

From research to reality: Social prescribing in Scotland



2026

About Royal Society of Edinburgh

The Royal Society of Edinburgh (RSE), Scotland's National Academy uses the combined knowledge of its 1,800-strong Fellowship to tackle the most pressing issues facing society, provide independent expert advice to policymakers, and inspire the next generation of innovative thinkers. The RSE's Health and Wellbeing Community of Interest group was established to convene individuals from different disciplinary and professional backgrounds, with the aim of exploring potential interventions which may be effective in preventing or mitigating the determinants of ill health. It includes RSE Fellows, members of the Young Academy of Scotland, and representatives from a range of academic, governmental, and non-governmental organisations. This workshop event emerged as a key initiative within the group.

About Voluntary Health Scotland

Voluntary Health Scotland (VHS) is a movement for health creation working to reduce health inequalities and enable the people of Scotland to live well. VHS believe that health is more than the absence of illness, and together with its members and partners, champion this belief. They collaborate to provide the national voice for third sector health organisations in Scotland.

VHS also hosts the Scottish Community Link Worker Network, which is a network and community of practice for Scotland's 350+ primary care community link workers. A community link worker is a non-clinical practitioner based in or aligned to a GP practice or cluster who works directly with individuals to support them to engage with wider services in their local community.

Executive summary

On 20 May 2026, the Royal Society of Edinburgh and Voluntary Health Scotland, co-hosted a workshop titled '*From research to reality: Social prescribing in Scotland*'. For the purposes of the workshop, social prescribing was defined as 'a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical support and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections.'¹ Nearly 60 representatives from academia, policy, public, and third sectors came together to share insights, discuss the current state of social prescribing in Scotland, and explore pathways for improvement. The diverse mix of participants enabled rich discussion around the challenges, opportunities, and priorities for advancing social prescribing across Scotland, with participants demonstrating a high level of interest in the topic.

The half-day event consisted of talks across three thematic sessions - Research and evidence, policy, and practice and implementation - followed by roundtable discussions based on pre-selected questions. This report distils the key messages from these discussions, highlighting critical barriers to social prescribing in Scotland and setting out actionable recommendations for the Scottish Government, local authorities, and other relevant decision-makers. These recommendations aim to support the embedding of social prescribing as part of a preventative, person-led, and community-based health and care system in Scotland.

The report is not a verbatim record of the workshop discussions, nor an exhaustive account of all points raised. Rather, it presents a synthesis of the key themes that emerged. While social prescribing services are delivered by a range of practitioners and organisations, this report places particular emphasis on community link working.

The report identifies three key barriers to social prescribing in Scotland:

1. Resource constraints across statutory and third sectors
2. A lack of structured evaluation frameworks and challenges to patient data accessibility
3. Barriers to accessing services

It sets out three corresponding recommendations to address these challenges:

1. Provide long-term, sustainable funding for community link worker programmes and third sector organisations to support the delivery and embedding of social prescribing across Scotland;
2. Establish clear data guidelines and remove barriers to data accessibility and sharing; and
3. Adopt a proportionate approach to service delivery, with additional support directed towards those with the greatest need.

¹ Muhl, C., Mulligan, K., Bayoumi, I., Ashcroft, R., & Godfrey, C. (2023). Establishing internationally accepted conceptual and operational definitions of social prescribing through expert consensus: a Delphi study. *BMJ open*, 13(7), e070184. [10.1136/bmjopen-2022-070184](https://doi.org/10.1136/bmjopen-2022-070184)

Introduction and background

Social prescribing involves connecting individuals with non-medical, health-related social needs to non-clinical support and services within their community. Typically, a healthcare professional refers an individual to a non-clinical practitioner, who then co-produces a 'social prescription' linking the individual to appropriate community support. It is an approach that builds on evidence that tackling the social determinants of health is key to improving health outcomes, recognising that many factors affecting health cannot be addressed through medical interventions alone. While job titles for those facilitating social prescribing vary across Scotland, this report uses 'Community Link Worker (CLW)' as it is the most commonly used term.² There are currently over 350 CLWs based in general practitioner (GP) practices across Scotland.

