



National
Academy
for Social
Prescribing



Good Faith
Partnership

Faith and Social Prescribing Roundtable report

Building Strategic Partnerships for Neighbourhood Health

Date: 10 December 2025

Venue: Southbank Centre, London

Organisers: National Academy for Social Prescribing (NASP) and Good Faith Partnership

Supported by: Sir Halley Stewart Trust



Contents

Executive Summary	3
1. Context: Social Prescribing and the Policy Window	4
2. Why Faith Communities Matter for Health.....	6
3. The Diversity of Faith Communities	10
4. Barriers to Partnership.....	11
5. Strategic Opportunities Within Neighbourhood Health	13
6. Strategic Priorities	15
7. Conclusion	16
Annex A: Attendees	18
Annex B: Agenda	19

The content of this report reflects the discussions and perspectives shared during the roundtable event held on 10 December 2025. Whilst we have sought to capture key themes accurately, the views expressed do not necessarily represent the positions of all participants or their organisations. The roundtable included representatives from multiple faith traditions, and we acknowledge the broader diversity of faith communities beyond those present on the day.

Executive Summary

This roundtable convened approximately 35 senior leaders from faith communities, NHS England, health partners, local government, and the voluntary sector. Representatives from Christian, Jewish, Hindu, Muslim, and Sikh communities sat alongside colleagues from statutory and voluntary sectors to identify opportunities, address barriers, and chart a way forward. It built on a [previous roundtable in April 2024](#) (chaired by the new Archbishop of Canterbury) led by the College of Medicine, and a [recent report by Theos and Good Faith Partnership](#) on the contribution of churches and faith groups to social prescribing in England.¹

The convergence of the [NHS 10-Year Health Plan](#), neighbourhood health service rollout, and recognition of faith communities as strategic assets creates an unprecedented policy window. The case for partnership is compelling. Faith communities serve as trusted anchor institutions with multi-generational presence in every neighbourhood, possessing unique assets including buildings, volunteers, pastoral expertise, and convening power. They are rooted in communities and have assets that support preventative wellbeing.

Despite these significant assets, faith communities receive a disproportionately low share of social prescribing referrals, suggesting substantial untapped potential for partnership.

Barriers raised for cross-sector working included: lack of understanding across the health system of faith groups' value; lack of clarity on how to engage (for both health partners and faith groups); patchy coordination between local faith groups; lack of understanding of spiritual/holistic health; inaccessible funding from Integrated Care Boards (ICBs) for smaller organisations; and lack of genuine, equal partnership between faith groups and the health system.

¹Theos and Good Faith Partnership, *Creating a Neighbourhood Health Service: The Role of Churches and Faith Groups in Social Prescribing* (London: Theos, 2025).

Opportunities for future work include: developing evidence and resource banks; disseminating existing resources; developing training; creating communities of practice; investing in opportunities to platform spiritual care; investing in local infrastructure to support connections between faith groups and public bodies; changes in funding and commissioning models; and advocating for and facilitating the inclusion of faith actors in strategic conversations regarding neighbourhood health.

Participants emphasised that effective partnership requires recognising and respecting the diversity of faith traditions, each with distinct needs, governance structures, and perspectives.

1. Context: Social Prescribing and the Policy Window

1.1 What is Social Prescribing?

According to the internationally agreed definition, social prescribing is: a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs, and to subsequently connect them to non-clinical support and services within the community by co-producing a social prescription: a non-medical prescription to improve health and wellbeing, and to strengthen community connections.²

The [NHS Long Term Plan \(2019\)](#) committed to introducing social prescribing link workers into Primary Care Networks so that every person in England might have access to social prescribing through their GP.³

Social prescribing helps reduce health inequalities by addressing non-clinical factors that impact health and reduces pressure on clinical NHS services. There is substantial evidence of social prescribing's success, including improved patient empowerment, reversal of disease progression, and reduction in hospital admissions for older adults.⁴

²Muhl C, Mulligan K, Bayoumi I, et al. Establishing internationally accepted conceptual and operational definitions of social prescribing through expert consensus: a Delphi study. *BMJ Open* 2023;13: e070184. doi: 10.1136/bmjopen-2022-070184

