

Response to the NHS call for evidence for the 10 Year Workforce Plan

This is the response from The National Academy for Social Prescribing to the call for evidence for the [NHS 10 Year Workforce Plan](#). Submitted 07/11/2025.

Section 1: supporting the three shifts

1. Introduction: Social Prescribing Link Workers

This briefing from the National Academy for Social Prescribing (NASP) focuses on evidence and examples showing how Social Prescribing Link Workers are shifting care from treatment to prevention and from hospitals to communities. It also focuses on how digital innovation in social prescribing can enable improved outcomes.

Latest figures show that there are around 3,300 Social Prescribing Link Workers (FTE) employed as part of primary care teams in England¹. Research by University College London suggests that there have been 5.5 million referrals from GPs to social prescribing services since 2019. In 2023 alone, more than one million people were referred.²

Referrals to Social Prescribing Link Workers come from GPs, other healthcare professionals, local community organisations and other sources. Link workers spend time understanding the social issues affecting a patient's health, co-developing personalised plans, and then connecting them to community-based non-clinical support. This support can include advice services for debt, housing problems or employment, volunteering opportunities, physical activity sessions and social activities, among many other options.

¹ <https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update/30-june-2025> Workforce Quarterly Update, 30 June 2025 - NHS England Digital

² <https://socialprescribingacademy.org.uk/resources/new-study-tracks-five-years-of-social-prescribing-growth/>

2. Evidence for Social Prescribing Link Workers – impact on patient outcomes

A large-scale national evaluation of the impact of Social Prescribing Link Workers on population outcomes found that the rollout of link workers was associated with improvements in patient experience and better outcomes for population groups specifically targeted for social prescribing.³

An additional full-time equivalent link worker per 50,000 patients was associated with:

- higher probabilities of having confidence in managing long-term condition(s) and having enough support from local services, for respondents with long-term conditions
- a higher probability of having their mental health needs understood, for respondents with mental health needs
- a higher probability of having a good experience at their general practice, for all respondents

An evaluation of the cross-Government Green Social Prescribing programme also showed statistically significant improvements in wellbeing, and reductions in anxiety and depression. It demonstrated that nature-based social prescribing programmes are effective, accessible and cost-effective compared to other interventions available through the NHS.⁴

Many other studies have shown that social prescribing leads to a range of positive outcomes for patients. There is also a strong evidence base for many of the activities that people may be connected to - including [physical activity](#), [nature-based activities](#), [creative health approaches](#) and [heritage projects](#).⁵

There is also a growing body of evidence to show how social prescribing can support people living with a range of long-term conditions.⁶

Recent unpublished analysis by NASP suggests that social prescribing directly raises patient activation levels, with Calderdale seeing a 19% improvement across all patients referred to social prescribing (n = 4,170).

³ <https://socialprescribingacademy.org.uk/resources/largest-ever-social-prescribing-study-shows-positive-impact-on-patients/>

⁴ <https://randd.defra.gov.uk/ProjectDetails?ProjectId=20772>

⁵ <https://socialprescribingacademy.org.uk/our-evidence-and-evaluation-work/what-is-the-evidence-for-social-prescribing/>

⁶ <https://socialprescribingacademy.org.uk/resources/social-prescribing-and-long-term-conditions-what-does-the-evidence-tell-us/>

3. Evidence for social prescribing - reduced pressure on health service and cost effectiveness

NASP's report, *The Impact of Social Prescribing on Health Service Use and Costs: Examples of local evaluations in practice*⁷, looked at analyses of system data from nine areas to unpick the difference that social prescribing is making. While the methodologies varied, the overall results suggest that social prescribing can lead to substantial reductions in health service use and costs:

- An evaluation of 1,751 people referred to social prescribing in Tameside and Glossop reported a 42% reduction in GP appointments for those patients after 12 months, compared to a 5.6% reduction in a control group, who did not access social prescribing.
- In Kent, A&E attendances were reduced by up to 23% among patients who accessed social prescribing, when comparing the six months before and the six months after.
- In Sussex, studies compared patient data over two years and found a 25% fall in demand for GP appointments among those supported by social prescribing, compared to 78% rise in those just starting support.
- Reductions in demand for health services were particularly high for frequent service users. In Kirklees, social prescribing support for frequent users reduced GP appointments by 50% and A&E attendances by 66%. Similar results were reported in Rotherham, where frequent users' A&E attendances were reduced up to 43%.