Most referrals to social prescribing in Scotland come via healthcare routes, with common reasons including mental health, social isolation and loneliness, and housing. Prescribed support can include arts and physical activities, befriending services, and housing or financial advice, among others. There is a growing body of evidence demonstrating the positive impact of social prescribing on health and wellbeing, its role in reducing pressure on the NHS, and its potential to deliver significant returns on investment (illustrated on Pg. 6). There is also strong evidence for the benefits of many of the activities and services to which people are referred. Social prescribing has the potential to address the social, emotional, and practical needs of patients that are often interconnected with medical needs but are not met through clinical interventions. These needs are estimated to account for up to 19% of GP consultation time.³

The RSE previously published a report on the origins of social prescribing in Scotland and the role that social prescribing could play in supporting the recovery of Scotland's public services following the COVID-19 pandemic.⁴ While that report described the range of social prescribing models operating across Scotland, the present report focuses on community link working, as it is the predominant model of social prescribing in Scotland and was a key focus of discussion during the workshop.

More than 30 countries have implemented social prescribing. Reflecting this growing global interest, consideration of the role social prescribing could play in Scotland led to a 2019 enquiry by the Scottish Parliament Health and Sport Committee, which concluded that social prescribing had significant potential for 'preventing long-term conditions and dependence on pharmaceutical prescriptions'.⁵ However, a disconnect

² Smith, F. (2023). *Essential Connections: Exploring the range and scope of community link worker programmes across Scotland*. https://vhscotland.org.uk/wp-content/uploads/2023/11/SCLWN_Essential_Connections_report_proof_05.pdf

³ Caper, K., & Plunkett, J. (2015). *A very general practice. How much time do GPs spend on issues other than health?* https://www.citizensadvice.org.uk/cach3.com/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf

⁴ Lejac B. (2021). *A Desk Review of Social Prescribing: from origins to opportunities*. The Royal Society of Edinburgh. <https://www.rsecovidcommission.org.uk/wp-content/uploads/2021/04/A-Desk-Review-of-Social-Prescribing-from-origins-to-opportunities.pdf>

⁵ Scottish Parliament. (2019). *Social Prescribing: physical activity is an investment, not a cost*. Health and Sport Committee. <https://bprcdn.parliament.scot/published/HS/2019/12/4/Social-Prescribing-physical-activity-is-an-investment-not-a-cost/HSS052019R14.pdf>

remains between national policy commitments and implementation at a local level. For example, community link working was included as one of six priority service areas within the Memorandum of Understanding for the 2018 General Medical Services contract. Health and Social Care Partnerships (HSCPs) are responsible for delivery of these services and the revised MoU in 2021⁶ encouraged action to be prioritised on Pharmacotherapy, the Vaccine Transformation Programme (VTP), and Community Treatment and Care (CTAC). These three services are now subject to a statutory requirement for delivery, whereas no such equivalent mandate exists for CLWs. This has negatively affected staff retention and recruitment and contributed to variation in service design and delivery across Scotland. This disparity is further reflected in funding allocations with community link working receiving the lowest level of investment among the six priority service areas in 2025-2026. The Scottish Government Primary Care Improvement Plan tracker data indicate that an estimated 19% of GP practices do not have access to a CLW, while the overall number of CLWs declined between March 2025 and March 2026.⁷

The commitment to develop a National Framework for Social Prescribing⁸ has been widely welcomed. However, progress is urgently needed to support a more coordinated national approach. This report provides a timely account of the challenges facing social prescribing in Scotland and offers recommendations for the Scottish Government, local authorities, and other decision-makers to help realise its full potential to improve the health and wellbeing of the people of Scotland.

