Working together

Guidance for occupational therapists and social prescribing link workers

May 2026

Royal College of Occupational Therapists

National Academy for Social Prescribing

Key Takeaways

'Working collaboratively with social prescribers helps towards the shared goal of supporting individuals to live more meaningful lives.'

Kim Dutton - OT

- Social prescribing link workers (SPLWs) and occupational therapists (OTs) have a shared purpose and both support people to live well, but they have different skills and responsibilities.
- OTs bring regulated clinical expertise; SPLWs bring strengths-based, non-clinical support – enabling community connection and empowerment to improve health and wellbeing outcomes. Together, they enable more holistic, person-centred care.
- Collaboration between the two professions improves outcomes by integrating clinical expertise and non-clinical support.
- Joint working reduces duplication and strengthens multi-disciplinary team (MDT) decision-making. Clear role boundaries and communication between SPLWs and OTs are important.
- A shared understanding of each other's roles enables SPLWs and OTs to work together effectively, recognising when to escalate concerns and when to step back.
- SPLWs lead where needs are social, practical or driven by the social determinants of health. OTs lead where there's a complex functional need or clinical risk.
- Supervision, establishing simple referral pathways and jointly contributing towards MDT working are some of the ways that OTs and SPLWs can effectively work together. This guidance supports joint working and does not replace existing professional standards or local policies.
- The examples identified by the National Academy for Social Prescribing (NASP) and the Royal College of Occupational Therapists (RCOT)' demonstrate the clear benefits and meaningful impact of working together. Embedding this approach into mainstream practice will depend on action from commissioners, system leaders, service managers and practitioners – particularly when developing neighbourhood teams.

'It's a wonderfully collaborative experience to work together with an OT to support patients with a range of social and health issues, especially in complex situations. My experience is of both roles, blending well with responsibilities clearly defined and regular communication while working on a case. It's reassuring to know that we can connect to each other when needed for mutual guidance when appropriate.'

Yasmin Zaman – SPLW

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We're proud to have worked in partnership on this guidance because we believe collaboration between occupational therapists and social prescribing link workers can make a real difference.

Royal College of Occupational Therapists
National Academy for Social Prescribing

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Executive summary

Occupational therapists (OTs) and social prescribing link workers (SPLWs) can work together to support people to live well in their communities. Both professions focus on what matters to individuals, recognising that health and wellbeing are shaped by meaningful activity, relationships, environments and wider social determinants.

As neighbourhood health models develop and systems place increasing emphasis on prevention, personalised care and reducing inequalities, collaboration between social prescribing and occupational therapy is both necessary and valuable.

This guidance supports practitioners to work together safely, effectively and confidently across a range of settings. It demonstrates the benefits of collaboration between roles for system leaders, managers and commissioners, whose support is needed to embed change.

This document also clarifies the distinct and overlapping contributions of each role.

OTs bring regulated, clinical expertise in functional assessment and interventions, activity analysis, environmental adaptation and risk management.

SPLWs provide non-clinical, strengths-based support to improve an individual's health and wellbeing by connecting people to community resources and addressing practical, social and emotional needs.

Together, these roles enable more holistic, person-centred care.

Key areas covered include:

- shared values and principles underpinning joint working
- role clarity, boundaries and areas of overlap
- establishing referral pathways
- strengthening multidisciplinary team (MDT) working
- escalation, de-escalation and risk management
- supervision and governance considerations.

Through practical examples, our guidance demonstrates how collaborative working can improve health and wellbeing outcomes, support participation and reduce duplication across services. It emphasises the importance of communication, mutual respect and shared understanding in maintaining safe and effective practice.

This guidance is intended for SPLWs and OTs working across health, care and community settings. It will also be useful for managers and other system leaders in a variety of settings. It complements, but doesn't replace, existing professional standards, organisational policies and national frameworks and depends on supportive, enabling infrastructure to be fully embedded into practice.

We encourage practitioners to use this guidance to actively build relationships, clarify roles and seek opportunities for joint working within their local context. By working together intentionally and consistently, OTs and SPLWs can strengthen multidisciplinary practice and ensure people receive coordinated, person-centred support that enables participation, independence and inclusion in everyday life.