NASP has developed a model to support Integrated Care Boards to calculate return on investment for link workers in their area. Our current estimate is that social prescribing saves the NHS around £4 for every £1 spent on salaries for Social Prescribing Link Workers (excluding costs for training, supervision and onward referrals).⁸

4. How social prescribing supports the shift from treatment to prevention: evidence and examples

Social prescribing can play a crucial element in successful preventative care. It can help people stay healthy by recognising the influence of the social determinants of health; proactively reduce risk factors; help enable early detection; and support

⁷ <https://socialprescribingacademy.org.uk/evidence-reports/the-impact-of-social-prescribing-on-health-service-use-and-costs/>

⁸ <https://socialprescribingacademy.org.uk/resources/exploring-the-financial-return-on-investment-of-social-prescribing-in-the-nhs/>

people with long-term conditions to maintain independence. It has been shown to be successful across the spectrum of prevention.

Examples include:

- **Using population health management to prevent secondary care usage.** A programme in Slough used population health management tools to identify 3,300 residents who were living in the most deprived areas, with multiple chronic conditions; they were contacted by a Social Prescribing Link Worker or another team member who focused on the wider determinants of health. This led to an increase in completed health checks among diabetic and hypertensive populations, preventing secondary care usage. Compared to a control group, there was 3% reduction in emergency calls, 59% reduction in NHS 111 queries, 9% reduction in A&E presentations, and 15% reduction in inpatient admissions. The results showed that these residents are engaging more with primary care and less with emergency care, so were shifting from reactive to proactive support.⁹
- In York, a Proactive Social Prescriber has worked across PCNs to directly reach out to people with COPD - improving patients' ability to manage their health effectively, improving access to services, and enabling overall improvements in wellbeing.¹⁰
- **Improving uptake of screening and prevention programmes** Primary Care Sheffield have been praised for their innovations to improve the uptake of cervical screening, which included the use of Social Prescribing Link Workers. This increased non-attender uptake by 24%, and overall uptake by 33%¹¹. This shows the impact of embedding Social Prescribing Link Workers into discussions to understand what matters to patients and design services accordingly.
- Research has found that more people at risk of type 2 diabetes were referred to social prescribing than to existing prevention programmes due to its highly supportive nature. It concluded that there is an opportunity for individual-level type 2 diabetes prevention to shift away from standardised,

⁹ <https://socialprescribingacademy.org.uk/resources/addressing-health-inequalities-in-slough-through-social-prescribing/>

¹⁰ <https://socialprescribingacademy.org.uk/resources/proactive-social-prescribing-service-for-people-with-respiratory-problems/>

¹¹ <https://primarycaresheffield.org.uk/2023/06/08/pcspractices-nursing-team-boosts-cervical-screening-uptake/>

targeted and short-term strategies to approaches that are increasingly personalised, inclusive and long-term.¹²

- **Preventing mild-moderate mental health problems from escalating** The cross-Government Green Social Prescribing Programme reached more than 8,300 people with mild-moderate mental health conditions across England. Evaluation findings showed statistically significant improvements in mental health and wellbeing and strong engagement among communities experiencing high levels of social inequalities that affect health and wellbeing.¹³

5. How social prescribing supports the shift from hospital based-care to community-care: evidence and examples

Social Prescribing Link Workers are supporting the shift from hospital to community through:

