



Llywodraeth Cymru  
Welsh Government

# Core Standards and Values for Social Prescribing in Wales

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# About this document

**This document outlines a set of standards and values for social prescribing in Wales, and provides guidance on how to monitor and evaluate effectiveness.**

Its purpose is to establish social prescribing as a recognised and credible approach within health and care systems, while maintaining flexibility to accommodate local needs and encourage innovation.

It is structured into five sections.

## **Section One – Background and Context**

- Outlines the purpose and methodology for developing the Core Standards and Values for Social Prescribing in Wales, defines the Welsh model, and why social prescribing matters.

## **Section Two – Social Prescribing – Core Standards**

- Identifies core standards that set out clear expectations for the delivery of social prescribing, and the enabling components that support effective delivery.

## **Section Three – Core Values across the social prescribing pathway**

- Describes core values that underpin positive behaviours and interactions, acting as guiding values and beliefs that shape behaviour, decisions, and culture of an individual, organisation, or community.

## **Section Four – Monitoring and Evaluation**

- Outlines the importance of monitoring and evaluation as essential components of understanding impact, accountability, and continued improvement of social prescribing, providing guidance on what data should be collected.

## **Section Five – List of Appendices**

- Provides supplementary material that supports the main body of the document.

# Foreword

I am proud to introduce the Core Standards and Values for Social Prescribing in Wales which builds on the National Framework for Social Prescribing (NFFSP) published in December 2023. This is a further key step toward improving health and wellbeing across Wales.

Our ambition is to make social prescribing high-quality, credible, and equitable in preventing ill health and improving wellbeing, achieved through collaboration, sustainability, and integration into the wider health and care system. Moving beyond fragmented projects, we aim for a nationally supported, co-ordinated approach, underpinned by clear standards. These standards ensure quality, strengthen leadership and partnerships, enable consistent data collection for evaluation and improvement, and help streamline processes to enhance communication and confidence.

The core values of social prescribing promote a whole-person approach, emphasising prevention, co-creation, and respect for lived experience, with services that are person-centered, culturally competent, and rooted in community assets. This guidance provides a shared approach, while embracing local diversity and the differences in application.

Social prescribing addresses the social determinants of health and strengthens community resilience, by empowering individuals and communities to improve their own health and wellbeing through what matters to them. With core standards and values designed to inspire progress, support self-assessment, and unite people around shared priorities for better outcomes, together we can make social prescribing in Wales an integral part of a healthier, more connected future for everyone, regardless of age or background.



**Sarah Murphy MS**  
Minister for Mental Health and Wellbeing



## Section One

# Background and Context

## Purpose

1. This guidance document sets out a nationally agreed set of 'Core Standards and Values for Social Prescribing in Wales'. It aims to ensure robust, consistent, and sustainable delivery, embed social prescribing within health and care systems, and allow flexibility for local innovation.
2. These 'Core Standards and Values for Social Prescribing in Wales' are primarily for commissioners of social prescribing (statutory services, third sector organisations, and funders) to guide planning, commissioning, and quality assurance. It also serves as a practical reference for providers, social prescribing practitioners, professionals across sectors, and service users, setting shared expectations of quality and enabling a common understanding of what good looks like.
3. Social prescribing aligns closely with existing Welsh legislation and strategic priorities, providing a way of supporting delivery of national ambitions.
  - **Well-being of Future Generations Act (2015)** – places a duty on public bodies to improve social, economic, cultural and environmental wellbeing.
  - **A Healthier Wales** – Vision for a seamless health and social care system.
  - **Connected Communities strategy** – Tackling loneliness and isolation.
  - **Mental Health and Wellbeing Strategy (2025-2035)** – Supporting mental health and resilience, with social prescribing a key component of the preventative and person centred approach the strategy promotes.
  - **Trauma informed Wales** – Embedding trauma informed practice.
  - **Compassionate Cymru** – Creating a compassionate and caring nation.
  - **Healthy Weight: Healthy Wales** – Promoting physical activity and healthier lifestyles, in turn, improving mental wellbeing through better physical health.
  - **Strategy for an Ageing Society** – Creating an age-friendly Wales that supports people of all ages to live and age well.
4. Social prescribing helps to support these policies and legislation by linking health services with community support, addressing wider determinants such as housing, loneliness and isolation, and healthy lifestyles, to improve overall health and mental wellbeing.
5. All terminology used within this guidance is as per the '**Splossary**', a glossary of key terms designed to make language associated with social prescribing in Wales more consistent and easier for everyone to understand, including both the public and professionals.

## Methodology

6. The **National Framework for Social Prescribing (NFfSP)** published in 2023, set out a commitment to deliver a national specification, standards for community assets, and a core data set.
7. Work on developing the specification consisted of developing a set of core standards building on the cross cutting themes set out in the NFSP through:
  - **Evidence Reviews:** Comprehensive analysis of policy and guidance to identify key themes; and
  - **Stakeholder Engagement:** Consultation with experts across health, social care, and community sectors.

This ensures the standards are evidence informed, practical, and reflective of best practice in Wales.
8. A Task and Finish Group was established to consider the role of community assets and developed a set of core values for the social prescribing pathway to complement the social prescribing core standards. Consolidating existing guidance into accessible values that promote warmth, compassion, inclusivity, and mutual respect. It encourages relationship building and flexibility, fostering a person centred, values driven model.

9. Furthermore, the Wales School of Social Prescribing Research (WSSPR) were commissioned to develop a core data set to underpin standardisation, evaluation, and improvement by using a Group Concept Mapping approach. The resulting dataset shown within this document helps ensure consistency, accountability, and supports evidence driven improvement across services.
10. This guidance document delivers on the three commitments by pulling all the elements together into 'Core Standards and Values for Social Prescribing in Wales'.

## Overview of the Welsh Model of Social Prescribing

11. As set out in the NFfSP, the Welsh model moves beyond a purely healthcare led approach. It adopts a 'no wrong door' philosophy, allowing simple, accessible referrals from health, education, local authorities, housing, the third and voluntary sector, and self-referral.
12. Referral pathways should be simple, clear, and linked into existing, understood referral pathways, ensuring quick access, particularly for people in crisis or experiencing disadvantage. Figure 1 sets out the social prescribing referral pathway. The NFfSP illustrates this in more detail.

**Figure 1: The social prescribing pathway**

13. Evidence<sup>i</sup> shows that models integrated with Voluntary, Community, and Social Enterprise (VCSE) partners are most effective, offering trusted, community centred, asset-based support<sup>ii</sup>.

14. Key features of the Welsh model include:

- **Holistic** support across social, practical and wellbeing needs.
- **Asset based** use of local strengths and resources.
- **Collaborative** work across government, VCSE organisations, and community assets.
- **Flexible**, enabling a wide range of roles to embed social prescribing in practice.

## Why Social Prescribing Matters in Wales: Driving Positive Impact

15. As outlined in the NffSP, social prescribing supports Welsh Government priorities on prevention and early intervention, strengthening community resilience and empowering people to manage their own health and wellbeing. By addressing social and lifestyle factors, it can ease pressure on frontline services and help reduce health inequalities.
16. Social prescribing improves mental and physical wellbeing, particularly in areas such as loneliness, isolation, self-management of long-term conditions and healthier behaviours. Evidence shows benefits including improved wellbeing scores, reduced loneliness, increased confidence, greater physical activity and, in some cases, reduced demand for GP and hospital services.

17. Where social prescribing has been implemented, evidence shows demand for primary care may fall by 15%-28%<sup>iii</sup>, with some programmes also showing reductions in A&E use and hospital admissions. As many people visit their GP with issues rooted in social need, social prescribing offers an important preventative alternative. It can also support people on waiting lists, contributing to Wales' 3Ps Waiting Well approach<sup>iv</sup>.
18. Economic analyses<sup>v</sup> indicate positive social returns on investment, though more long-term, rigorous studies are still needed to confirm cost-effectiveness<sup>vi</sup>.
19. Internationally, social prescribing is expanding, with countries adopting models suited to local systems, from primary care led approaches to community based, hospital based, and multi-agency models. Despite variation, the core principles are consistent worldwide<sup>vii</sup>.
20. Overall, the growing evidence base demonstrates that social prescribing is a practical, impactful approach that improves wellbeing, reduces isolation, strengthens communities, and supports a more preventative, sustainable health and care system in Wales.



## Section Two

# Social Prescribing – Core Standards

## Core Standards

21. To ensure consistency and quality across Wales, the six core standards below set clear expectations for everyone involved in social prescribing. These standards outline the shared principles that underpin the approach, and apply across all parts of the pathway, from referral and access, to *'What Matters'* conversations, practitioner practice, and the role of community assets.
22. The core standards are:
  - 1) Person-centered
  - 2) Address inequalities
  - 3) Safeguarding and managing risks
  - 4) Trauma informed and work that is relationship focused
  - 5) Life course
  - 6) Welsh language
23. An easy to read summary of the core standards and Enabling Components set out in this section can be found in Appendix One.

## One: Person-centered

24. Social prescribing should take a person centred, strength based, and culturally competent approach, guided by *'What Matters'* to the individual. This means intentionally understanding each person's unique circumstances, culture, identity, strengths, and relationships, and working with them as active partners to co-produce support that builds on what they value and the resources (including time, energy, knowledge and skills, social such as family and friends, and financial) within their lives and communities.
25. Every single person should always be informed and involved in social prescribing decisions. People must be treated with respect and as individuals, recognising what makes them unique and helping them to reach their personal goals. Everyone involved in social prescribing, such as referrers, social prescribing practitioners, and community assets, should make sure the person's needs and wishes are at the core of the service provided.

