OPINION · SOCIAL PRESCRIBING DAY 2026

Social prescribing is not a nice-to-have.

> Yesterday, I stood in the Houses of Parliament and watched something rare: politicians, clinicians, link workers and the World Health Organisation all speaking in one voice. Now it is time to match those words with appropriate funding, mandate and momentum.

There is a statistic that stopped me in my tracks yesterday. Around one in five GP appointments concern problems that no prescription can fix anxiety, loneliness, a loss of purpose. Those are not medical failures. They are social ones. And for too long, we have been asking health systems to solve them with tools that were never designed for the job.

Social prescribing changes that. It is, at its simplest, the practice of connecting people to the activities, communities and support that actually shape their lives walking groups, choir rehearsals, baking clubs, financial advice sessions, arts programmes. It is not alternative medicine. It is evidence-based, operationally proven, and already embedded in the NHS through more than 3,300 dedicated link workers making over one million referrals every year.

> *"Social prescribing is not simply an add-on to traditional healthcare. It is an essential part of neighbourhood health. It helps health systems tackle deep-rooted inequalities, strengthen communities, and improve lives in ways that medicine cannot alone."*

Those were not my words. They were spoken by a government minister, inside Parliament, on Social Prescribing Day. And they were followed within minutes by a formal designation from the World Health Organisation, making the National Academy for Social Prescribing a WHO Collaborating Centre. Countries from Greece to Japan to Canada are already looking to England as the model to follow.

The question policymakers must now answer is simple: if the world is watching us, are we ready to lead?

I heard yesterday from Gay Palmer, a social prescribing link worker, who described navigating the system for her mother living with dementia, finding a walking group that transformed her isolated father's social life, and when CAMHS waiting lists failed her teenage son drawing on her professional skills to connect him with football and baking. That is not a nice story at the margins of healthcare. That is what neighbourhood health actually looks like when it works.

Professor Kamilla Hawthorne, chair of NASP and a GP of over 37 years, put it plainly: for so much of what patients bring to us, medicine is simply not the right tool. Social prescribing gives clinicians somewhere to refer with confidence and gives patients the one thing a ten-minute appointment cannot: time, and someone who asks not “what is the matter with you?” but “what matters to you”

The evidence is no longer soft. Research conducted in partnership with UCL shows that social prescribing is reaching people in the most deprived areas, improving patient outcomes across a wide range of conditions, and reducing unnecessary GP appointments and hospital admissions. It aligns precisely with the government’s stated ambitions: moving from treatment to prevention, from hospital to community, from analogue to human.

> *Almost 900,000 deaths worldwide are linked to loneliness every year. That is not something biomedicine can solve — but social prescribing can begin to address it.*

That figure cited by the WHO should be written on the wall of every health select committee.

I work at the intersection of policy and delivery. My role is to take the strategic ambitions we heard so eloquently expressed yesterday and translate them into what actually happens on the ground in PCNs, in community organisations, in the conversations between a link worker and a patient who has run out of hope. And I will be honest: that gap between the rhetoric of the conference room and the reality of the community hall is where social prescribing most often struggles.

One of the hardest challenges I face is empowering wider multidisciplinary teams to understand and meaningfully use social prescribing. GPs, nurses, allied health professionals many still see referral to a link worker as an optional extra rather than a clinical decision as legitimate as any other. Changing that requires more than awareness campaigns. It requires a fundamental shift in how we train the health workforce from the very beginning of their careers.

That is why I believe one of the most urgent and undervalued levers available to policymakers is the curriculum. Higher education institutions medical schools, nursing faculties, allied health programmes must build social prescribing into their training as a core competency, not an elective module. We cannot keep graduating doctors and nurses who have never been taught to think beyond the biomedical model. If we want the next generation of clinicians to refer confidently to link workers, to understand the social determinants of health, to ask “what matters to you?” as instinctively as they reach for a prescription pad, then we must start teaching them that in year one, not as a postgraduate afterthought.

> *We cannot keep graduating doctors and nurses who have never been taught to think beyond the biomedical model. The curriculum is a policy lever — and it is currently being left unused.*

And then there is the workforce question that keeps me up at night: retention. We have invested significantly in recruiting link workers. But recruitment without career pathway is a revolving door. Link workers are doing some of the most emotionally demanding, systemically complex work in the NHS and too many of them are leaving within two years because there is no clear progression, no recognised professional identity, no structured supervision, and insufficient pay that reflects the weight of what they carry. We celebrate them in speeches. We must now invest in them as a profession.

As a workforce specialist, I want to see clearly defined career pathways for link workers from entry level through to senior practice, leadership and specialisation. I want to see HEIs partnering with training hubs to develop accredited training and continuing professional development that is rooted in the realities of local systems. I want to see social prescribing featured in NHS People Plan workforce strategies, not just in community health reports. And I want to see supervision and peer support built structurally into every link worker role, not funded from whatever happens to be left in a project pot at the end of the quarter.

Here is my challenge to policymakers reading this: the rhetoric is extraordinary. The designation is historic. The link workers on the ground are doing extraordinary work, often on short-term funding, fragmented commissioning, and institutional goodwill alone. That is not good enough for something we are now calling a global model.

England has built the largest social prescribing network in the world. Delegations from more than 25 countries including Japanese ministers, Korean academics, Singaporean health officials have travelled here specifically to study this model. They are not coming for the fish and chips. They are coming because social prescribing represents something they cannot find anywhere else: a simple, cost-effective, operational bridge between healthcare and community.

If we believe that, and yesterday's speeches suggest we do, then social prescribing must become structurally essential not periodically celebrated. That means appropriate, long-term, ring-fenced investment in the link worker workforce. It means embedding social prescribing competencies in undergraduate and postgraduate health curricula. It means commissioning community organisations with the stability that allows them to plan, recruit and deliver. It means building career frameworks that make link working a profession people grow into not a role they burn out of. And it means integrating social prescribing into every neighbourhood health model from the ground up, not retrofitting it as an afterthought.

The WHO has given NASP a mandate. The government has set the direction. The clinicians, researchers and communities have done the work. Yesterday in Westminster, I saw what it looks like when all of those forces align in one room.

Now the hard part begins. Not the speeches the budget lines. Not the launches the long game. Not the designations the daily grind of building a workforce that can sustain this movement for decades. Social prescribing day should not be the peak of ambition. It should be the starting gun.

Let's not have it as a nice-to-have for some. Let's make it essential for all.