Context

This joint guidance from RCOT and NASP aims to support safe, effective and confident partnership working within neighbourhood and integrated care models.

As neighbourhood and community-based approaches to health and wellbeing continue to develop, an increasing number of SPLWs and OTs are working in local communities and across place-based systems. This guidance sets out principles and examples of how the two professions can work together effectively as this shift continues.

We've included examples and approaches drawn from practice where SPLWs and OTs have been able to work closely together. They illustrate what good collaboration can look like, recognising that local context, resourcing and workforce pressures influence what's possible in practice.

Shared values, principles and strengths

Social prescribing link workers and occupational therapists share a commitment to enabling people to live well in their communities. Both recognise that health and wellbeing are shaped not only by clinical needs, but by access to meaningful activity, supportive relationships and inclusive environments.

Social prescribing takes a person-centred, strengths-based approach, supporting individuals to improve their health and wellbeing through connecting with community assets that foster purpose, belonging and self-efficacy.

Together, these shared principles provide a strong foundation for confident and ethical joint working. These include:

- holistic, person-centred practice
- respect for strengths, goals and lived experience
- prevention and early intervention
- inclusion and reducing inequalities
- collaboration across services and communities.

Occupational therapy also takes a person-centred, strengths-based approach and is grounded in the belief that participation in everyday occupations is fundamental to health. This includes self-care, work, learning, social and community life. Central to this is occupational justice – the right for all people to engage in meaningful activities that support wellbeing and identity. This recognises that barriers such as poverty, discrimination, ill health and inaccessible environments can limit participation. OTs bring clinical governance and apply regulated clinical reasoning to support the whole team in navigating complex risks and ensuring that person-centred pathways remain safe and effective for everyone involved.

While distinct in scope and regulation, both roles understand the immeasurable value of meaningful activities, participation and inclusion. SPLWs bring deep knowledge of working with patients holistically. This includes developing personalised care and support plans, mobilising community assets and providing sustained relational support. OTs contribute regulated clinical expertise in function, activity analysis and risk management. When combined, this ensures that the person gets the right support at the right time through a collaborative approach based on a person's changing needs. This helps ensure people can get clinical expertise where required, alongside sustained community-based support. This flexible way of working helps ensure continuity, safety and person centred care across services.

Understanding each other's roles

The role of the occupational therapist (OT)

Occupational therapists are Health and Care Professions Council (HCPC)-regulated health professionals who enable people of all ages to participate in the occupations that are meaningful and necessary for daily life. Occupations include self-care, productivity (including education and work), leisure and spiritual and cultural activities.

OTs:

- assess functional ability and the impact of physical or mental health conditions
- analyse activity demands and environmental barriers
- manage risk and complexity
- provide therapeutic interventions, rehabilitation and adaptation
- support independence, recovery and inclusion through goal setting and building connections.

OTs work across settings such as primary care, community services, hospitals, mental health, local authorities, social care and voluntary settings. Their practice integrates clinical reasoning, environmental adaptation and person-centred goal setting across the life course.

The role of the social prescribing link worker (SPLW)

Social prescribing link workers provide non-clinical, personalised and strengths-based support. They help people identify what matters to them and connect with community-based activities, groups and services that improve an individual's health and wellbeing.

SPLWs are embedded predominantly in primary care networks, but are increasingly working across wider health, care and community settings with emerging specialist and thematic roles (for example; cancer, respiratory, frailty, work and health and complex needs). SPLWs may also hold job titles such as Community Connector/Navigators, Wellbeing Coordinators, Community Wellbeing Practitioners, Social Prescribers, or Social Support Navigators. Often, SPLWs are trained in and use health coaching techniques.

Across all settings, SPLWs focus on the social, practical and emotional factors affecting health, including loneliness, long-term conditions and wider social determinants. They build trusted relationships, support goal setting and behaviour change and help individuals to navigate systems and reduce barriers to engagement.

SPLWs are skilled practitioners with defined competencies and must receive appropriate supervision. They work collaboratively and coordinate with other professionals to ensure a person's needs are met and to support continuity of care.

Where are the boundaries, and where are the cross-overs?