## How this works in practice

26. Build strong, trusting relationships through regular, meaningful contact, routinely checking understanding and inviting feedback. Practitioners should prioritise time, continuity, and rapport.
27. Hold a thorough ‘*What Matters*’ conversation to understand the person’s circumstances, goals, and preferences. Use open questions, active listening, and supportive dialogue to uncover what is truly important beyond the initial referral.
28. Respect and work with the person’s cultural background, values, communication needs, and identity. Adapt engagement methods to ensure cultural competence and inclusion.
29. Take a strength based approach: identify and build on the person’s abilities, resources, and confidence, and use these assets to co-produce support.
30. Provide clear, accessible information in formats and languages that suit the individual so they can make informed choices. Use respectful, understandable language consistently, including in consent and feedback processes.
31. Ensure recommended activities are accessible. Plan ahead for barriers such as transport, cost, child care, mobility, or scheduling, which can be particularly important for older people and rural communities<sup>viii</sup>.
32. Consider caring responsibilities. With over 310,000 unpaid carers<sup>ix</sup> in Wales, most of whom are older people, caring commitments can significantly limit time, energy, and financial resources. For unpaid carers, options should be flexible, realistic, and designed to complement rather than add to existing pressures.
33. Create personalised, co-produced plans with clear goals, and review them regularly as needs or circumstances change.
34. Maintain an up-to-date understanding of local community opportunities. Social prescribing practitioners should offer a range of practical support, from providing information to helping arrange activities or, where appropriate, supporting the person to attend.
35. Integrate support not only across services but also with the person’s wider network of family and friends. For children and young people, consider the needs and capacities of parents or carers.
36. Treat lived and living experience as expertise. In service development or review, use co-design approaches that value people’s direct experience equally with professional or academic knowledge. Appendix Two provides more detail regarding co-designing and fostering lived experience.

## Two: Address inequalities

37. This standard is directed primarily at commissioners of social prescribing, who hold responsibility for ensuring that social prescribing services are designed, commissioned, and monitored in ways that reduce inequalities. However, addressing inequalities is a shared responsibility across the whole social prescribing pathway, and applies equally to statutory partners, providers, social prescribing practitioners, referrers, and community assets.

38. **All partners must work collectively to ensure that** every person can access the right support, regardless of age, impairment, background, or circumstance. Furthermore, all partners are actively anti-racist and committed to addressing structural inequalities to ensure equitable outcomes for all communities. This includes ensuring digital inclusion so that people with limited digital skills, confidence, or connectivity are not disadvantaged and can access support through appropriate, non-digital routes where needed.
39. Statutory partners **must** demonstrate how they meet the requirements of the **Public Sector Equality Duty** and **Regulation 18 of The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011**, and ensure that equality and human rights duties are embedded within contracts, service specifications, and commissioning decisions.
40. The **Prevention Based Health and Care Framework** provides a whole system approach to reducing avoidable health inequalities by shifting focus toward prevention, early intervention, and community centred models of support. Commissioners of social prescribing and statutory partners should use this framework to inform strategic planning, service design, and decision making, ensuring that social prescribing contributes to improved population health outcomes and a reduction in inequity.

## How this works in practice

41. This means actively focusing on people who are often excluded from services by identifying and addressing the barriers that prevent access. To address inequalities all social prescribing partners should:
- Provide evidence of efforts to include people who do not use traditional services, for example through outreach, flexible delivery models, or partnership working with trusted community organisations.
  - Common barriers such as transport, digital access, language, literacy or education level, stigma, and cultural appropriateness must be routinely considered and addressed.
  - Social prescribing can play a key role in supporting people who do not access mainstream services or who experience social and structural inequalities and discrimination to reconnect with their communities. For example individuals who have experienced homelessness, substance misuse, or other forms of marginalisation. Cultural awareness and trauma informed competence are essential to improving engagement, outcomes and reducing inequalities and should be embedded throughout delivery.
  - Partners should also consider what other barriers may prevent a person from engaging with or sustaining behaviour change, including physical health limitations, financial pressures, and wider social or environmental factors. Services should be easy to access and responsive, particularly for people in crisis or those facing multiple forms of disadvantage.

- Addressing inequalities often requires a targeted or tiered approach where additional time, flexibility, and resources may be required to support individuals with more complex needs.
- Take a data led approach to identifying need, for example Population Health Management (PHM) is an approach that improves population health through data informed planning and proactive care, using linked datasets to segment, stratify, and model local “at risk” and “rising risk” cohorts. PHM can help commissioners and providers of social prescribing identify those most in need. By using PHM insights to design, target, and personalise interventions, services can be resourced appropriately so that extra time and effort are directed toward those experiencing the greatest disadvantage, rather than applying uniform approaches that risk reinforcing existing inequalities.

### Three: Safeguarding and managing risks

42. All members of the social prescribing pathway should understand when safeguarding thresholds are met, how to respond appropriately, and how to escalate concerns in a timely and proportionate way.
43. Social prescribing operates across multiple sectors and settings to support individuals experiencing vulnerability, adversity, trauma, or complex social needs, including children, young people, adults at risk, and those with hidden safeguarding concerns.
44. Safeguarding is a fundamental responsibility within social prescribing and must underpin all interactions, decisions, and partnerships. All organisations and individuals involved in social prescribing, whether referrers, social prescribing practitioners, or community assets, must therefore work within robust safeguarding policies, procedures, and governance structures that align with Welsh legislation and statutory safeguarding guidance.
45. Making clear, consistent, and legally compliant safeguarding arrangements is essential. Practice across the entire pathway, from referral and assessment, to *‘What Matters’* conversations, practitioner decision-making, and engagement with community assets, should adhere to safeguarding governance, duties of information sharing and escalation pathways.
46. Throughout the pathway, It is important everyone is clear on how social prescribing supervision differs from clinical supervision provided by regulated professionals, so that everyone understands the limits of the social prescribing role and recognises when more specialist support is needed. Practitioners must recognise when needs exceed the scope of social prescribing and escalate appropriately to regulated clinical or allied health professionals, with clear escalation pathways supporting safe practice and appropriate role boundaries.
47. Safeguarding within social prescribing is not limited to responding to disclosures or identified risks. It also involves creating psychological and physically safe, respectful, and trusted environments where people feel able to share concerns, and where practitioners are confident in recognising any early signs of harm, neglect, abuse, exploitation, or risk.

48. A strong safeguarding approach in social prescribing is relational, trauma informed, person-centred and strengths based. It balances protection with empowerment, respects individual autonomy wherever possible, and ensures that safeguarding action is proportionate, culturally sensitive, and in the best interests of the person. Safeguarding should be viewed as integral to quality social prescribing practice, reinforcing trust, credibility, and confidence across the system.

## How this works in practice

49. Statutory partners must ensure social prescribing is commissioned and delivered in line with the **Social Services and Well-being (Wales) Act 2014**, ensuring the safety and wellbeing of children and adults at risk.
50. Any concerns that someone may be at risk must be reported to the local authority in line with **Wales Safeguarding Procedures**. Services working with children and young people must follow national guidance and ensure staff are trained and supported to work safely with all age groups.
51. While detailed safeguarding training requirements sit outside the scope of this document, safeguarding must be embedded in workforce development. Organisations commissioning or delivering social prescribing must ensure staff have appropriate safeguarding knowledge, skills, and competency.
52. All staff and volunteers working with children, young people, or adults at risk must have the correct level of Disclosure and Barring Service (DBS) check for their role.

53. Referrals must be safe, appropriate, and contain all necessary information. Poor quality or inappropriate referrals create risk and must be addressed through clear and implemented processes and shared accountability.
54. Clear governance for information sharing and escalation is essential. If a referral is inappropriate due to safeguarding risks or acute mental health needs, it should be redirected to the appropriate service. Practitioners should continuously assess whether needs are being met and escalate promptly when required.
55. All concerns about abuse, neglect, or exploitation, especially forms that are emerging or harder to detect, should be shared in line with statutory safeguarding procedures. Community assets must be supported and encouraged to report concerns, as they may notice early signs of harm.
56. Community assets need clear guidance on their responsibilities, limits, and expectations. Strong communication between practitioners, referrers, and community organisations help maintain safety while avoiding inappropriate pressure on community settings.

## Four: Trauma informed and work that is relationship-focused

57. A trauma informed approach aligns closely with social prescribing, as both place an individual's lived experience, autonomy and sense of safety at the centre of care. Social prescribing uses relational approaches, for example '*What Matters*' conversations, and responds to need by connecting people with supportive, non-clinical options such as outdoor-based

activities, creative arts, exercise groups or peer support networks. These forms of support can help regulate the nervous system, reduce social isolation and rebuild a sense of control and agency. When social prescribing practitioners are trained in trauma informed principles, they are better able to create safe, empowering relationships, avoid re-traumatisation, and pace referrals in ways that feel manageable and responsive for the person.