⁶ NHS Scotland. (2021). *Memorandum of Understanding (MoU) 2: GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards*. <https://www.publications.scot.nhs.uk/files/memorandum-of-understanding-2-gms-contract-implementation-for-pc-improvement-30-july-2021.pdf>

⁷ Scottish Government. (2026). *Primary Care Improvement Plans: Summary of Implementation Progress at March 2026*. <https://www.gov.scot/publications/primary-care-improvement-plans-implementation-progress-summary-march-2026/>

⁸ Scottish Government and COSLA. (2025). *Scotland's Population Health Framework 2025–2035*. <https://www.gov.scot/publications/scotlands-population-health-framework/>

Evidence supporting the health, service, and economic benefits of social prescribing

SERVICE USER



Increases in happiness⁹,
life satisfaction⁹, and
self-esteem¹⁰



Improved mental
and physical health¹¹



Increased confidence
in managing long-term
conditions¹²



Feeling more supported
by local services and
organisations¹²



Improved GP
experiences¹²



Decreased
anxiety⁹

HEALTH CARE



Reduction in GP
appointments, hospital
admissions, and A&E visits¹³



Increased GP job
satisfaction¹⁴



Estimated return of £9
for each £1 invested⁹

⁹ Bu, F., Hayes, D., Munford, L., & Fancourt, D. (2026). The impact of social prescribing on well-being outcomes in a nationwide analysis. *Nature Health*, 1-8. [10.1038/s44360-026-00099-w](https://doi.org/10.1038/s44360-026-00099-w)

¹⁰ Chatterjee, H. J., Camic, P. M., Lockyer, B., & Thomson, L. J. (2018). Non-clinical community interventions: a systematised review of social prescribing schemes. *Arts & health*, 10(2), 97-123. [10.1080/17533015.2017.1334002](https://doi.org/10.1080/17533015.2017.1334002)

¹¹ Makanjuola, A., Lynch, M., Hartfiel, N., Cuthbert, A., & Edwards, R. T. (2023). Prevention of poor physical and mental health through the green social prescribing opening doors to the outdoors programme: a social return on investment analysis. *International Journal of Environmental Research and Public Health*, 20(12), 6111. [10.3390/ijerph20126111](https://doi.org/10.3390/ijerph20126111)

¹² Wilding, A., Agboraw, E., Munford, L., Sutton, M., Mercer, S. W., Salisbury, C., ... & Wilson, P. (2025). Impact of the rollout of the national social prescribing link worker programme on population outcomes: evidence from a repeated cross-sectional survey. *British Journal of General Practice*. [10.3399/BJGP.2024.0542](https://doi.org/10.3399/BJGP.2024.0542)

¹³ O'Connell Francischetto, E., Bradly, J., & Knight, K (2024). *The impact of social prescribing on health service use and costs: Examples of local evaluations in practice*. National Academy for Social Prescribing. https://socialprescribingacademy.org.uk/media/ibtdvgn0/nasp_sp_impactonservice_nov24.pdf

¹⁴ Evers, S., Kenkre, J., Kloppe, T., Kurpas, D., Mendive, J. M., Petrazzuoli, F., & Vidal-Alaball, J. (2024). Survey of general practitioners' awareness, practice and perception of social prescribing across Europe. *European Journal of General Practice*, 30(1), 2351806. [10.1080/13814788.2024.2351806](https://doi.org/10.1080/13814788.2024.2351806)

Barriers to social prescribing in Scotland and recommendations for improvement

Barrier one: Resource constraints across statutory and third sectors

A lack of sustainable funding was consistently highlighted as a key barrier to social prescribing in Scotland. CLWs are increasingly supporting individuals with basic needs including housing, heating, welfare benefits, and food.¹⁵ Increasing workload complexity, combined with job insecurity, risks burn out and the loss of highly skilled staff. This sentiment was echoed in discussions during the workshop, noting a shift towards crisis support. Strengthening statutory services would enable link workers to focus on earlier, preventative support aligning with priorities in the Scottish Government's Population Health Framework.⁸

Third sector organisations are central to communities across Scotland, providing services that improve an individual's health and wellbeing. However, they face significant constraints from rising costs, workforce challenges, and increasing service demand. Precarious funding cycles – costing an estimated £900 million annually in application processes – divert time and resources away from the crucial services being provided in communities nationwide.¹⁶ The following quote from the discussions underscores the essential role of the third sector in the delivery of social prescribing:

‘Social prescribing is not effective without services to prescribe to.’