Scope of practice

SPLWs and OTs share many values to help people to engage in meaningful activity, connect with their communities and achieve personal goals. This overlap is a strength. However, clarity about scope of practice is essential for safe and effective working.

Areas of crossover

Both roles may:

- use person-centred conversations to identify what matters to an individual
- support goal setting and action planning
- address practical barriers to participation
- encourage confidence, motivation and self-efficacy
- promote engagement in community-based activities and services.

In many situations, collaboration enhances outcomes – for example, where functional challenges and social barriers intersect.

Case example

OTs and SPLWs co-designing community intervention

A woman in her early 40s, recovering from a long-term health condition, was referred to occupational therapy by a social prescribing link worker after years of unemployment.

Initial OT assessment highlighted barriers, including low stamina, loss of routine and anxiety in social settings.

Together, the occupational therapist and social prescribing link worker co-designed a graded programme of community-based activity. This included supporting the person to build skills, like confidence and time management. This helped her to volunteer and later secure a role in a local organisation. This also resulted in a reduction in GP and A&E attendances.

Distinct professional boundaries

Social prescribing link workers provide non clinical, person centred support and are accountable for enabling individuals to engage with non medical resources that support health and wellbeing. Their role focuses on identifying social, emotional and practical factors affecting wellbeing and facilitating access to appropriate community-based support. SPLWs do not undertake regulated clinical assessment or diagnosis, but they're skilled in recognising emerging concerns, including safeguarding issues, and work collaboratively with regulated professionals to escalate issues and support coordinated care where required.

Occupational therapists are regulated by the HCPC and are accountable for clinical reasoning. This includes assessment of functional impact, therapeutic intervention and risk management. OTs are trained to assess physical, cognitive and psychosocial function, and to manage complexity, safeguarding concerns and environmental adaptation.

When there is a significant risk or complex functional impact, clinical assessment may be required – this can be provided by an occupational therapist. Conversely, where the primary need relates to community connection, social participation, practical navigation or sustained relational support, a SPLW may be best placed to lead.

Occupational therapy and social prescribing

Roles, differences and overlap

OCCUPATIONAL THERAPIST (OT)

Clinical professional enabling function and independence

ROLE AND APPROACH

HCPC-regulated clinician
Works within clinical governance

CORE FOCUS

Physical, cognitive and psychosocial function
Functional assessment and clinical reasoning

INTERVENTION

Therapy, rehabilitation and adaptation
Activity analysis and environmental modification

RISK AND COMPLEXITY

Manages clinical risk
Supports complex needs

SETTINGS

Health, social care, community, private, and independent settings

SHARED APPROACH

- Goal setting and action planning
- Build confidence and motivation
- Reduce barriers to participation
- Enable engagement in meaningful activities

SOCIAL PRESCRIBING LINK WORKER (SPLW)

Non-clinical professional taking a personalised approach to improve health & wellbeing

ROLE AND APPROACH

Strengths-based and holistic, working to a set of core competencies defined by NHSE.

CORE FOCUS

Addresses the social determinants of health including emotional and practical needs

INTERVENTION

Co-produced personalised care & support plans. Supports behaviour change and improves health and wellbeing

RISK AND BOUNDARIES

Supports those with complex needs within wider MDT. Does not manage clinical risk independently

SETTINGS

Primary & secondary care, VCFSE organisations, wider community settings including statutory services

Working at the boundary

Open communication and shared understanding are critical when working at the intersection of roles. Practitioners should feel confident to:

- seek advice from one another
- clarify responsibilities explicitly
- escalate concerns in line with local governance
- avoid role drift that places individuals or practitioners at risk.

Healthy collaboration respects both shared aims and professional accountability.

Case example

Supporting social participation beyond the home

An occupational therapist referred an individual with a learning disability to a social prescribing link worker for support with social connection.

The OT had focused on building confidence and engagement in activities within the person's living environment. The SPLW worked with the individual and their support worker to explore preferences for social interaction and identify suitable options.

This led to a connection with a befriending service aligned with the person's communication needs and interests. The SPLW maintained contact to ensure the arrangement was sustainable and fed back to the OT. This coordinated approach supported continued participation beyond the home environment.