58. A trauma informed approach in social prescribing should recognise that past experiences can have a lasting impact on how people feel and behave, with heightened stress responses, difficulty trusting professionals, or nervous-system dysregulation. In this way, trauma informed thinking strengthens social prescribing by ensuring that activities offered are not only meaningful, but also supportive of healing, emotional regulation and long-term wellbeing in ways that avoid re-traumatisation.

## How this works in practice.

59. Prioritise activities and environments that promote safety and calm. Adjust physical spaces to reduce stress (e.g. quiet areas, softer lighting, reduced sensory triggers) and offer grounding or calming techniques that help regulate the nervous system.
60. Recommend gentle activities, such as walking, yoga, tai chi, or creative arts, that support emotional regulation, reduce isolation, and help people regain a sense of control without risking re-traumatisation.
61. Build strong, trusting relationships. See **Standard One: Person-centred**, for the core principles that underpin this approach. Recognise that trauma affects trust, behaviour, and engagement. Support and referrals should be paced appropriately to avoid overwhelm and to ensure the person maintains a sense of control.
62. Embed trauma informed principles across services and partnerships, using tools such as the **TrACE (Trauma and Adverse Childhood Experiences) Toolkit** to shape safe environments, related practice, consistent communication, and reflective practice.
63. Support practitioners and organisations to reflect on how past experiences influence behaviour and engagement, and to adapt approaches in ways that build trust and reduce the risk of re-traumatisation.

## Five: Life course

64. A life course approach is fundamental to social prescribing, including children, young people, pregnancy, postpartum, and older adulthood.
65. For example, evidence from the 'Development Origins of Health and Disease (DOHaD)\* shows early life experiences strongly shape lifelong health. Early intervention through social prescribing can strengthen protective factors, reduce inequalities, and establish healthy, sustainable behaviours.

66. Babies, children and young people need support that enables healthy development. Social Prescribing should link families to community services that promote wellbeing and positive relationships, particularly through play<sup>xi</sup>. It can directly support children's United Nations Convention on the Rights of the Child (UNCRC) rights, particularly Article 24<sup>xii</sup> (healthy) and Article 31<sup>xiii</sup> (play), which is vital for resilience, social connection, learning and emotional wellbeing.
67. Similarly, the global response to an ageing population has focused on creating age-friendly cities and communities. The World Health Organisation (WHO) defines an age-friendly world as one where people of all ages can participate in community life and are treated with respect.
68. Welsh Government funds local authorities to join the WHO's Global Network of Age-friendly Cities and Communities and embed the UN Principles for Older Persons, as required by the Social Services and Well-being (Wales) Act.
69. A recent evaluation<sup>xiv</sup> shows the age-friendly programme has significantly improved older people's wellbeing. Loneliness has reduced, social connections strengthened, and people report feeling more valued and involved. Increased physical activity has supported healthier lifestyles, and better access to information has improved use of services and support. The programme has also empowered older people to volunteer, lead activities, and contribute more actively to their communities.
70. These developments align closely with social prescribing in that they aim to strengthen community participation, reduce loneliness, and support healthier ageing through connections to local, non-clinical resources.

Through linking older people to age friendly community assets, social prescribing helps maintain independence, promote physical and emotional wellbeing, and uphold the UN Principles of Older Persons within local practice. In this way, social prescribing acts as a practical mechanism for ensuring that communities are age friendly, resilient, and support Wales' long-term preventative health agenda.

## How this works in practice.

71. Stakeholders should ensure when commissioning services relating to babies, children, young people and families that they have regard to the UNCRC and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and have regard to '**THE RIGHT WAY – A Children's Rights Approach for Social Care in Wales – A Children's Rights Approach is a principled and practical framework for working with children**, grounded in the UN Convention on the Rights of the Child as well as the '**Corporate Parenting Charter – A Promise from Wales**' so that children and young people fulfil their potential.
72. Commissioners should have regard to **the NEST Framework**, which is a key part of delivering a 'whole system' approach for developing mental health, wellbeing and support services for babies, children, young people, parents, carers and their wider families across Wales. It aligns with social prescribing as it aims to ensure a "no wrong door approach" and to broaden the conversation away from thinking that only specialist services can provide help.

73. Social prescribing can help improve children and young people's health and development by offering support that complements clinical care or education. Community based spaces and activities have an additional value supporting social and emotional development and strengthening their sense of belonging and connection to their environments.
74. To be effective, social prescribing for babies, children, and young people should be rooted in family and community contexts. Planning should prioritise access to family friendly spaces and services, recognising that most children benefit from remaining close to their families, carers and communities.
75. The preventative role of social prescribing should be emphasised, with a focus on helping families build healthy habits and positive lifestyles. For children living with chronic conditions, consideration should be given to how social prescribing can help improve wellbeing and coping mechanisms, while for families experiencing stress or disadvantage, it should help provide access to practical support and nurturing community relationships.
76. Play should be central within social prescribing for children and families, requiring knowledgeable practitioners, supportive communities, and accessible, high quality play spaces.
77. For older adults, commissioners should continue to apply the UN Principles for Older Persons and use social prescribing to help people remain active and engaged in their communities.

## Six: Welsh Language

78. The Welsh language is a fundamental part of Wales' national identity, culture, and community life. It is integral to the wellbeing of individuals and communities. Being able to access services through the medium of Welsh supports dignity, inclusion and equality, and is essential to providing safe, effective, and person centred care. In the context of social prescribing, the Welsh language plays a vital role in building trust, strengthening relationships, and ensuring that people can fully express their needs and experiences in their native language.
79. The provision of social prescribing through the medium of Welsh **must** be a right and is a matter of need and necessity, not choice.

## How this works in practice

80. Adoption and delivery of More than just words, the Welsh Government's strategic framework to strengthen Welsh language provision in health and social care, will help improve the quality of care for individuals living in Wales.
81. Statutory partners should ensure compliance with the Welsh Language (Wales) Measure 2011 when planning and delivering care and support services and that they exercise the 'Active Offer', offering services through the medium of Welsh rather than people having to request it.
82. Statutory partners should treat the Welsh language the same as English, and people should be able to use Welsh Language in their everyday life.

83. Statutory partners should ensure that their population needs assessment establishes the range and level of services that will be required through the medium of Welsh including identifying where there are currently gaps in provision and the action that will be taken to increase the range and level of services that are required through the medium of Welsh.
84. Statutory partners must also comply with all Welsh language duties and obligations contained within legislation, codes of practice and statutory guidance issued, and have regard to any other relevant guidance.

## Enabling Components

85. Effective social prescribing requires strategic and operational components to be aligned, resourced, and understood.
86. To help achieve this, a set of enabling components should support delivery, providing structures and resources that make social prescribing both effective and sustainable.

## Environmental sustainability

87. **Environmental sustainability** is a distinct but integral aspect of social prescribing covering climate adaptation, ensuring services are responsive and resilient to changing environmental condition, reducing carbon emissions as well as addressing the wider environmental impacts of healthcare, such as pharmaceutical residues entering water systems and harming ecosystems.

88. By actively supporting **Wales' Net Zero and climate resilience objectives** and embedding resource-efficient, climate resilient practices into service design and delivery, social prescribing helps deliver long-term health, social and environmental goals.
89. **Green prescribing** approaches, for example nature-based interventions such as community gardening, conservation activities, and outdoor physical activities, enhance both health and environmental outcomes. These could act as alternatives to unnecessary medication and not only lower the carbon footprint but also reduce pharmaceutical waste and pollution<sup>xv</sup>. Furthermore, fostering connection to nature through social prescribing encourages positive environmental behaviours, including sustainable land use, recycling, and biodiversity protection. As set out in the Welsh Government's **Mental Health and Wellbeing Strategy**, social prescribing can enhance mental wellbeing, reduce stress, and support healthier behaviours by helping people connect with nature, delivering benefits for health, communities, and the environment.
90. Applying, for example, **Sustainable Quality Improvement (SusQI) principles**<sup>xvi</sup> ensures that social prescribing interventions improve the health and wellbeing of individuals and populations while minimising environmental, financial, and social impacts. Commissioners and providers of social prescribing should assess and report on the **carbon footprint** of activities and **actively embed climate adaptation considerations**, prioritising local delivery, low-carbon alternatives, and efficient use of community assets to ensure sustainability.

## Workforce

91. In Wales, social prescribing is an activity carried out by individuals holding various job titles across different settings. For some roles, such as Community Connectors, Link Workers, and Community Coordinators, social prescribing may be a specific responsibility. However, professionals from a range of backgrounds can also incorporate social prescribing into their broader roles.
92. The emphasis of social prescribing in Wales is as a function, rather than a specific job role, and can be applicable regardless of job title.
93. **The Competence Framework for Social Prescribing Practitioners in Wales** is available, providing guidance on the knowledge, skills, and behaviours required to deliver high quality, person-centred social prescribing. The Competence Framework defines good practice and consistent standards in delivering social prescribing as a function.

## Leadership

94. Social prescribing is at its most effective when it is embedded into wider health and social care pathways, rather than operating as a standalone intervention.
95. **Leadership and Governance** – Local leadership plays a critical role in embedding and sustaining social prescribing.