³NHS England, *The NHS Long Term Plan (2019)*:25

⁴Abigail Sabey, Helen Seers, Helen Chatterjee, Marie Polley, How can social prescribing support older people in poverty? A rapid scoping review of interventions. *National Academy for Social Prescribing (2022)*:5

The current context is challenging: health inequalities appear to be worsening and there is recognition that the current model of medicine, centred around acute care, needs reorienting towards community-based, preventative care.⁵⁶

1.2 A Converging Policy Landscape: The Window for Faith Engagement

The NHS 10-Year Health Plan centres on three shifts: hospital to community, sickness to prevention, and analogue to digital. Yet a fourth shift remains largely unrecognised: moving beyond community services to people, families, and communities themselves, where the greatest health outcomes often occur and where faith communities have operated for centuries.⁷

The neighbourhood health service represents the primary implementation mechanism for the 10-Year Health Plan, with an initial rollout in 43 places across England and plans for 250 neighbourhood centres. This creates a once-in-a-generation opportunity to embed faith communities at the heart of health service redesign. However, as one roundtable participant noted, these shifts have been discussed for 15 years, yet health inequalities have worsened. This creates urgency around ensuring this implementation is genuinely different, with faith communities involved from the design stage.⁸

Faith communities sit at the intersection of several converging policy agendas that together make the case for deeper integration into neighbourhood health systems.

The National Resilience Strategy (July 2025) explicitly identifies faith communities as a strategic objective. The UK Government's Youth Strategy, which addresses challenges facing young people not in education or employment, provides a further lever given faith communities' intergenerational structures and mentorship capacity. Local government restructuring alongside the Pride in Place Programme's Neighbourhood Boards and the new Community Wealth Fund, creates new channel and decision-making structures through which faith-health collaboration at neighbourhood level can be resourced and recognised.

⁵Goldblatt, P. (2024). Health Inequalities, Lives Cut Short. Institute of Health Equity

⁶House of Commons Health and Social Care Select Committee, Inquiry on Prevention in health and social care. <https://committees.parliament.uk/work/7205/prevention-in-health-and-social-care/publications/> (accessed 24 December 2025)

⁷NHS England, Fit for the future: 10-Year Health Plan for England (2025):9

⁸HM Treasury, 'Chancellor to double down on drive to cut NHS waiting times and rollout of new neighbourhood health centres'. <https://www.gov.uk/government/news/chancellor-to-double-down-on-drive-to-cut-nhs-waiting-times-and-rollout-of-new-neighbourhood-health-centres> (accessed 5 January 2026)

2. Why Faith Communities Matter for Health

2.1 The Scale of Faith Engagement

The majority of people in England and Wales continue to identify with a faith, with the 2021 Census for England and Wales showing that 56.8% of the population report a religious affiliation. Faith holds importance in many people's lives and plays a role in their health and wellbeing. This connection becomes particularly relevant when considering health inequalities, as faith observance tends to be higher in areas experiencing greater deprivation.⁹

Communities are widely recognised as vital to health and wellbeing, offering spaces for social connection that reduce isolation and loneliness, alongside numerous accessible services, and activities. Faith groups understand the holistic health of their communities and hold the trust of many, often stepping forward to meet the health needs their communities present.¹⁰¹¹

2.2 Four Core Assets That Faith Communities Bring

The Theos and Good Faith Partnership report, Creating a Neighbourhood Health Service, examining the role of churches and faith groups in social prescribing has identified four distinctive assets that faith communities bring:¹²

Trusted Anchor Institutions

Faith communities provide consistency and constant presence. As one participant described: "They're here from heart conviction rather than cash incentives. When the cash gets cut, people jump out. But these people are here for the long haul." This longevity creates deep understanding of local populations, trust built over decades, time to listen without appointment limits, and safe spaces for populations that may distrust statutory authorities.

⁹Office for National Statistics (2022) Religion, England and Wales: Census 2021. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/bulletins/religionenglandandwales/census2021> (accessed: 2 January 2026).

¹⁰David Buck, Lillie Wenzel and Jake Beech 'Communities and health' (2021). Available at: www.kingsfund.org.uk/publications/communities-and-health

¹¹Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups. PHE Publications (2020):38.

¹²Theos and Good Faith Partnership, Creating a Neighbourhood Health Service: The Role of Churches and Faith Groups in Social Prescribing (London: Theos, 2025).