Establishing referral pathways

Referral pathways between OTs and SPLWs vary across systems and are often shaped by local commissioning, service design and capacity. However, they don't need to be overly complex to be effective.

Where possible, SPLW and OT teams should:

- understand each other's referral criteria and scope of practice
- agree on clear points of contact
- clarify information-sharing arrangements in line with local policy
- establish feedback loops.

As part of onboarding, new practitioners should be made aware of local occupational therapy and social prescribing provision, including how and when to initiate contact.

Formal conversations – for example, through MDT meetings – or more informal conversations, can be valuable starting points for collaboration. These may develop into more structured referral processes over time, where appropriate.

In systems where formal pathways are not yet established, practitioners are encouraged to proactively connect, introduce their role and explore opportunities for joint working. Early relationship-building often lays the foundation for sustainable, person-centred referral processes.

How SPLWs and OTs can strengthen MDT working

Emerging neighbourhood health models depend on close, place-based collaboration between professionals who understand both the clinical and social drivers of wellbeing.

When appropriately embedded within MDTs, occupational therapists and social prescribing link workers bring two complementary perspectives that are essential to delivering integrated, preventative and community-based support. OTs and SPLWs can help MDTs make more informed decisions, reduce duplication, coordinate care more effectively and provide earlier, more holistic, person-centred interventions. Their combined expertise strengthens neighbourhood-level problem-solving, supports smoother care transitions and ensures that individuals receive the right type of support, from the right professional, at the right time.

OTs and SPLWs inputting together can strengthen MDTs by:

- providing a holistic blend of clinical and social insight
- co-presenting at MDT meetings to clarify roles
- offering joint training or 'teach-ins' on their roles
- sharing brief summaries or 'role-at-a-glance' resources
- demonstrating, through case examples, how joint working improves outcomes.

Case example

Shared caseloads

In First Coastal Primary Care Network, OTs and SPLWs work as part of a fully integrated multidisciplinary team serving a population with high deprivation and complex need. They share caseloads, undertake joint visits and use regular case discussions to identify when joint working is beneficial.

Leadership shifts flexibly depending on need – with OTs leading on functional, cognitive and environmental assessment, and SPWLs leading on community connection and practical support.

Joint supervision and informal case reflection support shared learning and consistent risk management. This model enables a responsive, person-centred approach – improving coordination, reducing duplication and supporting individuals to engage more fully in their communities.

Implementation considerations

Effective collaboration between OTs and SPLWs requires supportive infrastructure, governance and leadership.

Key considerations include:

- **Supervision and governance:** Establish clear supervision arrangements, access to clinical advice where required and alignment with Health and Care Professions Council (HCPC), NHS England and local organisational standards.
- **Caseload and capacity:** Awareness of safe and sustainable caseload expectations, recognising existing workforce pressures and variation in provision.
- **Training and development:** Opportunities for shared learning, role awareness sessions and joint reflective practice.
- **Inclusion in MDT structures:** Involving both roles in relevant case discussions, neighbourhood meetings and service development conversations.
- **Information sharing:** Agreed processes that enable timely communication while respecting data protection requirements.

Commissioners and service leads should recognise that collaboration requires time for relationship-building and structured communication – not solely referral exchange.

Embedding these foundations strengthens safe practice, reduces duplication and supports consistent, person-centred care across neighbourhood systems.

Escalation, de-escalation and risk

Safe and effective joint working requires clarity about responsibility and timely escalation where concerns arise. Occupational therapists and social prescribing link workers remain accountable within their own governance structures and must follow local safeguarding, lone working and risk management procedures.

At the outset of joint working, practitioners should clarify:

Who is leading on which aspects of support?

How will concerns be communicated?

Who holds responsibility for clinical risk?

Which service(s) should be contacted in urgent situations?

Escalation may be required where there are safeguarding concerns, deterioration in health, significant environmental risk or complexity beyond the scope of one role. Internal pathways (for example; GP, safeguarding lead, duty team or mental health services) should be followed and relevant colleagues informed. De-escalation is equally important.

Case example

Safely managing complex needs

A 55-year-old woman facing eviction due to hoarding and complex stoma care needs was initially supported by a SPLW.