For example:

- a. Ensuring long term and secure funding arrangements and strong and transparent governance structures in line with the principles of the **Third Sector Funding Code**.
  - b. Creating a community of practice to provide leadership on the dissemination of knowledge.
  - c. Multiagency steering groups to support integration and provide support on, for example, the allocation of resources and assurance on the provision of appropriate training.
96. **Integration** – when different organisations agree to work together and share the same goals, it helps social prescribing become a normal part of health and care services. This joined up approach makes it easier to grow social prescribing, keep it running smoothly, and helps everyone understand that it is a real and useful option for supporting people’s health and wellbeing.
  97. **Regional Partnership Boards (RPBs)** – RPBs in Wales have been established as part of the **Social Services and Well-being (Wales) Act** to improve the well-being of the population, and to improve how health and care services are delivered. Therefore, RPBs have an important role in demonstrating leadership and supporting integration in the delivery of social prescribing. RPBs support partnership working at the local level, providing a platform for place-based networks that support social prescribing at a local level.

## Community Assets

98. The NFfSP outlines how community assets, as defined within this context, are central to the delivery and success of social prescribing and play a pivotal role in providing local, non-clinical support that enhances the health and wellbeing of the communities they serve by building on existing strengths. See **Section One: Background and Context – Overview of the Welsh Model of Social Prescribing.**



## Communication and collaboration

99. Social prescribing involves multiple partners, so clear communication and collaboration is essential. Social prescribing practitioners need to build relationships with referrers and community assets, and in return need to receive regular updates. Practitioners also need to build understanding of local services, working closely with partners. The core expectations set out in the **'Competence Framework for Social Prescribing Practitioners in Wales'**, are designed to support consistent, high quality, person-centred practice and clear communication and collaboration.
100. Digital tools are essential for supporting collaboration and access<sup>xvii</sup>. While existing systems such as **Dewis** and **InfoEngine** already provide valuable information and a 'spine' for a national Once for Wales directory, it is recognised that the current mix of national and local platforms results in a fragmented range of information sources creating the risk of confusion for users and professionals alike. Options are therefore being considered for a single, user friendly national system, including an up-to-date online directory of community assets.



## Section Three

# Core Values across the Social Prescribing Pathway

## Core Values

101. Strong, inclusive communities are built on shared values that ensure people feel safe, respected, supported, and empowered. Clearly defined core values help align expectations across the social prescribing pathway, strengthen trust, collaboration, and appropriate use of community assets.
102. These values guide behaviour, decision-making, and culture, shaping social prescribing as a compassionate, person centred, and community focused approach. The vision and core values below (Table 1) set out shared expectations from the perspective of the person, the social prescribing practitioner and the community asset.

## Vision

103. To promote the use of community spaces that are welcoming, safe places where everyone feels respected and supported – working together to agree principles that recognise and value the importance of community assets and resources that have a positive and sustainable impact on community wellbeing.



**Table 1: Core Values**

Perspective	Core Values	What Good Looks Like	Mutual Expectations
Person	Respect and Dignity Choice Empowerment Trust Empathy Confidentiality Holistic Co-production Social Value <sup>xviii</sup>	Feels heard, respected, and supported in a way that reflects their identity and community. Has access to appropriate services and participates in shaping their journey. Experiences improved wellbeing and contributes to wider community value.	Treated as a partner in care/support. Provided with clear, culturally sensitive information. Given opportunities to co-produce and give feedback. Not over promised or overwhelmed.
Social Prescribing Practitioner	Respect Avoid Harm Transparency Accountability Integrity Creativity Flexibility Empathy Governance Support Social Value <sup>xix</sup>	Makes ethical, informed referrals that reflect the person's needs and context, while supporting the sustainability and value of community assets. Works collaboratively with community assets and values their role.	Refers appropriately and realistically. Maintains clear governance and boundaries. Supports community assets through partnership. Communicates openly, clearly, and empathetically.
Community Asset	Accessibility Co-production Cultural Inclusion Sustainability Adaptability Governance Social Value <sup>xx</sup>	Provides inclusive, responsive support that reflects community needs. Encourages open feedback to adapt practices and explore alternative referrals when something isn't working. Works in partnership and maintains clear roles and boundaries. Welcomes feedback to continually improve.	Welcomes diverse individuals. Participates in co-production. Communicates capacity and limitations clearly. Works collaboratively to generate social value, communicates emerging capacity issues, and seeks mutual support, including from Regional Partnership Boards, to avoid overextension.

## Implementation Considerations

104. To embed these core values into practice, implementation must translate principles into clear, actionable steps that guide collaboration across all stakeholders, especially when third and voluntary sector resources are stretched. This includes clarity of roles and responsibilities, fostering co-production, and maintaining open communication to manage expectations. Inclusivity should remain central, focusing on what each partner can realistically contribute to maximise community strengths, while recognising achievements and adapting together when challenges arise.

## Clarity of Roles

105. Ensuring clarity of roles is important as this prevents duplication, confusion, and unrealistic expectations. In terms of how this may be implemented:

- Use role descriptions outlined in **Appendix Three**.
- Create visuals that show boundaries and contributions.
- Provide clarity regarding training for social prescribing practitioners, using the **Core Competence Framework for Social Prescribing Practitioners in Wales**.
- Regularly review roles to adapt to evolving need.

## Inclusivity

106. Inclusivity is another important factor as it focuses on what each party can do, maximising community strengths. In terms of how this may be implemented:

- Use Asset Based Community Development (ABCD)<sup>xxi</sup> approach for building stronger communities by identifying what each party, including children and young people, can contribute.
- Identify community capabilities beyond the formal services provided, such as identifying strengths like skills, lived/living experience, and informal networks.
- Train social prescribing practitioners and partners on inclusive practices and community assets.
- Provide clear, culturally sensitive information in accessible language.

## What Good Looks Like

107. Some practical examples of what good looks like include:

- **Person:** Through the '*What Matters*' conversation receives clear information about their role in the co-production of an action plan, and feels empowered to share feedback.
- **Social Prescribing Practitioner:** Maintains transparent referral processes and proactively supports community partners. Furthermore, maintains local knowledge of what is available and where, while maintaining relationships with partners (public, third and private sectors), and builds their skills and knowledge to appropriate levels.

- **Community Asset:** Communicates capacity, available services and limitations, honestly and collaborates on inclusive service design reflecting community need.

## Shared expectations in action

108. Some practical examples of what this looks like could include:

- **Shared Agreements:** Develop a partnership charter outlining expectations for respect, communication, and accountability.
- **Monitoring:** Monitor engagement, feedback, and recognition activities, and build in the ability to change direction if it is not working for the person or community asset.
- **Adaptability:** Regular review of expectations to reflect changing community needs.





## Section Four

# Monitoring and evaluation

109. Monitoring and evaluation are essential components of understanding the impact, accountability and continued improvement of social prescribing in serving the different needs of the Welsh population. Evaluating outcomes, for example in terms of improving physical and mental wellbeing, builds trust among stakeholders, including potential funders, helping to secure sustainable investment through the demonstration of clear holistic benefits.

## Continuous improvement cycle

110. Commissioners of social prescribing are expected to make decisions that are **evidence-informed, outcomes-focused, and responsive to both current and future population needs**. Organisations and individuals involved in commissioning social prescribing services should follow the **National Framework for Commissioning Care and Support Code of Practice** (the Code), and **should** include consideration of the purpose and value of proposed interventions, as well as the sustainability of services, and their social, environmental, cultural and economic impact. The Code also sets out that stakeholders must collate robust quantitative and qualitative data to assess implementation outcomes, monitor progress, and inform ongoing improvement.

Stakeholders must also consider the characteristics of people currently using services, and those who may require them in the future, including cultural, linguistic, and other relevant needs.

111. Organisations and individuals involved in commissioning and delivering social prescribing services should record accurate workforce information. Maintaining an up-to-date dataset on the social prescribing workforce enables strong and strategic workforce planning, ensuring that commissioning decisions are supported by a clear understanding of workforce capacity, capability, and distribution.

## Monitoring and evaluation – Social Prescribing?

112. As social prescribing takes a holistic approach, its impact can vary widely across individuals and different aspects of health, wellbeing, and quality of life. People may experience improvements in mental wellbeing, loneliness, stress, sleep, or physical health, while others may benefit through increased confidence, skills, social connections, or access to financial and housing support that can also improve employability.

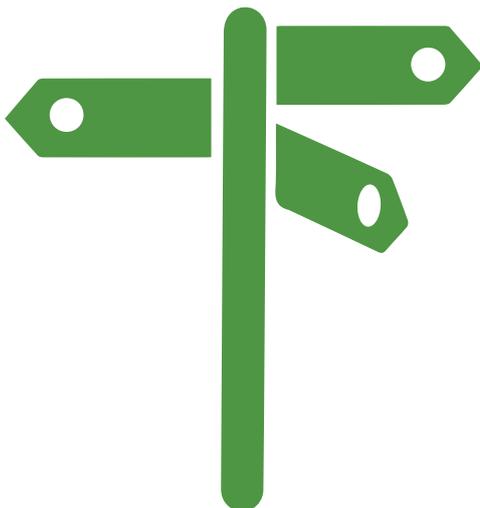
113. The breadth of impact is a key strength of social prescribing, but it also presents challenges for evaluation, as different activities and approaches may require different measures. In response, national research has developed evaluation frameworks and reporting standards, informed by reviews and consensus studies, including the international Delphi study and the ACCORD study led by the Wales School for Social Prescribing Research (see **Appendix Four**).