Convening Power

Faith communities demonstrate capacity to bring together diverse stakeholders. One example is Broadmead Community Church in Northampton which convenes communities of practice for all local faith groups, social prescribing link workers, public health leaders, GPs, and police to coordinate neighbourhood support.

Physical and Human Resources

Faith communities often possess centrally located buildings, skilled volunteers from local communities, and retired professionals with expertise to contribute.

Pastoral and Spiritual Care

Faith communities address spiritual dimensions of health, offering holistic understanding of meaning, purpose, loss, and bereavement. As a roundtable attendee articulated: “Faith groups trade in hope, positivity, compassion, and benevolence – doing something for a greater good. These are tremendously positive to people’s mental health and social health.”

2.3 Existing Practice: Key Case Studies Presented and Initiatives Highlighted

Many faith communities have engaged with health and social prescribing at a local level. The following case studies were presented at the roundtable or highlighted as exemplars of existing best practice:

Temple-Based Integrated Services - Shree Ghanapathy Temple, Wimbledon

A key case study at the roundtable, Shree Ghanapathy Temple in Wimbledon offers a compelling example of comprehensive health and faith integration, including weekly GP surgeries, community health clinics, psychological therapy programmes, career fairs showcasing NHS opportunities, and health presentations after religious services.

Success factors include rapid decision-making, leveraging congregation members’ professional healthcare expertise, and trust built over 44 years of community service.

Mosque-Based Health Hub - Cambridge Central Mosque

Cambridge Central Mosque has developed a dedicated Health Hub delivering events and workshops in partnership with national organisations and healthcare providers, covering diabetes management, first aid training, mental health awareness, and more.

This model demonstrates how a mosque can function as a proactive health resource for both its congregation and the wider community.

Sikh Community Hub - SCCYC, Northampton

The Sikh Community Centre and Youth Club (SCCYC) in Northampton is a multi-award-winning hub serving disadvantaged communities across Northamptonshire. With services spanning health and wellbeing, education and training, elderly day centres, and youth provision, it exemplifies how a Sikh community organisation can operate as a comprehensive community anchor.

During the COVID-19 pandemic, SCCYC supported up to 300 people each week through food parcels, prescription collection, and outreach to vulnerable groups.

Faith-Led Mental Health Support - Lincolnshire Night Light Cafés

The NHS-funded Night Light Café network in Lincolnshire, coordinated by Acts Trust, operates across church venues seven days a week, providing non-clinical, out-of-hours spaces for people in mental health crisis.

Evaluated outcomes show a sevenfold return on investment for mental health improvements, demonstrating the economic as well as social value of faith-hosted community health provision.

National Initiatives: The Warm Welcome Campaign and the Gather Movement

The Warm Welcome Campaign, facilitated by the Good Faith Partnership, has mobilised thousands of warm spaces across England, many of these are run by faith communities. These can function as informal social prescribing hubs providing a range of support including companionship, warm meals, and signposting.

The Gather Movement is working with local church networks to map church-based wellbeing initiatives. These maps can be used by the health service to enable partnership working and integration on wellbeing support and social prescribing. These initiatives represent a growing ecosystem of best practice on which neighbourhood health systems can build.

During the pandemic, faith communities demonstrated what is possible when statutory bodies work together with reduced bureaucratic barriers. Faith communities across the UK stepped up to provide vaccine clinics, communication, food assistance, and mental health support.¹³¹⁴

Faith-based vaccination clinics proved particularly effective. When priests, imams, and other faith leaders visibly took vaccines in their places of worship, combined with multilingual support, this addressed vaccine hesitancy in ways clinical settings could not achieve.¹⁵¹⁶

The roundtable acknowledged that effective partnerships during the pandemic emerged from pre-existing relationships, local trust, and pragmatic problem-solving. For social prescribing to benefit from faith sector assets, similar principles apply: investment in relationship-building at neighbourhood level, recognition of what faith communities already offer, and flexibility in how partnerships are structured.

¹³Health Inequalities Action Group, *On Faith, Place and Health: harnessing the power of faith groups to tackle London's health inequalities*. (2022):16.