Recommendation one: Provide long-term, sustainable funding for community link worker programmes and third sector organisations to support the delivery and embedding of social prescribing across Scotland

An expanding economic evidence base indicates that social prescribing generates a significant return on investment. Consequently, it should be regarded as a strategic investment with the potential to avert future costs to public services. CLWs are currently operating largely in crisis-response roles, highlighting the need for increased investment in statutory services to enable a shift towards a more preventative approach to health and wellbeing.

A sustainable, independent, and thriving third sector is essential for the success of social prescribing in Scotland. The recent commitment to establish a formal

¹⁵ Donaghy, E., Mercer, S. W., Brant, H., Collins, H., Etemadi, M., Hamashima, Y., ... & Wilson, P. (2026). Embedding social prescribing in primary care in England and Scotland: a qualitative study of experiences, roles, challenges, and sustainability. *The Lancet Primary Care*, 2(4).10.1016/j.lanprc.2026.100128

¹⁶ Fiennes, C., Bull, G., & Sandford, S. (2022). *Understanding and Reducing the System Costs of Foundations' Application Processes*. *Giving Evidence*. <https://giving-evidence.com/wp-content/uploads/2022/09/understanding-and-reducing-the-system-costs-of-foundations-application-processes.pdf>

partnership between the Scottish Government and the third sector is a positive step in recognising the sector's vital contribution to society.¹⁷ To build on this progress, both central and local governments should adopt multi-year funding as the default approach, with funding arrangements accounting for inflationary increases.

Multi-year funding would allow both CLW programmes and third sector organisations to plan ahead, retain staff, and maximise the impact of their services. It would also help strengthen trust and collaboration between primary care teams and CLWs, giving GPs and multidisciplinary teams confidence that the services to which they refer individuals will remain available over the longer term. The same applies to relationships between CLWs in primary care and the third sector organisations to which they refer people. Sustainable funding therefore has the potential to strengthen relational working across the social prescribing pathway, which was identified during workshop discussions as fundamental to the success of social prescribing in Scotland. Ensuring sustainable, long-term investment would help guarantee that socially prescribed services are consistently available, accessible, and responsive to individual needs. This would support a shift from addressing acute crises towards an upstream approach that prioritises prevention, early intervention, and long-term wellbeing, thereby supporting priorities outlined in Scottish Government's Population Health Framework.

Barrier two: A lack of structured evaluation frameworks and challenges to patient data accessibility

While there is no 'one-size-fits-all' approach to evaluation, the absence of structured guidelines for service- and patient-level data collection has hindered robust evaluation and made it difficult to compare services across Scotland. Previous research by VHS found that monitoring and evaluation was identified by CLW programmes as a key area requiring greater consistency and coordination across the country.² The Scottish Government is currently reviewing CLW programmes and has established an evidence and outcomes workstream aimed at improving consistency in data collection. Guidance in this area is urgently needed as there are currently no national standards or recording requirements for CLW programmes.

This does not reflect a lack of data. Many CLW programmes collect substantial information on referrals including referral volumes, reasons for referral, referral destinations, demographic characteristics, and wellbeing measures. However, the type of data collected varies between programmes. In addition, systemic barriers to patient data accessibility and sharing across statutory services limit its effective use. Fragmented systems and data sharing restrictions make it difficult to track an individual's journey across services and evaluate the medium- and longer-term impacts of social prescribing on health and wellbeing. As a result, opportunities for more complete analysis of social prescribing impact are constrained, including identifying the optimal number of sessions, understanding reasons for disengagement, and determining which individuals are most likely to benefit and why.