## Quantitative Measures

114. Based on research commissioned by Welsh Government in 2025 and led by WSSPR, a **Core Data Set** for social prescribing has been published. Core Data Set Guidance outlines the essential information that all organisations involved in referring, delivering, or supporting social prescribing activities should collect. WSSPR's work also identified that, quantitative performance measures for social prescribing should be based on the three key questions used in Outcome Based Accountability, (OBA) otherwise known as Results Based Accountability (RBA).

- How much did we do?
- How well did we do it?
- Is anyone better off?

115. **Appendix Five** provides a detailed list of possible performance measures that can be used, while Table 2 highlights the Top 5 performance measures recommended as most appropriate, aligned to the OBA/RBA Questions.



**Table 2: Top 5 performance measures by OBA/RBA Questions**

OBA/RBA question	Performance Measures
<b>How much?</b>	Was a 'What Matters' conversation completed?
	Number of people who receive a social prescription/referral who then go on to access what has been prescribed.
	Demographics of people accessing social prescribing practitioners (including protected characteristics, NHS number, name, postcode, DoB, etc.).
	Reason for referral to social prescribing practitioner (e.g. physical, mental, social or financial wellbeing).
	Types of social prescribing activity/service (e.g. exercise referral activity, creative referral activity) an individual is referred to by geographical location (e.g. exercise referral activity, creative referral activity).
<b>How well?</b>	Service user satisfaction scale (for social prescribing service).
	If the person attended the activity or service they were referred to?
	If the individual is satisfied with the information they received from the social prescribing practitioner.
	If the individual felt that they had influenced the decisions that affected them.
	Barriers to attending/engaging with the activity or service to which the individual was referred.
	Themes on what the person wants to achieve/what matters to them (e.g. reduce isolation, increase physical activity).
	Changes to mental wellbeing (using a validated tool(s)).
<b>What difference?</b>	If the individual achieved their personal outcomes as a result of engagement with the social prescribing practitioner.
	Changes to feelings of loneliness (using a validated tool(s)).
	Changes to social wellbeing (using a validated tool(s)).

116. The following examples of validated tools directly align with the performance measures in Table 2 by providing the standardized methods used to assess wellbeing, outcomes, and impact across the OBA/RBA categories:
- **WEMWBS** – Warwick-Edinburgh Mental Wellbeing Scale. Measures mental health in the general population. Focuses on positive feelings and functioning. Available in both full (14-items) and short (7-items).
  - **ONS-4** – Office for National Statistics 4 measures. A set of 4 subjective wellbeing questions (life satisfaction, feeling that life is worthwhile, happiness, and anxiety). developed by the UK ONS for use in population surveys and public health monitoring.
  - **PAM** – Patient Activation Measure. Measures an individual’s knowledge, skills, confidence, and engagement in managing their own health and care. Often used in healthcare interventions to tailor support for self-management.
  - Longitudinal follow-up of cases.
  - Mixed method approaches alongside quantitative approaches, wellbeing outcomes can be captured qualitatively.

## Qualitative measures

117. As well as quantitative methods it is also important to include more qualitative approaches. Case studies, feedback and stories demonstrate values in action, humanising context, evoking emotion, and fostering connection and trust in the positive impact of social prescribing. They make impact more relatable, memorable, and actionable.

118. Those commissioning and delivering social prescribing should:
- Collect case studies from all perspectives, the person, the social prescribing practitioner, and the community asset.
  - Use multimedia tools, such as short films/videos, infographics, to share stories.
  - Implement feedback opportunities, such as surveys, comments, which can then be clearly reported back to relevant stakeholders.
  - Embed storytelling into reports and community engagement sessions.

## Recognising success

119. Recognising success is also vital as it builds trust and strengthens collaboration and co-production. Those commissioning and delivering social prescribing should:
- Create mechanisms that celebrate contributions and success i.e. newsletters, social media highlights, recognition events.
  - Support peer-to-peer appreciation between social prescribing practitioners and community assets.
  - Develop and use shared communication platforms for updates and success stories.
  - Connect recognition to real impact, for example how many people were helped and how diverse the engagement was. The full **Core Data Set Guidance** and **Appendix Five** can also assist in terms of identifying suitable metrics.



## Section Five

# List of Appendices

<b>Appendix One</b>	Summary of Core Standards & Enabling Components
<b>Appendix Two</b>	Co-designing and fostering lived experience
<b>Appendix Three</b>	Role descriptions related to Core Values across the Social Prescribing pathway
<b>Appendix Four</b>	Delphi study and ACCORD study
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<b>Appendix Six</b>	References

## Appendix One

# Summary of Core Standards and Enabling Components

Section	Description	Example in Practice
<b>Core Standard 1: Person-centred approach</b>	Social prescribing is guided by what matters to the individual, using a strengths-based, culturally competent and co-produced approach.	Practitioner builds trust and co-creates a personalized plan and reviews goals that adapt to the person's needs, culture and circumstances.
<b>Core Standard 2: Address inequalities</b>	Services are designed and delivered to reduce inequalities, remove barriers and actively include underserved communities.	Targeted outreach, flexible delivery, non-digital access routes, and additional time/support for people with complex needs.
<b>Core Standard 3: Safeguarding and managing risk</b>	Safeguarding is embedded across the pathway, balancing protection with empowerment through clear governance and escalation pathways.	Concerns are identified early, referrals include information about risks, staff are trained, and issues are escalated when scope exceeded.
<b>Core Standard 4: Trauma informed and relationship-focused</b>	Practice recognises the impact of trauma, prioritising the feeling of safety, trust, choice and supportive relationships.	Gentle pacing, calm environments, consistent relationships, activities such as nature walks, arts or peer support.
<b>Core Standard 5: Life course approach</b>	Support for people at all life stages, with a focus on prevention, early intervention and children's rights.	Children and families are linked to play, youth or family-based community activities close to home. For older adults, apply the UN Principles for Older Persons and support them to remain active and engaged in their communities.

Section	Description	Example in Practice
<b>Core Standard 6: Welsh language</b>	Access through the medium of Welsh is a right and a need, supporting dignity and person-centred care.	Welsh is proactively offered; conversations and materials are available in Welsh without needing to ask.
<b>Enablers</b>		
<b>Environmental sustainability</b>	Social prescribing contributes to environmental goals through low-carbon and nature-based approaches.	Green prescribing, (conservation, gardening, walking groups), local delivery, carbon footprint estimations.
<b>Workforce standards</b>	Practitioners are trained, supported and supervised using the National Competence Framework. Induction, CPD and reflective supervision	Staff demonstrate skills in motivational interviewing, trauma informed practice, and addressing inequalities.
<b>Leadership and integration</b>	Strong leadership embeds social prescribing into wider health, care and community systems.	Regional Partnership Boards support a shared vision, multi-agency governance and integrated pathways.
<b>Community Assets</b>	Central to the delivery and success of social prescribing in Wales.	Offers a range of accessible health and wellbeing activities, tailored to local need.
<b>Communication and collaboration</b>	Effective partnership working and information sharing across the system.	Multi-agency meetings, National community assets directory, digital platforms or tools, regular communication/feedback loops.

## Appendix Two

# Co-designing and fostering lived experience

## Principles of Co-Design

Co-design is rooted in the belief that those who are directly affected by a service are best placed to help shape and improve it.

This approach ensures that services are not only more effective but also more equitable, inclusive, and empowering.

### Key principles include:

- **Equal partnership:** People with lived experience are engaged as equal contributors alongside professionals. Their knowledge and insights are valued throughout the process.
- **Recognition of expertise:** Lived experience is treated as a form of expertise on par with academic or professional knowledge.
- **Accessibility and equity:** Sessions and materials must be inclusive and accessible to all participants, removing language, physical, or emotional barriers.
- **Feedback and iteration:** Co-design is not a one-off activity – it requires continuous engagement, responsiveness, and willingness to change based on feedback.

## Recruitment and Inclusion

Inclusive recruitment of people with lived experience is foundational to authentic co-design. It's important to proactively engage underrepresented voices and ensure participation is safe, supported, and valued.

### Steps include:

- Creating recruitment materials in plain language and multiple formats (e.g., posters, videos, Easy Read).
- Working through trusted local organisations (VCSE, housing, advocacy) to identify and invite individuals.
- Providing incentives such as honoraria, gift cards, or travel reimbursements to compensate participants fairly.
- Ensuring diversity by monitoring and encouraging representation from different demographic and lived experience groups.

## Capacity Building

Many individuals may need support to engage fully in co-design processes. Organisations should provide learning, encouragement, and tools that build confidence and agency.

### Support strategies:

- Offer pre-session orientations explaining goals, structure, and terminology in accessible ways.
- Provide one-on-one or buddy support where needed, especially for participants who may have anxieties or additional needs.
- Develop psychologically safe spaces, including trauma informed practices, inclusive facilitation, and flexible participation options.
- Ensure all materials are available in formats such as Easy Read, BSL-interpreted, large print, or audio.

## Designing Co-Production Sessions

Effective co-design sessions create space for reflection, storytelling, creativity, and shared problem-solving. Facilitators must structure sessions around the needs and experiences of participants.

### Practical approaches include:

- Using visual and creative tools such as empathy maps, user journey mapping, and storytelling.
- Anchoring discussions in real service challenges (e.g., barriers to access, gaps in provision, transition between services).
- Ensuring emotional and physical safety, including ground rules and breaks.
- Training facilitators in inclusive, culturally competent, and trauma informed techniques.
- Providing safe spaces for faith based activities.