As her needs became more complex, an OT assessed her cognitive function and environmental risks – sharing findings with the wider MDT to inform coordinated planning. The SPLW continued to provide relational support, helping her engage with services and maintain stability, while the OT guided risk management and functional understanding.

As risks escalated, involvement shifted to a High Intensity User lead, supporting her transition into appropriate accommodation.

This joint approach enabled safe, person-centred decision-making, combining clinical insight with sustained community support.

Case example

Stepping down from secondary to primary care

An occupational therapist had been supporting a man with recovery from health anxiety in a community mental health setting, and he had reached a stage of recovery where primary care was more appropriate. He was referred to a social prescribing link worker for further support.

The OT and SPLW completed two joint visits to establish this new relationship. The SPLW was happy to continue supporting the person to find suitable activity groups and facilitate some short-term mindfulness to support him in managing his anxiety.

He completely recovered, joined a walking group and has not returned to secondary mental health care. Additionally, the SPLW maintained access to supervision through a mental health professional working at the GP surgery and could consult and raise concerns with the OT in the community mental health team if needed.

Case example

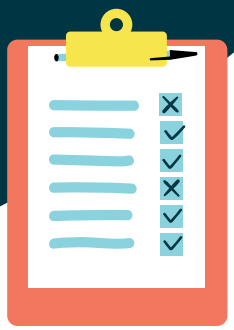
Managing risk at home

An older person was referred to a social prescribing link worker for housing support. During an initial visit, concerns emerged about financial abuse and unsafe living conditions. The SPLW coordinated referrals to safeguarding, housing and community support services.

This led to a joint visit with a Community Independence Service occupational therapist and housing officer to assess risk and the home environment. The OT assessed functional needs and environmental risks, arranging immediate safety adaptations, while the SPLW coordinated communication across services and kept the individual informed.

Ongoing joint working and decision making, including regular communication and MDT discussions, ensured continuity and all agreed actions were completed. This approach enabled timely risk management alongside coordinated, person-centred support.

Supervision



Supervision is essential to safe, reflective and effective practice. It provides a structured space to review cases, manage complexity, consider risk and support professional development. Supervision can also provide sustained exposure to one another's roles as well as encourage greater collaboration.

Each profession has established guidance around supervision. Occupational therapists must meet HCPC Standards for supervision and professional accountability. Social prescribing link workers should follow NHS England's workforce development guidance – which is appropriate to SPLWs based in settings beyond the NHS – alongside other local guidance or standards relevant to their setting/employer. Both roles should also follow local organisational policies. This guidance complements, but doesn't replace, those frameworks.

SPLWs must receive monthly clinical supervision from a relevant healthcare professional. This is most often a GP, but there are examples of an occupational therapist providing this level of supervision where they have an appropriate scope of practice, experience and organisational arrangements.

Collaborative supervision may include:

- **Regular structured 1:1 or group sessions:** An OT may provide functional, cognitive, clinical or environmental insight. SPLWs may share social, motivational or community-based knowledge. These sessions should sit alongside, not in place of, an SPLW's required line management or reflective supervision.
- **Case-based discussions:** Particularly where a SPLW and an OT are co-working with an individual. These sessions deepen shared understanding, clarify roles and strengthen safety and consistency.
- **MDT or peer reflective spaces:** Joint reflective practice sessions (formal or informal) that allow OTs, SPLWs and other MDT members to reflect on complexity, boundaries, risk and team learning. Time should be proactively allocated to build mutual understanding.
- **Joint debriefs after high-risk or complex cases:** Brief, structured conversations that support learning, clarify next steps and ensure shared accountability across roles.

Case example

Taking a joint approach to improve outcomes

The social prescribing link worker and occupational therapist both work in primary care. After referral to the SPLW, the SPLW and OT conducted a joint visit to the person's house, as the person enjoys gardening but has been unable to participate due to living with the physical symptoms of fibromyalgia.

The OT was able to go through pacing/energy conservation advice with the person and review their outdoor mobility to adapt the activity, making it more accessible.