¹⁴Inter Faith Network for the UK (2021). *Faith communities and COVID-19: learning from the journey – Report on the 2021 National Meeting*

¹⁵Faith Action, *Challenge, Innovation, Friendship: Exploring health and VCFSE partnerships between 2020–2022 – What we've learned and where we go next*. (2023):19

¹⁶Strategy Unit (2024). *Increasing vaccine uptake: Good practice examples — use of local places of worship as vaccine clinic sites encouraged uptake among religious communities*.

3. The Diversity of Faith Communities

A key roundtable theme was that faith communities are profoundly diverse and cannot be treated as a single entity. As one participant emphasised: “We don’t want the same thing. We don’t all have the same means. We don’t come at this from the same faith perspective.” The use of collective terms like ‘faith communities’ can convey the misleading impression that they form a homogeneous whole, when this fails to do justice to the distinctiveness of different religions and the considerable diversity that exists within many individual faiths themselves.¹⁷

This diversity exists between faith traditions (different theological perspectives on health, governance structures, resource levels, relationships to power, and cultural expressions of care) and within them. While it is important to recognise the common groups across ‘faith communities’, the challenge is holding the balance between talking about ‘all faiths’ whilst also recognising the distinctive cultures, histories, governing models, and privilege that different faiths and expressions of those faiths have in UK society.

Roundtable participants recommended:

- **Avoid one-size-fits-all:** Partnership models must accommodate different governance structures and organisational capacities.
- **Engage specific traditions:** Build relationships with specific faith traditions, understanding their particular perspectives.
- **Support both faith-specific and interfaith approaches:** Both have value and should be developed side-by-side.
- **Ensure faith is genuinely integrated into VCSE frameworks:** As one participant powerfully urged: “Please do not drop the F in the VCFSE.” Faith organisations have long struggled to maintain visibility within the Voluntary, Community, Faith and Social Enterprise (VCSE) sector. Genuine integration means that faith groups are not merely tolerated within VCSE structures but recognised as distinctive partners with their own contribution, voice, and infrastructure needs. This requires dedicated representation in commissioning conversations and a proactive commitment from health and local government partners to ensure faith is named, resourced, and included.

¹⁷Inter Faith Network for the UK (2007). Faith, Citizenship and Shared Life in Britain Today: A Discussion Document, p.2

4. Barriers to Partnership

Roundtable participants identified two broad categories of barriers: those rooted within faith communities and those within health and statutory systems.

4.1 Barriers Within Faith Communities

Lack of Coordination Across Faith Groups Locally

In some areas, faith groups do not necessarily have a united voice or joined-up delivery, making it harder for health partners to engage systematically. The absence of local interfaith infrastructure can mean that individual organisations are isolated and unable to represent or convene the breadth of faith activity in a given area. This lack of coordination can exist between communities of the same faith and from an interfaith perspective.

Volunteer Capacity and Sustainability Pressures

Many faith-based activities are sustained significantly, or entirely by volunteers. Faith groups that stepped forward during the pandemic, sometimes at the direct request of statutory bodies, have experienced volunteer burnout without sustained partnership or support. Short-term engagement without reciprocal investment places the burden of delivery on faith communities whilst offering little in return.

4.2 Barriers Within Health and Statutory Systems

Insufficient Recognition of Faith Groups' Value

There is insufficient understanding across the health system of the value that faith groups bring to health and wellbeing, a knowledge gap that prevents effective partnership from forming in the first place.

Lack of Clarity on Engagement Pathways

Health system partners lack clarity on how to engage with faith groups, and faith groups similarly lack clarity on how to identify appropriate contacts for their work.

At a NASP Link Worker Advisory Group (LWAG) focused on faith and social prescribing in February 2026, a significant proportion of link workers reported being unaware of available faith-based services in their area, limiting the potential for referrals and partnership.

Link Worker Capacity and System Variation

The aforementioned LWAG highlighted significant challenges with link worker capacity and inconsistent approaches across areas, reflecting national survey data showing that many link workers report high caseloads. This prevents link workers from undertaking proactive community engagement, with only a fifth engaging in co-production activities regularly, despite this being identified as essential for building sustainable community assets.¹⁸¹⁹

Additionally, faith groups encounter operational inconsistencies including different digital platforms and referral processes across localities, meaning faith communities must invest considerable effort in building hyper-local relationships with limited ability to scale.

Lack of Understanding of Spiritual and Holistic Health

There is insufficient recognition within the health system of the importance of spiritual dimensions of health and wellbeing. This limits commissioning ambition and can lead faith contributions to be narrowly understood as service delivery rather than holistic community care.

