - very little available and I will have to leave the role to progress"

SUPPORT & SUPERVISION

"Wellbeing activities for staff"

"Support for Mental Wellbeing – Working with challenging cases can take a mental toll. Implementing regular check-ins, peer support sessions, or access to counseling could help staff manage stress and maintain wellbeing"

"I would have supervision more akin to counselling supervision"

"Reflective supervisions please"

"Ensure appropriate supervision is in place by qualified staff who have a good understanding of the role"

"Good supervision and support from appropriate line manager, to ensure workload isn't unfeasible, or cases are not inappropriate for role"

"Clinical supervision from a clinician preferrable someone within the Mental Health system or mental health experience"

"Longer supervision with GP"

"A senior or lead SPLW to ask advice"

"Better and more regular supervision"

"Have more contact and peer support from my SPLW colleagues. Home working is very isolating"

"Regular contact with my peers"

"More time for peer support"

"Better supervision in-house/externally and clear chains of escalation"

"Better supervision – 1-to-1 quarterly rather than Teams meetings every 4/6 weeks with multiple other roles included"

"I would have 1-1 supervision as mine is a group one"

TOOLS & RESOURCES

"More effective IT to log outcomes rather than using things that don't align with our role"

"Having some way of collating patient/family feedback"

"Less formal outcome scoring, PAM and ONS4 are often not well received by patients"

"Better outcome data tool – ONS4 is not fit for purpose, anything else we have to pay for and most PCNs do not want to pay for this"

"The wellbeing scores don't give the full picture of the level of support that SPLW give to the clients and are dependent on their moods and feelings on the day. The wellbeing score is not holistic as clients receive a lot of support from SPLW but this not captured in the data"

"National outcome recording tools.... We need to urgently be able to demonstrate the impact we are having in our work"

"Data collection so that outcomes can be analysed and services increased for those most in need"

"EMIS upgrade to code all of our work. We have to duplicate information onto spreadsheets as EMIS is not able to code this. It's a huge waste of time"

"Having access to client's details on SystmOne would save a lot of back and forth with GP administrators to get basic information"

"Being able to check/update patient clinical systems"

"Being able to have constant CLINCIAL space. It is nice to work in the community, however sometimes community spaces are not fit for certain conversations etc. Clinical space also helps to keep a professional rapport I think and helps patients to understand our role more"

"We had a proper community based to work from which would enable us to be better connected to local services, have space for in-person appointments and potentially have group sessions or drop-ins running from them"

"Work environment (dedicated space in surgeries or community to see people face to face when they want this)"

"GP surgeries having a room in their surgery for the option to work there – not having to wait 2 weeks to get a room"

"It would be good to have a small budget to be able to meet referrals in a cafe. Our referrals are often socially isolated but we don't have a budget to be able to meet out in the community and have a cup of tea. This is often a really good first step towards alleviating social isolation, I sometimes just pay for this myself"

"A budget for activities and drinks etc rather than spending my own money or asking parents to pay for their child"

"A laptop so that I can work in the community!"

"Having appropriate equipment to do the role is: smartphones or laptops with SIMs to use out of the surgeries"

ROLE UNDERSTANDING & INTEGRATION

Ensure referrers explain SPLW role to participants

Understanding of non-clinical practices within clinical practice

More professionals in health and care sectors to recognise and understand our role

Be a recognised support in our own right and not trying to fit our details/aims/processes into clinical guidelines

Better buy-in from some GPs and value us more eg expansion in ARRS roles to include trainee GPs has meant they've prioritised that over retaining us

Be properly valued for the work I do. The gap I fill. The bridges I create for patients and the services they need

Increased support and recognition from Clinical leads, PCN Management and Practice management

It should be a recognised protected role within the NHS (similar to allied healthcare) with real qualifications – other link workers we meet in different sectors do not do the same in-depth role as we do, I think this degrades our role and the respect for the work we do

Better understanding about the role being far more than just signposting

Greater recognition and respect for the profession – Improve recognition of social prescribing as a skilled, high-impact profession that supports large numbers of people and creates significant capacity for GPs and wider services by addressing needs that sit outside traditional medical pathways

Prioritise the role within the PCN so that more patients can be supported and referrals can be actioned

More awareness of what we do and the value of non-clinical intervention in general public

For clinicians to truly understand what we can and cannot support with

I would have the opportunity to attend primary and secondary care MDTs

Being seen as part of healthcare systems

Not be seen as outsider of the Team in each GP practice, inclusion within the team to motivate PCN staff

To be able to interact with the wider teams. When I began my SPLW journey, we all used to get together to share services, ideas and reflections

COMMUNITY ENGAGEMENT & OUTREACH

"Time for ABCD, I do a lot of this on my own time - clinicians understanding this is more than SPLW just having 'free time'"

"More time to network with my local community, visiting local services to see how they work to have an idea on suitability for people, have people engage"

"More time for outreach/accompany patients rather than just clinic time"

"More opportunities to network in the community and be able to plug gaps, put on our own social groups/workshops"

"More opportunities to work in the community and group settings rather than at the GP"

"Time to actually connect with community – proactive work more as a lot of the time spent working on caseloads"

"Greater focus on co-producing and setting up community groups for gaps in services"

"More work in the community. I do a lot of work from home and phone calls"

"Be linked with community groups and activities more with funding to develop and enhance services to grow and develop"

"Be able to do community development work"

"More time to network and visit community venues and VCS groups"

"To have more time in the community and not in the office in front of a PC"

"More contact with VCSE and less healthcare"

"Be able to have some time each week to visit services"

"Establish manageable caseloads with protected time for community engagement"

"More funding to develop proactive engagement activities"