## Building Lived Experience Advisory Panels

Advisory panels provide ongoing input into service strategy and governance. They formalise the role of lived experience in continuous service improvement.

### Steps to establish panels:

- Invite consistent contributors from co-design sessions to join longer-term advisory roles.
- Define clear roles, expectations, and supports, including time commitments and feedback mechanisms.
- Ensure representation on decision-making bodies (e.g., Regional Partnership Boards or steering groups).
- Provide training or support to enable members to contribute confidently to formal governance structures.

## Embedding Lived Experience in Evaluation

Evaluation must go beyond metrics and include the voices of those with lived experience. Their insights help reveal whether services are truly person-centred and effective.

### **Recommended methods:**

- Involve participants in defining what success looks like (e.g., changes in confidence, community connection, empowerment).
- Co-produce data collection tools such as feedback journals, interviews, and case studies.
- Prioritise qualitative as well as quantitative data, including creative outputs such as storytelling or artwork.
- Ensure findings are shared in accessible ways and used to inform service improvement.

## Sustaining Engagement

Sustained involvement of lived experience contributors helps to avoid tokenism and build long-term trust and service resilience.

### **Actions to sustain engagement:**

- Provide ongoing feedback showing how contributions shaped change (“you said, we did” reports or videos).
- Recognise contributions through certification, public thanks, and professional development opportunities.
- Embed lived experience roles into staffing structures, including peer mentors or co-production officers.
- Develop mechanisms for continuous recruitment and succession planning for advisory groups.

## Appendix Three

# Role descriptions related to Core Values across the Social Prescribing pathway

Through extensive engagement with stakeholders prior to publication of the NFfSP, and since, it was clear that a shared understanding of social prescribing terminology was needed. Clear terminology can help avoid confusion, improve communication, and ensure consistency across services. When everyone, public and professional alike, are able to understand and use the same language, it builds trust, supports the collection of evidence, and makes evaluation more effective.

To support a shared understanding of social prescribing, a glossary of terms, known as a ‘Splossary’<sup>xxii</sup>, has been developed. It can be accessed for further clarity and insight, however, some of the key definitions taken from the ‘Splossary’ include:

**Social prescribing** is an umbrella term that describes a person-centered approach to connecting people to local community assets. It can help empower individuals to recognise their own needs, strengths, and personal assets and to connect with their own communities for support with their personal health and wellbeing.

**Social Prescribing practitioner** is an umbrella term that is used to describe someone who assists individuals with identifying their non-medical needs through a ‘*What Matters*’ conversation, and helps them co-produce an action plan and access local community assets, such as groups, interventions or services.

**A ‘What Matters’ conversation** is a central part of the social prescribing process. A ‘*What Matters*’ conversation takes place between a social prescribing practitioner and the social prescribing beneficiary/individual to identify what is important to the individual and in what areas they require support. The conversation informs the co-production of an action plan.

The **Person** refers to those who access social prescribing services, who can come from any age or background and seek community support to better manage their health and wellbeing.

The NFfSP acknowledges that while many people can access community resources independently, some face barriers, and social prescribing is designed to help those individuals overcome these challenges.

**The evidence suggests that social prescribing particularly supports individuals who:**

- Have long-term health conditions
- Experience low level mental health issues
- Are lonely and isolated
- Facing financial, housing or employment challenges
- Recovering from trauma or adversity
- Face complex social needs that affect their wellbeing.

In essence, the person accessing social prescribing in Wales is viewed as a whole person, not just a patient or service user. The National Framework promotes dignity, agency, and community connection as central to improving health and wellbeing.

In terms of the **Social Prescribing Practitioner**, Wales is taking a distinctive approach to social prescribing, shifting beyond a healthcare centric model. Our approach embraces a ‘no wrong door’ philosophy, enabling referrals from a range of sectors, including the option of self-referral. The NfSP acknowledges a wide range of individuals and organisations who may initiate or facilitate social prescribing.

**These can include:**

- Primary Care professionals
- Community and voluntary sector organisations
- Social care professionals
- Housing officers
- Job centre staff
- Statutory services
- Education professionals
- Social prescribing practitioners.

**Social Prescribing Practitioners are expected to:**

- Recognise when a person’s needs are met through community asset social prescribing support, rather than clinical intervention.
- Refer or signpost individuals to a social prescribing practitioner or directly to a community asset.
- Work collaboratively with social prescribing practitioners and community assets to ensure continuity and appropriateness of support.

**The NFfSP highlights the importance of ensuring that social prescribing practitioners are appropriately trained and supported. This includes developing a clear understanding of:**

- The purpose and principles of social prescribing.
- The range of community assets and services available within their area.
- How to conduct person-centred '*What Matters*' conversations and support individuals to identify their own needs and priorities.

To support this, the Competence Framework for Social Prescribing Practitioners in Wales<sup>xxiii</sup> is available, providing guidance on the knowledge, skills, and behaviours required to deliver high quality, person-centred social prescribing.

**Community Assets** are central to the delivery of social prescribing. Community Assets provide a collective term for anything that can be used to improve the quality of community life. This can include community groups, interventions and services which could be delivered online or in person, as well as buildings, land or even a person within the community.

Cultural assets, or heritage assets, are community assets that have value due to their historical, artistic, scientific, and environmental value. The assets hold their value due to their contribution to knowledge and culture in the community.

People are referred into these community assets through various referral routes, including self-referral, healthcare, community and voluntary sector organisations, statutory services, and via targeted referrals. Social prescribing practitioners then play a key role by working collaboratively with individuals to understand '*What Matters*' to them and then signpost or directly refer them to suitable local activities or services, green and blue space initiatives, learning and education, and welfare support referrals, all helping people to find the right support for their health and wellbeing.

These community assets offer a wide range of opportunities for people to improve their health and wellbeing. Below are more detailed descriptions of some of the interventions delivered by community assets.

**Nature-based interventions'**, an umbrella term used to describe groups, interventions or services that support individuals to improve their health and wellbeing through contact with nature and spending time in natural or semi-natural environments. An example of nature-based interventions includes blue and green referral.

**Blue referral** is an umbrella term used to describe the referral of individuals to groups, interventions or services that support engagement with nature-based interventions based in natural or semi-natural 'blue' environments, to improve health and wellbeing. The term 'blue' is used to describe a water-based environment, such as a lake or coastline, in which an individual may partake in water based or water adjacent activities and/or exercise. Examples of blue referral activities include swimming, surfing, rowing, and beach yoga.

**Green referral** is an umbrella term used to describe the referral of individuals to groups, interventions or services that support engagement with nature-based interventions based in natural or semi-natural 'green' environments, to improve their health and wellbeing. The term 'green' is used to describe environments such as forests, grasslands, gardens, and parks in which individuals may partake in physical activities and/or exercise. Examples of green referral activities can include walking or running in parks, or volunteering to clear and maintain woodland.

**Creative referral** is an umbrella term that is used to describe the referral of individuals to community assets to participate in a broad range of creative activities. Examples of creative referral activities include singing/music making, painting, dance, drama, crafts, photography and film, theatre, and creative writing.

**Social referral** refers to activities such as coffee mornings, bingo sessions, and gatherings in warm spaces, which provide safe and welcoming environments for people to meet others, reduce isolation, and build supportive networks. These activities not only foster a sense of belonging but also contribute to improved mental wellbeing and resilience by encouraging participation in meaningful, enjoyable experiences within the community.

## Appendix Four

# Delphi and ACCORD studies

The ACCORD (ACcurate CONsensus Reporting Document) study<sup>xxiv</sup> included a methodology called group concept mapping to record consensus from different stakeholders (majority researchers but with representation from managers, governance, commissioning), about good practice in social prescribing. The study identified 8 clusters that should be considered as good practice when evaluating social prescribing. Results from ACCORD report, rated collectively on importance and helpfulness to their role, from most important and helpful to least were:

1. Person-reported outcome measures – their satisfaction/view, feedback about their experience, if they felt heard, if they had their needs met, quality of life, client insights as a result of social prescribing.
2. Patient's health outcomes: wellbeing.
3. Use a mixture of quantitative (how much) and qualitative (why) measures to capture numbers and nuanced understanding of social prescribing benefits for different people in different circumstances.
4. Capturing how far/whether individuals have achieved their goals.
5. Agreement on clear goals and objectives before the social prescribing started.

### **Other outcomes identified in the ACCORD study:**

- Demographics the health information of participant.
- Use validated tools, measures and questionnaires.
- State if there was proper funding to do evaluation.
- Show understanding of the local context.
- Social Prescribing Practitioners' time taken with individuals (including research beforehand, time in consultation, referrals made for them after consult, follow up.)
- Social determinants assessment: index of multiple deprivation, options for transport, unemployment, poverty (for individual or environment/area in which individual lives).
- Social prescribing workforce profile in the organisation (workforce).
- Information on intersectoral work (collaboration) and input from partners.
- Guidance on how to read the evaluation, limitations, transferability, data sources, and timescales to give context and understanding to funders and decision makers.