Inaccessible and Unsustainable Funding

Current ICB funding approaches are often inaccessible for smaller organisations such as faith-based partners. Short-term, project-based funding creates volunteer burnout and prevents sustainable partnership.

Transactional Rather Than Genuine Partnership

Administrative barriers for faith groups can be high and there can be a sense of needing to fit into NHS boxes as a delivery partner, rather than an equal player in the shaping and supporting of community wellbeing. Partnership requires recognising that faith groups have ownership of wellbeing and health alongside the NHS, not as subordinate service providers. Some faith communities report distrust towards statutory bodies who engage transactionally, contrasting with their own generational commitment to place.²⁰

¹⁸Sewell, K. (2025). Social Prescribing Link Worker Survey 2025. National Academy for Social Prescribing, p.7

¹⁹Sewell, K. (2025). Social Prescribing Link Worker Survey 2025. National Academy for Social Prescribing, p.15

²⁰Health Inequalities Action Group, On Faith, Place and Health: harnessing the power of faith groups to tackle London's health inequalities. (2022):23.

5. Strategic Opportunities Within Neighbourhood Health

The following opportunities emerged from roundtable discussion, all framed within the context of neighbourhood health, social prescribing, and faith engagement:

5.1 Embedding Faith in Neighbourhood Health Design from the Outset

The planned 250 neighbourhood centres present opportunities to embed faith communities from design stage, including: co-designing neighbourhood models incorporating faith buildings, representation on neighbourhood health boards – such as neighbourhood health development and Pride in Place boards – from inception, and integrating existing community infrastructure.

5.2 Chaplaincy and Spiritual Care as a System Asset

Chaplains, both employed and voluntary, possess decades of experience with bereavement, end-of-life care, and spiritual crisis, alongside established links between places of worship and healthcare settings. Opportunities exist to explore chaplaincy roles beyond hospital boundaries, including neighbourhood chaplaincy models linking statutory services and faith communities, and reciprocal training programmes where chaplains train link workers on spiritual care and link workers train chaplains on social prescribing. The Care Quality Commission currently assesses spiritual care primarily in end-of-life contexts, presenting opportunities to develop spiritual care standards across all care settings and build an evidence base for spiritual care impact on wellbeing outcomes.²¹

5.3 Building the Evidence Base: NASP's Role in Collating and Sharing Knowledge

Participants identified a clear need for accessible, high-quality evidence to make the case for faith-social prescribing partnerships to commissioners and system leaders. NASP has a central role to play in collating and curating this evidence, including: developing an accessible information resource with key statistics and impact examples, building a case study repository demonstrating effective faith-social prescribing practice, producing evidence summaries for NHS commissioners, and establishing a National Centre for Social Prescribing Data and Analysis to track outcomes. Building relationships with communications leads in faith groups was identified as important for sharing case studies across conferences, roundtables, and research publications.

²¹Inter Faith Network for the UK (2021). Faith communities and COVID-19: learning from the journey – Report on the 2021 National Meeting

5.4 Training, Capacity, and Awareness Building

A strong theme emerged around reciprocal training needs. For faith communities: mental health awareness, safeguarding protocols, social prescribing fundamentals, and understanding NHS structures. For healthcare professionals: cultural competency and faith literacy, understanding faith community governance and diversity, recognising spiritual dimensions of health, and effective partnership approaches. Developing a common language and shared understanding is an essential foundation for all these opportunities.

5.5 The Value of Local Government as a Facilitating Partner

Local government is uniquely well-placed to broker between the NHS and faith communities, given its public health mandate, existing community relationships, and access to less restricted funding streams. An enhanced local government role could provide brokering capacity, integration across housing, education, and social care in support of neighbourhood health goals, and deployment of community investment funds – including those linked to local government restructuring – to support faith-health partnerships.

5.6 Sustainable Funding: Building on Existing Mechanisms

NASP's proposed National Community Health and Wellbeing Fund – a £1 billion, ten-year fund bringing together public, philanthropic, and private sector contributions – was identified as an important mechanism for providing the long-term, sustainable investment that faith communities need to participate as genuine partners in neighbourhood health. Participants were clear that this must move beyond small pilots: “This isn't about small pots of funding with pilots which don't have long-term impact. We need strategic commissioning with faith communities as part of those conversations.” The fund builds on existing models of best practice – including Warm Welcome Spaces, Night Light Cafés, and temple-based health hubs – and provides a structure through which these can be sustained, evaluated, and scaled.