"Create a bit more time to work proactively to make more of a difference"

WORKLOAD & TIME MANAGEMENT

"We'd have a smaller caseload which would enable us to work longer with individuals where necessary"

"Less admin time/more time with patients"

"More SPLWs in team (only myself and now 2 x temporary P/T staff) to cover approx. 49,000 pts across 4 GP Practices"

"To have a more fluid timeline to work to, be able to spend more time with those who require it"

"Fewer referrals, more time for each, and reduced administrative work"

"Address the issue of too many referrals, either by increasing staff numbers or reduce incoming referrals"

"Enough time to visit more patients in their own home"

"My wait list is long – Another SPLW in the team is needed"

"Establish manageable caseloads with protected time for community engagement"

"More time and access to patients – telephone calls limit openness"

"I would have a smaller caseload with more face-to-face appointments"

"Workload Management – The current workload can be overwhelming at times. Reassessing task distribution, prioritizing essential duties, or allowing for flexible deadlines could help staff manage responsibilities more sustainably"

"A colleague who is able to deal with secondary mental health SP work"

"More and longer contact with patients rather than referring them on"

"More funding for extra MH SPLW in my area"

"To increase the number of Social Prescribing within G.P. surgeries which would relieve GPs even more and allow them to focus on more health-related appointments"

"To have a better ratio of staff to referrals"

"More SPLW funded in my PCN to allow more capacity to accept referrals and support everyone who needs it"

SERVICE ACCESSIBLITY

"Have more funding in society for more effective social prescribing (in terms of services to refer onto) and more social housing, more resources for less waiting times for services"

"More time to set up community events, eg: menopause workshop, or health workshops, as the area is rural pts find travelling difficult and most community support is in main towns. Poor transport"

"Having funds to develop community activities such as coffee mornings to reduce social isolation"

"There would be more services for us to refer into and that they would be less of a postcode lottery for accessing them"

"Greater focus on co-producing and setting up community groups for gaps in services"

"Increased specialist services to reduce wait times"

"Funding to be able to offer transport so patients can attend groups & activities"

"Further funding to support patients to attend activities – pots of money to prescribe activities would be amazing"

"Ideal world - no waiting lists, no vanishing services"

"Shorter waiting list for housing, mental health support and social care"

"Services with more capacity and funding, I can refer a patient on knowing they will be supported and I can close the case and move onto the next patient. I am holding too many people!!"

"Have the time and managerial backing to facilitate more patient-focused / health condition-focused support groups, e.g. carer support groups, coffee mornings for lonely elderly, etc"

"Gaps in community services: Groups are full/Funding is unstable/Services close unexpectedly/Transport is limited"

"Being able to offer better/affordable transport options to those who can't get out to bus stops"

"More timely and effective responses from ASC and Mental Health services"

"To ensure YP can attend activities that have costs associated with attending"

"Better support for voluntary sector orgs we refer to (funding to keep running etc.)"

"More capacity in the team to widen scope for groups/outreach/initiatives"

"More accessible, affordable transport"

"To have a minibus"

JOB SECURITY

"To not worry about the contract ending every year due to funding cuts"

"I would like to have more job security, always worried when funding due to end"

"Longer contracts with PCNs for more job security"

"Certainty on the future of the role"

"For it to be a permanent contract"

"Lack of job security – not knowing if the role will continue to be funded"

"Fund the role for longer than 1 year at a time, so it can be adequately staffed with longevity of contracts to support more patients"

PAY & BENEFITS

"We should be included in the NHS banded pay scale with longer contracts, pensions etc once we are employed over 2 years"

"Salary doesn't reflect - I am not a Social Worker"

"To be employed by NHS directly due to better T and Cs"

"Improve professional status, pay and pensions for staff doing these sorts of roles, we are often paid considerably less and do not have NHS pensions or permanent contracts as our peers in the health centres"

"Pay does not reflect workload and level of patient support"

"To be paid adequately to reflect the emotional toll which this role takes on my own health and wellbeing. As minimum wage has risen, we are hardly above the minimum wage, which is not sustainable in keeping experienced SPLWs"

"Pay. I do not feel the low pay reflects the hard work I put into the role. I have the lowest pay out of everyone I know, yet I work just as hard and feel the work I am doing deserves more recognition financially"

"Properly banded NHS 5 as per original framework"

"Salary matched with NHS rather than Voluntary sector"

"Pay and adopting AFC NHS pay scales – pay is so differential across regions and is not monitored or regulated. We pay into an NHS pension, yet do not receive any of the benefits of NHS pay offers. We do not receive NHS Agenda for Change pay scales which mean SPLWs do not receive NHS pay increments, pay rises in line with NHS staff"

"Higher pay depending on service delivered/training etc"

AUTONOMY & FLEXIBILITY

"Flexibility in working location- there's too much focus on where we are working from rather than the work we are doing"

"To have a more fluid timeline to work to, be able to spend more time with those who require it"

"More flexibility with appointments rather than being locked to EMIS like a clinician"

"To be able to work in a hybrid fashion, remotely, in the office and in surgeries"

"More autonomy over my time, appointments and diary, freedom of movement"

"Allow appointments to be more flexible for CYP"

"Having autonomy to do the job I'm here to do"

"Flexible working hours - be able to chose my hours to work round patient needs"

"Flexible Work Options – Currently, work is required to be done on-site in practice. Introducing remote work options where feasible could reduce commuting stress, improve focus, and help balance workload more effectively"

"Working one day at home to catch up on admin"

"Flexi time working would enable more community involvement"

"More flexibility to see patients outside of the surgery but not in their homes - in a neutral location like a community centre (easier to get people to try a group if they are already there!)"

National Academy for Social Prescribing