¹⁷ Scottish Parliament. (2026). *Strengthening Scotland's Partnership with the Third Sector*. <https://www.parliament.scot/chamber-and-committees/votes-and-motions/S7M-00356>

Much CLW activity is not routinely captured within electronic health records in primary care. It was observed that access to data is much easier in England compared to Scotland. Information governance constraints therefore represent a significant structural barrier to robust evaluation of social prescribing.

Policymakers also tend to favour quantitative measures of success. However, many outcomes associated with social prescribing cannot be meaningfully reduced to numerical indicators alone. Qualitative data should be recognised as an essential evidence source, capturing the community- and service-level nuances that underpin what works in practice. As highlighted in stakeholder discussions:

‘While metrics are valuable, it is the story behind the data which is important... to help understand the context, culture, and underlying factors that explain what works and why.’

Recommendation two: Establish clear data guidelines and remove barriers to data accessibility and sharing

National data collection guidelines would help health boards assess the impact of social prescribing across Scotland. Routine post-referral follow-up, including service user feedback, would provide valuable insight into service design, delivery, and reasons for disengagement. However, any requirements must be proportionate and avoid placing additional pressure on already stretched staff and services or unnecessary demands on people accessing support.

Greater consistency and standardisation in data collection and reporting are needed to support robust evaluation. However, this must not come at the expense of local flexibility, which is central to the effectiveness of social prescribing, meaning a balanced approach is required. Evaluation frameworks should therefore adopt a mixed-methods approach, combining quantitative and qualitative evidence to assess what is working well and where improvements are needed.

To fully realise the potential of social prescribing, systemic barriers to data accessibility must be addressed. A more joined-up approach across statutory services would support integrated service delivery and align with Scotland’s Public Service Reform Strategy¹⁸ on data sharing and data usage, as well as the National Framework for Social Prescribing commitment to enabling better data sharing.

There is also an opportunity to make more strategic use of existing data. CLW programmes and third sector organisations possess deep knowledge of their local communities and could serve as valuable assets for informing service planning at both local and national levels. Harnessing this knowledge more effectively would strengthen decision-making and ultimately improve health and wellbeing outcomes across Scotland.

¹⁸ Scottish Government. (2025). *Scotland's Public Service Reform Strategy: Delivering for Scotland*. <https://www.gov.scot/publications/scotlands-public-service-reform-strategy-delivering-scotland/>

Barrier three: Barriers to accessing services

Scotland experiences some of the worst health inequalities in Western Europe as evidenced by stark socioeconomic differences in healthy life expectancy. Compared with those living in the least deprived areas, males and females in the most deprived areas spend 25.6 and 26.7 fewer years in good health, respectively.¹⁹

Evidence from England indicates that patients living in the most deprived communities are less likely to be offered social prescribing compared to those in more affluent areas.²⁰ Unequal access to services risks entrenching existing health inequalities. However, once an offer is made, the level of deprivation does not appear to affect uptake. This suggests that the primary barrier lies in access rather than engagement with social prescribing activities. This provides an important lesson for Scotland: services must be proactively targeted towards communities with the greatest need to ensure equitable access.

The Scottish Index of Multiple Deprivation (SIMD) divides Scotland into zones that are ranked according to multiple measures of deprivation, including employment, income, and housing.²¹ The index is sometimes used to assess needs and inform the allocation of health and care resources. However, there are limitations to using SIMD as a measure of poverty and deprivation, particularly in rural Scotland. Rural data zones tend to cover larger geographical areas and encompass populations with a wider range of circumstances, with deprivation therefore being more spatially dispersed. As a result, households experiencing financial hardship may live within communities that appear relatively affluent at aggregate level. This is highlighted by the fact that nine out of ten income-deprived people living in rural Scotland do not live in areas identified as deprived by SIMD.²² Consequently, relying on SIMD to inform service delivery in rural areas risks overlooking and further marginalising these individuals.