6. Strategic Priorities

Based on the roundtable discussion and NASP's strategic responsibility for this area, the following priorities have emerged:

6.1 Requirements for Effective Partnerships

Reciprocity and Mutual Benefit

Partnership cannot mean faith communities filling gaps or volunteer labour substituting for paid professionals. Required shifts include training exchange (mental health awareness for faith leaders; cultural competency for healthcare professionals), resource exchange, and knowledge exchange.

Co-Production from Design

Movement from healthcare services designing interventions then seeking community implementation, to joint problem definition, collaborative solution design, and shared decision-making. As referenced at the roundtable, the 'Triple-E' framework: clinical experts, experts by experience, and experts in communities all with equal voice.

Sustainable Investment

Movement from short-term project funding toward strategic commissioning with long-term investment, core funding for coordination functions, and outcomes-based approaches. As one participant stated: "This isn't about small pots of funding with pilots which don't have long-term impact. We need strategic commissioning with faith communities as part of those conversations." NASP's National Community Health and Wellbeing Fund was identified as an important mechanism.

Respect for Diversity

Engagement with the diversity of faith traditions (both between and within faiths) rather than a generic 'faith sector' approach, recognition of differential power dynamics, and support for both faith-specific infrastructure and interfaith platforms.

6.2 Sector-Specific Priorities

For Faith Groups

Where capacity permits across the board, proactively connect with local link workers using the [guide developed by Theos and Good Faith Partnership](#). Where

possible, offer cultural competency training to statutory bodies. Seek to evaluate services using comparable measures where evaluation support is available. Build relationships with other local faith groups and consider hosting forums for sharing best practice across faith, community, and health services.

For Health Services

Ensure cultural competency and faith literacy training for link workers and primary care teams. Encourage link workers to proactively engage faith groups in social prescribing, using the [Theos and Good Faith Partnership guide](#). Enable healthcare professionals of faith to draw on their experience. Develop standardised yet flexible partnership approaches reducing administrative burden.

For Integrated Care Systems

Pursue sustained strategic engagement with faith partners building on COVID-19 collaboration models. Include faith community representation in strategic planning and commissioning, moving from consultation to co-decision making. Develop systematic approaches to mapping faith-based health activities.

For Local Government

Recognise enhanced role in brokering between NHS and faith communities, given public health mandate, community relationships, and less restricted funding streams. Utilise community investment funds to support faith-health partnerships.

For System-Wide Action

Develop shared evaluation frameworks with accessible support. Address infrastructure organisation sustainability to maintain brokering capacity. Evolve funding models to enable smaller organisation participation through strategic commissioning. Create guidance for neighbourhood teams on effective faith partnership.

7. Conclusion

This roundtable demonstrated significant readiness among faith communities and health partners to develop more systematic and strategic partnerships. The convergence of neighbourhood health rollout, youth strategy, national resilience priorities, and the development of the NHS 10-Year Health Plan creates an unprecedented policy window.

The question is not whether faith communities have the capacity and assets to contribute to improving the holistic wellbeing of all communities across the UK – they demonstrably do. What is needed now is genuine partnership built on principles of reciprocity, sustainable investment, and shared power.

As one participant powerfully articulated: “The brain power, the hitting power, the boxing power of this table – if we can identify successful projects in each community and share that success, it will inspire replication and scale-up.” The foundations for this work already exist. Initiatives such as the **Warm Welcome Campaign**, the **Lincolnshire Night Light Cafés**, and the **Gather Movement** demonstrate what is possible when faith communities and statutory partners invest in relationship and co-design. These models of best practice provide templates that can be adapted, evaluated, and scaled across the 200 Neighbourhoods identified by the Department for Health and Social Care. The task ahead is not to start from scratch, but to learn from what works, invest sustainably in what is already growing, and create the conditions for faith communities to play their full part in a genuinely neighbourhood-centred health system.