Some of the reflective conclusions and guidance tips for evaluating social prescribing interventions drawn from the realist review methodology were:

1. Identify and describe well the social prescribing intervention – aims, objectives, participants, context, activities and settings, processes etc.
2. Use when possible, an independent and appropriately funded evaluator to remove any additional burdens on social prescribing practitioners and is also important for rigorous evaluations without bias.
3. Mapping exercise to identify all stakeholders required to feedback and involve them in design, analysis and interpretation of findings – ensuring that evaluation questions are relevant to intervention and stakeholders – and any key decision making is supported by evaluation.
4. Apply mixed methods design to capture impact of social prescribing at multiple levels.
5. Triangulate data from different sources when possible, to capture different perspectives and then provide an overarching commentary explaining links between different study components.
6. Report not only difficulties but also good practice examples, success, compliments, strengths and also methods in place to mitigate failures and challenges.
7. Involve members of the public when disseminating results and even when evaluating (public involvement).
8. Identify gaps and future evaluation questions.

## Appendix Five

# Core Data Set: All statements with associated bridging values, rankings, and categorisation

## All statements with associated bridging values, rankings and categorisation

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
1 108	Themes on what the person wants to achieve/what matters to them (e.g. reduce isolation, increase physical activity)	0.38	4.50	3.79	ILO & PLO	What difference?
1 91	Changes to mental wellbeing (using a validated tool(s))	0.00	4.44	3.00	ILO & NI	What difference?
1 93	Changes to social wellbeing (using a validated tool(s))	0.00	4.38	3.21	ILO & PLO	What difference?
1 87	Changes to feelings of loneliness (using a validated tool(s))	0.00	4.38	3.07	ILO & NI	What difference?
1 97	Social prescribing recipient reported outcomes e.g. the change it has made to them	0.10	4.38	3.36	ILO	What difference?
1 96	Changes in motivation (using a validated tool(s))	0.00	4.31	2.93	ILO & PLO	What difference?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
1 84	Changes to quality of life (using a validated tool)	0.00	4.25	2.93	ILO & PLO	What difference?
1 83	If the individual achieved their personal outcomes as a result of engagement with the activity/service to which they were referred	0.21	4.25	3.00	ILO & PLO	What difference?
1 94	Service user satisfaction scale (for social prescribing service)	0.00	4.19	3.00	PM	How well?
1 92	Changes to physical wellbeing (using a validated tool(s))	0.25	4.19	3.64	ILO & PLO	What difference?
1 88	Changes to feelings of isolation (using a validated tool(s))	0.00	4.19	3.07	ILO & NI	What difference?
1 65	Changes in general health (using a validated tool(s))	0.00	4.19	3.00	PLO	What difference?
1 78	Patient-reported outcome measures (PROMs)	0.12	4.13	3.14	ILO & PLO	What difference?
1 72	If the individual is satisfied with the information they received from the social prescribing practitioner	0.26	4.06	3.64	PM	How well?
1 70	If the individual felt that they had influenced the decisions that affected them	0.26	4.06	3.21	PM	How well?
1 64	Changes in happiness (using a validated tool(s))	0.00	4.06	3.07	NI	What difference?
1 75	Changes to physical activity levels	0.12	4.06	3.00	ILO & PLO	What difference?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
1 73	Changes to self-efficacy (using a validated tool)	0.10	4.00	3.14	ILO & PLO	What difference?
1 67	Changes to resilience (using a validated tool(s))	0.00	3.94	2.86	PLO	What difference?
1 90	Changes to financial wellbeing (using a validated tool(s))	0.01	3.88	3.00	ILO & PLO	What difference?
1 66	Changes to social inequality (using a validated tool(s))	0.12	3.88	2.50	PLO	What difference?
1 1	If the individual learnt new skills	0.14	3.88	3.29	ILO & PLO	What difference?
1 74	If the individual has increased knowledge of the services and support available to them	0.20	3.88	3.00	ILO	What difference?
1 89	Changes to benefits/income	0.20	3.88	3.14	ILO & PLO	What difference?
1 77	Patient-reported experience measures (PREMs)	0.25	3.81	3.21	PM	How well?
1 62	Change in medication/prescriptions over time	0.34	3.75	2.79	PLO	What difference?
1 20	Case studies	0.30	3.63	3.43	ILO	What difference?
1 79	If the individual started to volunteer as a result of social prescribing	0.27	3.31	2.71	ILO & NI	What difference?
1 63	Changes in level of employment	0.20	3.13	2.86	PLO	What difference?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
1 17	Has travel (distance) increased/decreased as a result of accessing social prescribing?	0.35	2.88	2.64	ILO	What difference?
2 10	Running costs of the social prescribing service	0.54	3.56	3.36	PM	How much?
2 11	Running costs of the activity/service	0.47	3.50	3.36	PM	How much?
2 54	Details of any other agencies involved	0.40	3.25	3.14	PM	How well?
2 5	If staff are trained in data collection	0.49	3.25	3.43	PM	How well?
2 26	If the social prescribing practitioner has been DBS checked	0.58	3.13	4.14	PM	How much?
2 39	Clinical diagnosis of referral	0.33	3.00	3.07	PM	How much?
2 14	Job satisfaction of activity/service staff	0.67	3.00	3.00	PM	How well?
2 99	If a social prescribing practitioner outsources to another social prescribing provider	0.42	2.94	3.21	PM	How much?
2 6	Number of social prescribing staff who complete the targeted training provided by the project	0.69	2.94	3.71	PM	How much?
2 29	Number of volunteers supporting delivery	0.50	2.88	3.36	NI	How much?
2 8	Number of social prescribing staff accessing training sessions offered by the project	0.58	2.88	3.50	PM	How much?
2 7	Number of training sessions delivered by the project to social prescribing staff	0.52	2.81	3.79	PM	How much?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
2 28	Number of staff employed in an organisation	0.49	2.50	4.21	PM	How much?
3 80	Barriers to attending/engaging with the activity or service to which the individual was referred	0.71	4.06	3.14	PM	How well?
3 98	If the individual co-produced an action plan	0.63	4.00	3.50	ILO	What difference?
3 110	Whether social prescribing is filling a gap in statutory services (eg, whilst someone was waiting for SW/ care package)	0.71	4.00	2.64	ILO & PMO	What difference?
3 13	If the individual received their social prescription in their language of choice	0.55	3.94	3.86	PM	How well?
3 81	Barriers to engaging with the social prescribing practitioner	0.69	3.94	2.64	PM	How well?
3 68	Economic evaluations of the activity/service	0.80	3.88	2.43	PM	What difference?
3 124	Accessibility of the project	0.58	3.81	2.93	PM	How well?
3 16	Results-based accountability (how much, how well and what difference? )	0.55	3.75	3.00	PLO	N/A
3 69	Economic evaluations of the social prescribing service	0.76	3.69	2.50	PM	What difference?
3 56	Long term healthcare and/or social care use	0.52	3.56	2.57	PLO	What difference?
3 19	Journey mapping of individual	0.63	3.56	2.93	ILO	What difference?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
3 85	National Indicators for Wales (as required by Well-being of Future Generations (Wales) Act 2015)	1.00	3.56	3.00	ILO & NI	What difference?
3 125	Comparison of issues raised during 'What Matters' conversation to those described at referral	0.44	3.50	2.71	ILO	What difference?
3 34	If a carer is supporting the individual to access the social prescribing practitioner	0.54	3.44	3.43	PM	How much?
3 12	If the social prescription resulted in a carers assessment	0.42	3.38	3.50	PM	How much?
3 9	Changes in the continuation of service funding	0.86	3.38	3.36	PM	How much?
3 33	If a carer is supporting the individual to access an activity/service to which they were referred by a social prescribing practitioner	0.36	3.19	3.43	PM	How much?
3 35	Information on housing i.e. private rented, Local Authority, Housing Association etc	0.46	3.06	3.21	PM	How much?
3 32	If the person accessing the support/service is a carer	0.35	3.00	3.71	PM	How much?
3 15	Job satisfaction of social prescribing practitioners	0.81	3.00	3.07	PM	How well?
3 58	Number of A&E appointments	0.53	3.00	3.07	PLO	What difference?
3 18	Has travel (method) changed as a result of accessing social prescribing?	0.59	2.94	2.50	ILO	What difference?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
3 37	Preferences for indoor or outdoor activities	0.72	2.81	3.46	PM	How well?
4 82	If the individual achieved their personal outcomes as a result of engagement with the social prescribing practitioner	0.31	4.44	2.93	ILO & PLO	What difference?
4 109	If the person attended the activity or service they were referred to?	0.36	4.13	3.71	PM	How well?
4 71	If the individual reports that the support they received from the social prescribing practitioner was a positive experience	0.30	4.06	3.71	PM	How well?
4 76	Number of people reporting a positive experience	0.30	4.06	3.71	PM	How well?
4 101	If the individual completed their programme of support with the social prescribing practitioner	0.27	4.00	3.86	PM	How well?
4 123	Number of people who receive a social prescription/referral who then go on to access what has been prescribed	0.33	3.94	3.64	PM	How much?
4 102	If the individual withdraws from social prescribing practitioner support	0.29	3.81	3.57	PM	How well?
4 100	If the individual completed their programme of support with the activity/service	0.30	3.75	3.43	PM	How well?
4 95	Service user satisfaction scale (for referred services/activities)	0.38	3.75	3.79	PM	How well?
4 103	If the individual disengages from the activity/service they were referred to	0.46	3.75	3.64	PM	How well?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
4 113	Number of sessions/length of engagement with a activity/service	0.28	3.56	3.86	PM	How much?
4 23	Number of individuals receiving Information, Advice, and Assistance (IAA) services	0.28	3.56	3.79	PM	How much?
4 2	Number of service users who complete the targeted training provided by the activity/service	0.29	3.50	3.64	PM	How much?
4 22	Number of individuals receiving early help and support services that target specific needs and issues. This could include groups and events.	0.31	3.50	3.07	PM	How much?
4 4	Number of service-users accessing training sessions offered by the activity/service	0.35	3.50	3.57	PM	How much?
4 86	Number of new activities engaged in	0.34	3.50	3.43	ILO	What difference?
4 25	Number of individuals who access the project for the first time	0.32	3.44	3.86	PM	How much?
4 24	Number of contacts (count multiple contacts per individual)	0.27	3.38	3.79	PM	How much?
4 106	Number of non attenders (DNA's)	0.27	3.38	4.00	PM	How well?
4 60	Number of GP contacts	0.34	3.25	3.21	PLO	What difference?
4 57	Patient contact with other services pre/post SP	0.36	3.19	2.21	PLO	What difference?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
4 61	Number of GP appointments	0.32	3.13	3.43	PLO	What difference?
4 59	Number of calls to emergency services	0.35	3.06	2.71	PLO	What difference?
5 122	Was a what matters conversation completed?	0.27	4.25	4.29	PM	How much?
5 55	Social prescribing recipients' reasons for not acting on a prescription/referral	0.28	4.00	2.50	PM	How well?
5 36	Demographics of people accessing social prescribing practitioners (including protected characteristics, NHS number, name, postcode, DOB etc)	0.22	3.94	3.86	PM	How much?
5 51	Reason for referral to social prescribing practitioner (e.g., physical, mental, social or financial wellbeing)	0.23	3.94	3.64	PM	How much?
5 112	Type of social prescribed activity/service (e.g., exercise referral activity, creative referral activity) an individual is referred to by geographical location (e.g., exercise referral activity, creative referral activity)	0.31	3.88	3.71	PM	How much?
5 119	Form of support signposted to (e.g., physical, mental, social or financial support)	0.24	3.75	3.86	PM	How much?
5 120	Type of services referred and/or sign-posted to (e.g., statutory service, community group/activity or voluntary sector support)	0.23	3.69	4.07	PM	How much?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
5 47	Time from referral to first contact with social prescribing practitioner	0.21	3.69	3.85	PM	How well?
5 46	Time from referral from social prescribing practitioner to individuals first contact with activity/service	0.28	3.69	3.57	PM	How well?
5 105	Length of waiting time to see a social prescribing practitioner	0.30	3.69	3.71	PM	How well?
5 43	Number of referrals received by the community asset/service	0.18	3.63	3.86	PM	How much?
5 121	Number of onward referrals and/or sign-posts from social prescribing practitioners	0.19	3.63	3.86	PM	How much?
5 116	Number of appointments/length of support offered by a social prescribing practitioner	0.21	3.63	3.93	PM	How much?
5 111	Number of people accessing social prescribing practitioners	0.24	3.63	4.14	PM	How much?
5 21	Number of individuals receiving intensive support services that are tailored to meet their specific and more complex needs	0.30	3.63	3.43	PM	How much?
5 117	Length of time an individual accesses a social prescribing service	0.20	3.63	3.71	PM	How well?
5 104	Length of waiting time to access an activity/service to which the individual was referred	0.28	3.63	3.29	PM	How well?
5 42	Number of referrals accepted by the community asset/service	0.19	3.56	3.79	PM	How much?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
5 27	If any safeguarding issues were raised for the individual	0.29	3.56	3.62	PM	How well?
5 53	Number of health and wellbeing needs a person has presented with	0.25	3.50	3.46	PM	How much?
5 52	Where a referral originated	0.17	3.50	4.07	PM	How well?
5 30	Does the person require a holistic approach? (A broad range of interventions over time with the SPP connecting their person local services and networks)	0.25	3.50	3.08	PM	How well?
5 50	Reason for referral to activity/service (e.g., physical, mental, social or financial wellbeing)	0.21	3.44	3.71	PM	How much?
5 114	Number of sessions/length of support offered by a activity/service	0.26	3.44	3.86	PM	How much?
5 115	Number of appointments/length of engagement with a social prescribing practitioner	0.24	3.38	3.93	PM	How much?
5 48	What roles/professions refer into social prescribing	0.31	3.38	3.71	PM	How much?
5 44	Number of referrals accepted by the social prescribing practitioner	0.16	3.25	4.07	PM	How much?
5 40	Number of referrals to a social prescribing practitioner before an individual accesses the social prescribing service	0.18	3.25	3.07	PM	How well?
5 49	Number of inappropriate referrals to social prescribing practitioners	0.20	3.25	3.29	PM	How well?