In addition to socioeconomic status, barriers to accessing health and care can arise from a range of factors, including biological sex, gender, carer status, disability and immigration status. These factors can contribute to health inequalities by preventing certain groups from accessing the support they need due to reasons such as health infrastructure and societal norms and stigma. For example, anecdotal evidence suggests that men are significantly less likely to be referred to a CLW than women, potentially due to clinician bias or men not making use of this type of support.²³

¹⁹ National Records of Scotland. (2026). *Healthy Life Expectancy 2022-2024*. [Healthy Life Expectancy, 2022-2024 - National Records of Scotland \(NRS\)](#)

²⁰ Agboraw, E., Wilding, A., Munford, L., Sutton, M., & Wilson, P. (2026). Inequalities in referrals to social prescribing from primary care in England: A retrospective observational study. *PLoS One*, 21(6), e0350842. [10.1371/journal.pone.0350842](#)

²¹ Scottish Government. Scottish Index of Multiple Deprivation: data and resources. <https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020>

²² Scottish Government. (2020). *Rural Planning Policy to 2050: Research to Inform the Preparation of NPF4*. <https://www.gov.scot/publications/rural-planning-policy-2050-research-inform-preparation-npf4/>

²³ Voluntary Health Scotland. (2026). *(IN)VISIBLE Report into Sex and Gender-related Health Inequalities*. https://vhscotland.org.uk/wp-content/uploads/2026/05/FINAL_VHS_INVISIBLE_report_May_2026.pdf

The accessibility of healthcare systems is not equitable across Scotland. This is demonstrated by the concept of 'missingness', defined as the repeated tendency not to take up offers of care such that it has a negative impact on the person and their life chances.²⁴ Missingness disproportionately affects marginalised groups and is associated with poor health outcomes and premature mortality.²⁵ Its causes are complex and include sociological factors such as mistrust of the healthcare system, past negative experiences or attitudes towards seeking care as well as more practical reasons such as transport and work commitments.²⁶ This means that social prescribing is inaccessible to many vulnerable individuals who may benefit from these services due to systemic failures in healthcare structures. A disproportionate approach to service delivery, where resources are not aligned with population need or are inadvertently made inaccessible to those who need them most, risks exacerbating existing inequalities. This sentiment was highlighted during the workshop:

'Think carefully about [the] distribution of resources, or [there is a] risk of widening inequalities.'

Recommendation three: Adopt a proportionate approach to service delivery, with additional support directed towards those with the greatest need

It was emphasised that proportionate universalism should be embedded as a core principle whereby social prescribing services are universal in principle but resourced and delivered in proportion to need. This could involve prioritising investment in more deprived areas, for example by allocating CLWs to communities according to levels of socioeconomic disadvantage and social need. However, consideration must be given to the problem of hidden rural poverty. Approaches to identifying deprivation in rural areas should extend beyond place-based measures and incorporate individual-level indicators alongside local knowledge, to ensure communities are not further isolated. At the same time, services should ensure equitable access for other marginalised groups who experience health inequalities, regardless of where they live. For example, referral criteria in more affluent areas could be designed to prioritise those who face significant challenges in accessing healthcare services, such as unpaid carers, people with disabilities, and migrant communities.

Proportionate universalism should also involve identifying and engaging those who are currently 'missing' from the system. Community-based approaches have the potential to reach individuals who do not routinely access primary care services. In this context, CLWs play an important role in bridging the gap between healthcare

²⁴ Lindsay, C., Baruffati, D., Mackenzie, M., Ellis, D. A., Major, M., O'Donnell, K., ... & Wong, G. (2024). A realist review of the causes of, and current interventions to address 'missingness' in health care. *NIHR Open Research*, 3, 33. [10.3310/nihropenres.13431.2](https://doi.org/10.3310/nihropenres.13431.2)

²⁵ McQueenie, R., Ellis, D. A., McConnachie, A., Wilson, P., & Williamson, A. E. (2019). Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. *BMC medicine*, 17(1), 2. [10.1186/s12916-018-1234-0](https://doi.org/10.1186/s12916-018-1234-0)

²⁶ Lindsay, C., Baruffati, D., Mackenzie, M., Ellis, D. A., Major, M., O'Donnell, C. A., ... & Wong, G. (2024). Understanding the causes of missingness in primary care: a realist review. *BMC medicine*, 22(1), 235. [10.1186/s12916-024-03456-2](https://doi.org/10.1186/s12916-024-03456-2)

services and communities, helping to build trust, raise awareness of available support, and connect people who may otherwise struggle to navigate complex health and social care systems.