Next Steps

Key priorities emerging from the roundtable include building accessible evidence and resources, developing reciprocal training programmes, integrating faith communities into neighbourhood health planning from design stage, and evolving funding models to enable sustainable partnership. NASP is actively working to coordinate efforts with partners including Good Faith Partnership across these areas, convening stakeholders, and supporting the development of systematic approaches to faith engagement in social prescribing and neighbourhood health.

To get involved in this work, please contact: hello@nasp.info

With grateful thanks to the Sir Halley Stewart Trust for supporting this work.

Annex A: Attendees

Nigel Adams	Coordinator, Christian Community Hub Movement
Taibah Al-Fagih	Researcher, Equi
Olivia Amartey	Executive Director, Elim Pentecostal Church , and ChurchWorks Commissioner
Jeanette Bain-Burnett	Executive Director, Sports England
Dr Mohan-pal Chandan	Nishkam GP, Nishkam Healthcare Trust
Neil Churchill	Director of Partnerships and Experience, NHS
Dee Dillistone	Policy Adviser, Department of Health and Social Care
Professor Sir Sam Everington	Chair GP , Board Member of NHS England , President of the Royal College of GPs , Honorary Vice President of the British Medical Association
Mustafa Field	Director, Faiths Forum for London
Andy Frost	Senior Leader, Gather Movement
Kate Garbers	Trustee, Sir Halley Stewart Trust
Josh Gaventa	External Affairs Lead, Progressive Judaism
Andrew Gilbert	Vice-President, Board of Deputies of British Jews
David Hampshire	Senior Policy Advisor, Historic England
Professor Kamila Hawthorne	Chair, NASP
Hassan Joudi	Member, Muslim Council of Britain
James Maddocks	Communities Lead, Neighbourhood Health , NHS Confederation
Geetha Maheshwaran	Director of RE, Culture and Community, Shree Ghanapathy Temple
Sarah Maxfield	Head of Operations, Support Staffordshire representing NAVCA
Simon Morioka	Joint Chief Executive, PPL
Charlotte Osborn-Forde	CEO, NASP
Jack Palmer-White	Senior Director, Good Faith Partnership
Yusuf Patel	Strategic Faith and Social Prescribing Lead, NASP
Hilary Paxton	Senior Adviser, Local Govt Association
Esther Platt	Senior Consultant, Good Faith Partnership
Dr Rachel Quinn	Executive Director of Strategy and Partnerships, NASP
Dr Iram Sattar MBE	GP, Associate Non-Exec Director, NHS and Co-Chair Muslim Women's Network
Dr Imrana Siddiqui	GP, British Islamic Medical Association
Jeremy Simmons	Policy and Programme Officer, Faith Action
Amrick Singh Ubhi	Director of Civic Engagement and Partnerships, Nishkam Civic Assoc

Annex B: Agenda

14:00 - 14:15 | Welcome, Housekeeping and Setting the Scene

Lead: Professor Sir Sam Everington OBE, NHS Board Member

14:15 - 14:25 | Context Setting

Lead: Charlotte Osborn-Forde, CEO, NASP

14:25 - 14:30 | Good Faith Partnership

Lead: Jack Palmer-White, Senior Director, Good Faith Partnership

14:30 - 14:40 | Theos Research: Findings and Emerging Themes

Lead: Esther Platt, Senior Consultant, Good Faith Partnership

14:40 - 14:45 | Q&A

14:45 - 15:00 | Case Studies: Faith in Action

Case Study 1: Faith engagement in social prescribing, Ms Geetha Maheshwaran, Shree Ghanapathy Temple

Case Study 2: Faith and neighbourhood health integration, Nigel Adams, Christian Community Hub Movement

Q&A (5 mins)

15:00 - 15:30 | Discussion

Chair: Professor Sir Sam Everington OBE

15:30 - 15:35 | Next Steps

Lead: Yusuf Patel / Professor Sir Sam Everington OBE

15:35 | Thank you and Close

Lead: Professor Sir Sam Everington OBE / Professor Kamila Hawthorne

15:40 - 16:00 | Networking

Developed in partnership by the National Academy for Social Prescribing and the Good Faith Partnership, this report highlights the vital role of faith communities in supporting health and wellbeing.

It sets out opportunities to build stronger, more equal partnerships at neighbourhood level.

To get involved in this work, contact:
hello@nasp.info

With thanks to the roundtable participants whose insights shaped this report, and to the Sir Halley Stewart Trust for their support.



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