- **Reducing avoidable hospital admission and GP attendances.** (See 3 and 4 above)
- **Supporting discharge and transitions to prevent readmission.** For example, the Healthy & Home service pilot embedded Social Prescribing Link Workers in their discharge service, reaching over 2,500 people in two years. 81% were not readmitted to hospital in the following 12 months, with minimum cost savings of £321,880.¹⁴
- **Integrating community assets into care pathways.** For example:
 - St Bartholomew's Hospital have set up a social prescribing programme within the cardiovascular pathway, enabling patients' holistic needs to be addressed. While economic analysis is ongoing, this approach is demonstrating how social prescribing in secondary care can help to complement the primary care model by reaching underserved groups.¹⁵

¹² Calderón-Larrañaga, S., Greenhalgh, T., Clinch, M. et al. [Unravelling the potential of social prescribing in individual-level type 2 diabetes prevention: a mixed-methods realist evaluation](#). BMC Med 21, 91 (2023)

¹³ <https://socialprescribingacademy.org.uk/resources/green-social-prescribing-improves-your-mental-health/>

¹⁴ <https://socialprescribingacademy.org.uk/evidence-reports/the-impact-of-social-prescribing-on-health-service-use-and-costs/>

¹⁵ <https://www.bartshealth.nhs.uk/news-from-st-bartholomews/putting-prevention-at-the-heart-of-care-17516>

- Ways to Wellness Perioperative Social Prescribing service supports people on waiting lists for surgery. This programme demonstrated significant improvements in patient wellbeing and enabled patients to meet their own goals.¹⁶
- Macmillan Cancer’s Social Prescribing Link Worker service provides holistic support at any stage of a patient’s cancer journey. This service demonstrated that 89% of clients reported a significant reduction in the severity of their self-identified concerns. 85% of healthcare staff agreed it benefitted their patients, and there was also a 17% reduction in GP appointments thanks to the implementation of the service.¹⁷

6. Social prescribing and the shift to digital innovation

A key outcome of the new workforce plan must be to be to equip staff across the NHS with the skills to make the shift from analogue to digital, and to support patients to do the same.

The Neighbourhood Health Guidance rightly highlights the need for local systems to be able to evaluate how effectively individual interventions link together to improve the way services are delivered. This requires a person-level, longitudinal, linked dataset encompassing the different parts of the system.¹⁸

Social Prescribing Link Workers use EMIS & System 1 to enable information on social determinants of health to be collected and utilised (for example, for population health management).

Link workers already use population health management data to proactively identify patients that can most benefit from social prescribing, but increasing caseloads are a barrier to mobilising this approach effectively (See sections 2 and 3).

The social prescribing information standard¹⁹ that was mandated in 2023 already exists to improve data sharing and recording of the whole patient journey. This enables information to be made available to the right professionals at the right

¹⁶ <https://socialprescribingacademy.org.uk/resources/waiting-well-perioperative-social-prescribing-in-north-east-and-north-cumbria/>

¹⁷ <https://socialprescribingacademy.org.uk/resources/the-macmillan-community-cancer-link-worker-service/>

¹⁸ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/5/26>

¹⁹ <https://digital.nhs.uk/data-and-information/information-standards/governance/latest-activity/standards-and-collections/dapb4066-social-prescribing/>

time, to ensure informed decisions about patient care. A minimum dataset, a sub section of the information standard, also exists and is supported by 78 SNOMED codes. This enables link workers and wider PCN teams to better understand who is being referred, what interventions have taken place and what community assets have been used. It helps to demonstrate the value of social prescribing within existing clinical systems.

Some link workers use other platforms such as Elemental or Joy to streamline referrals and track outcomes. These can increase referral rates, improve case recording and some offer supervision tools. These tools can enable bidirectional referral pathways between NHS and Voluntary, Community and Social Enterprise (VCSE) groups - closing a gap between the health system and community assets to create a connected system supporting Neighbourhood Health.

The Ten Year Plan for Health includes an ambition to make the NHS App a world-leading tool for patient choice, including *My Care* becoming a “digital social prescriber”.²⁰ Link workers are already supporting patients to use the NHS App, supporting with digital inclusion. While digital signposting initiatives can support individuals with less complex needs, there will always be a requirement for staff who are skilled in having the ‘what matters to you’ conversation with patients, enabling behaviour change. Link workers are also needed in order to map and support community assets.