Cluster	Statement	Bridging value	Importance	Ease of collection	Type of data	RDA question
5 41	Referral route	0.20	3.19	3.93	PM	How much?
5 45	Number of referrals received by the social prescribing practitioner	0.17	3.13	4.29	PM	How much?
5 3	Number of training sessions delivered by the activity/service to service users	0.26	3.06	4.00	PM	How much?
5 107	If the individual was only signposted to a community activity (provided with information and choice through the process of highlighting services in the community)	0.22	3.06	3.57	PM	How well?
5 118	Name of organisation sign-posted to	0.24	2.94	3.86	PM	How much?
5 31	Has the person used social prescribing service before	0.24	2.88	3.50	PM	How much?
5 38	Type of outdoor setting prescribed (i.e. park, coast, woodland etc.)	0.30	2.81	3.86	PM	How well?

**Key:** ILO = individual-level outcome, NI = national indicator, PLO = population level outcome, PM = performance measure

## Appendix Six

# References

- i See: [Community-led social prescribing – NASP evidence | NASP](#)
- ii *Social Prescribing Around the World: A World Map of Global Developments in Social Prescribing* (Khan & Giurca et al., 2023)
- iii See: [www.cavrpb.org/app/uploads/2023/01/Patient-Experience-of-Social-Prescribing-A-Scoping-Review1-1.pdf](http://www.cavrpb.org/app/uploads/2023/01/Patient-Experience-of-Social-Prescribing-A-Scoping-Review1-1.pdf)
- iv See: [Extra support for people on waiting lists could prevent some of the 6,000 cancelled NHS treatments | GOV.WALES](#)
- v See: [wcva.cymru/wp-content/uploads/2025/11/The-contribution-of-voluntary-organisations-to-the-health-and-care-prevention-agenda.pdf](http://wcva.cymru/wp-content/uploads/2025/11/The-contribution-of-voluntary-organisations-to-the-health-and-care-prevention-agenda.pdf)
- vi Social Finance. (2015). *A Review of the Evidence Assessing Impact of Social Prescribing on Healthcare Demand and Cost Implications*. University of Westminster
- vii See: Giurca, B., Khan, A., Choudhury, N., Thompson, J., Han, C., & McGregor, A. (2023). *A Comparison Between High-Income Countries: Social Prescribing Across Global Health Systems*. National Academy for Social Prescribing
- viii See: [what-matters-to-you---current-experiences-of-people-aged-50-or-over-in-wales---september-2025.pdf](#)
- ix See: [Unpaid care by age, sex and deprivation, England and Wales – Office for National Statistics](#)
- x Heindel, J.J. & Vandenberg, L.N. (2016). *Developmental Origins of Health and Disease: A Paradigm for Understanding Disease Etiology and Prevention*. **Current Opinion in Pediatrics**, **27(2)**, 248-253
- xi In 2010, Wales became the first country in the world to legislate for play through the **Children and Families (Wales) Measure 2010**, which places a duty on local authorities to access and secure sufficient play opportunities for children in their area. Evidence shows that play helps children build resilience, form relationships, stay active, and develop a strong sense of belonging in their communities. It also supports learning, coping with stress, and recovering from trauma
- xii See: [UNCRC Article 24 – The Children and Young People’s Commissioner Scotland](#)
- xiii See: [United Nations Convention on the Rights of the Child: Full text - Children’s Commissioner for Wales](#)

- xiv See: [Age-friendly-Communities-Impact-Report-Full.pdf](#)
- xv See: [Pharmaceuticals in the Environment | UNEP – UN Environment Programme](#)
- xvi See: [Sustainable Quality Improvement \(SusQI\) – Sustainable Healthcare](#)
- xvii See: [www.knowledgehub.cymru/](http://www.knowledgehub.cymru/)
- xviii Person – Social Value: benefits experiences by the individual and their community
- xix Social Prescribing Practitioner – Social Value: making referrals that maximise community benefit
- xx Community Asset – Social Value: creating wellbeing, prevention, and community benefits
- xxi See: [Asset Based Community Development \(ABCD\) – Co-production Network for Wales Knowledge Base](#)
- xxii See: [Social Prescribing Glossary of Terms](#)
- xxiii See: [Competences. The Competence Framework for Social Prescribing Practitioners in Wales. 2023](#)
- xxiv Elliot, M., & Wallace, C. (2021). *The ACCORD study: Developing a social prescribing evaluation framework & reporting standards. A group concept mapping study report*. Wales School for Social Prescribing Research