Ensuring that services are most accessible to those who need them the most is essential to reducing inequalities. Without targeted allocation, universal provision risks perpetuating, and potentially widening, existing health disparities, especially given the finite resources that are available.

Scotland's Population Health Framework supports this approach, positioning social prescribing within a broader strategy to reduce health inequalities. However, social prescribing should not be viewed as a panacea. Instead, it must be embedded within a coordinated, multi-level system that addresses both the social and medical needs of individuals and communities, with a sustained focus on those experiencing the greatest disadvantage. Achieving this will require stronger alignment between national policy priorities and local implementation.

Concluding remarks

There was broad consensus among participants from across the diverse sectors represented at the workshop regarding the positive role social prescribing can play in a community-led, person-centred approach to health and wellbeing in Scotland. The growing evidence base - which demonstrates benefits for individual health and wellbeing, reduced pressure on health services, and a significant return on investment - further reinforces the need for sustained policy and funding commitments to support the development and expansion of social prescribing. The priority must now shift away from pilot studies and exploratory initiatives to implementation, scale-up, and embedding of social prescribing as a core, sustainable service.

The proposed development of a National Framework for Social Prescribing was recognised as an important step forward. However, its success will depend on balancing national standards with local flexibility, enabling a holistic and responsive approach rather than a one-size-fits-all model. Standardised access to training and development, alongside professional recognition for CLWs, will be critical for retaining a skilled and stable workforce.

Building trust and strengthening relationships with the third sector, whilst recognising its vital contribution to the health and wellbeing of communities across Scotland, is essential. However, ongoing financial pressures mean that many third sector organisations are facing rising demand with limited resources. Ensuring sustainable investment in onward referral services is therefore a key priority. The RSE has previously recommended resourcing statutory and third sector services to improve social prescribing in Scotland.⁴

A well-functioning ecosystem beyond health and care, including sectors such as planning, housing, and transport, is crucial to ensuring equitable access to social prescribing. Achieving this will require stronger cross-government integration and investment in community assets and infrastructure, in addition to closer alignment between national policy priorities and local implementation. Improved communication channels, alongside more structured data sharing between local authorities, statutory services, and the third sector, would support more effective evaluation and inform service design and delivery at both local and national levels. Services providing social prescribing represent a valuable source of insight for the government and local authorities to identify the most pressing issues facing people and communities throughout Scotland in real-time.

The workshop also highlighted the need for a joined-up system. Currently, multiple agencies often work with the same individuals in a fragmented way. There is clear scope for improved collaboration and resource sharing across sectors to deliver more coordinated, person-centred support, while avoiding disproportionate cost pressures falling on the health system.

A recurring theme was the increasing number of individuals presenting with acute and complex needs, with CLWs frequently intervening at the point of crisis. Social prescribing could be embedded into a patient's healthcare plan, alongside medical support where needed, to provide a holistic model of care. This also recognises that individuals often have both clinical and social needs. Embedding proportionate universalism as a core principle would help ensure that those with the greatest need can access support in a timely and equitable manner. To shift towards a more preventative, early-intervention model, and to fully embed social prescribing in Scotland, sustained and long-term funding is required across statutory services, CLW programmes, and the wider network of community organisations that deliver social prescribing.

Acknowledgements

With thanks to the speakers and participants who attended and contributed insight during the workshop which helped inform this report.



CREATED IN 1783 BY ROYAL CHARTER
SCOTTISH CHARITY NO. SC000470

22–26 George Street
Edinburgh
EH2 2PQ

Telephone: +44 (0)131 240 5000
Email: info@theRSE.org.uk

Discover more at rse.org.uk