The SPLW colleague now plans to carry out a few visits with the person to do some gardening with them, help build a rapport and further signpost to services in the local area.

The OT continues to support their SPLW colleague with this person through supervision/ advice and guidance on supporting the person with building fatigue management strategies. The supervision enables the SPLW to continue to socially support the client to reach their goals.

Case example

Establishing strong support systems

Establishing strong support systems As part of an ageing well service, an occupational therapist supervises three social prescribing link workers.

The OT supervises each SPLW individually once every three months. The other two months are split into facilitating group supervision, and then each SPLW has supervision from a clinical director in the following month.

This is formal supervision built into the service, and informal supervision is also included when people need it. Supervision is a space where people can bring complex cases, identify training needs, discuss new projects, utilise as a safe space to bring challenging situations and exchange new information. SPLWs have identified this as a good support system that enhances their roles, responsibilities and professional practice.

Statement of Review

This guidance reflects practice at the time of publication and will be reviewed in response to policy, governance and workforce developments.

Glossary

Additional Roles Reimbursement Scheme (ARRS) – NHS funding mechanism supporting the employment of additional roles, including social prescribing link workers, within primary care.

Clinical reasoning – The structured thinking and decision-making process used by regulated professionals to assess needs, plan intervention and evaluate outcomes.

Community assets – Local groups, services, organisations and informal networks that support health and wellbeing.

Functional ability – An individual's capacity to perform tasks and activities.

Graded – A therapeutic process used to gradually increase a person's participation in an activity by breaking it down into manageable stages.

Health care professional (HCP) - A regulated practitioner who is qualified to assess, treat and support people's health and wellbeing within their professional scope of practice, such as an occupational therapist, nurse, physiotherapist or doctor.

Lone working – Working without direct supervision or immediate access to colleagues or support.

Multidisciplinary team (MDT) – A group of professionals from different disciplines working collaboratively to support individuals.

Neighbourhood Health – Place-based, integrated working across health, care and community services to improve local population wellbeing.

Occupational Health (OH) – Occupational Health is an area of work in public health to promote and maintain the highest degree of physical, mental and social well-being of workers in all occupations (WHO). Whilst some OTs do work in OH settings, this is an entirely distinct area of practice, mostly undertaken by nurses and doctors.

Occupation (occupational therapy context) – The everyday activities that people need, want or are expected to do – including self-care, work, education and leisure.

Occupational justice – The principle that everyone has the right to engage in meaningful occupations that support their health, identity and inclusion.

Occupational therapist (OT) – A Health and Care Professions Council (HCPC)-regulated professional who enables people of all ages to participate in meaningful activities through assessment, intervention and adaptation.

Person-centred care – An approach that centres on an individual's strengths, goals and preferences in planning and delivering support.

Referral pathway – An agreed process for directing individuals between services to ensure appropriate and timely support.

Risk management – The identification, assessment and mitigation of risks to individuals, families or others.

Safeguarding – The protection of children and adults from abuse, neglect or exploitation.

Scope of practice – The boundaries within which a professional operates, based on competence, training, regulation and role remit.

Social determinants of health – The wider social, economic and environmental factors that influence health and wellbeing.

Social prescribing – A means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections.[1]

Social prescribing link worker (SPLW) – A non-clinical professional who works with individuals to identify what matters to them and connect them to community-based support to improve wellbeing.

Supervision (clinical/reflective/peer) – Structured professional support that enables practitioners to reflect on practice, manage complexity and risk and support professional development.

1 https://bmjopen.bmj.com/content/13/7/e070184

Royal College of Occupational Therapists

National Academy for Social Prescribing

We're RCOT, the Royal College of Occupational Therapists. We've championed the profession and the people behind it for over 90 years; and today, we are thriving with over 36,000 members.

Then and now, we're here to help achieve life-changing breakthroughs for our members, for the people they support and for society as a whole.

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The National Academy for Social Prescribing was established as a charity in 2019 to champion social prescribing.

Our work includes:

- connecting the social prescribing system, through training, consultancy, resources and our Champions scheme
- creating innovative partnerships, from local to international
- boosting investment for frontline organisations delivering social prescribing
- building the evidence base
- raising the profile of social prescribing.

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