Data quality and information governance remains a challenge for service improvement and research. For social prescribing, this includes the need to link primary and secondary care data, have consistent referral pathways and capture community data. It is vital that the NHS invests in digital infrastructure and data interoperability across PCNs and VCSE organisations.

7. Professions, roles and skills that are critical to implementation

Social Prescribing Link Workers are already operationalising the shifts from treatment to prevention and from hospital to community-based care. Key to the successful initiatives above were:

- The full integration of link workers into multidisciplinary teams.
- Link workers having capacity and permission to innovate and work beyond standard practice.

²⁰ <https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf-plan-for-england.pdf>

- Recognition by clinical leadership in primary and secondary care of the importance of the social determinants of health and the impact that a social prescribing approach can have on their patients.
- Manageable caseloads (operating no higher than the NHS recommendation for safe caseloads of 200-250 patients per year), so that link workers can operate according to guidance (e.g. so they have time to map and support assets, support activation and motivation of patients).
- Funding for proof of concept (occasionally philanthropic funding has been required - for example, in the St Bartholemew's model outlined above).
- Accessible and sustainable community assets and groups that patients can be connected to. In many places, there is a lack of funding for community groups that underpin neighbourhood health.
- Adequate support for the workforce, which includes effective training and supervision.
- Easy referral processes and interoperability to gather and share data effectively.
- Co-production and robust links between health and provider services.
- Meaningful outcome measures to effectively demonstrate the impact and output of social prescribing services.
- Ability to learn from other examples and be championed at a national level.

8. Overcoming barriers

The standard model of social prescribing developed by NHS England outlines the requirements for link workers to do their job effectively²¹. However, there can be challenges in achieving this.

NASP's survey with 411 stakeholders in Autumn 2025 (not yet published) asked what they felt was the biggest challenge for the future of social prescribing in England. The most common responses were around funding for community groups, greater awareness of social prescribing, and better connections between the NHS and community groups.

²¹ <https://www.england.nhs.uk/personalisedcare/social-prescribing/>

Our survey specifically for link workers in March 2025 highlighted the need for training and professional development.²²

Training and skills

Core NHS training for link workers includes: co-production, motivational interviewing, trauma-informed care, data literacy, building referral pathways, integrating within primary care and community development.

NASP's link worker survey showed that link workers feel high levels of confidence in their competencies:

- Engaging and connecting with people
- Enabling and supporting people
- Utilising safe and effective practice
- Enabling community development

Link workers also reported skills in supporting people with their daily needs; in mental health; in long-term conditions; in person-centred working and decision-making; and in establishing referral pathways with other professions.

Subsequent guidance and frameworks that include these approaches as standard practice can continue to strengthen delivery and outcomes.

Based on feedback and consultation, we know that there is further need and desire for continuous professional development, on-the-job training, and regular review of development. It is important that link workers have the chance to learn from one another and forge strong networks and have time for peer learning and support.

NASP has made strides to overcome workforce development challenges through our developing support offer for link workers. This includes creating an induction guide and the first ever national training roadmap for link workers²³. The roadmap outlines the key skills and learning outcomes required by link workers, and will support national training providers, employers and commissioners to establish a consistent training offer.

Staff retention

High turnover of link workers can affect sustainability and productivity. A peer reviewed study examined retention in 2023 and highlighted the importance of: peer

²² <https://socialprescribingacademy.org.uk/resources/link-worker-survey-2025-understanding-what-matters-to-social-prescribing-link-workers/>

²³ <https://socialprescribingacademy.org.uk/media/nzbfajb1/social-prescribing-link-workers-training-roadmap.pdf>

support groups; time for link workers in their working week to connect with the VCSE sector; time to undertake training; and frequency of supervision.²⁴

This has been reconfirmed in our more recent national link worker survey. This suggested that the main reason for staff turnover was a lack of training and development opportunities and lack of supervision and support.

Wider teams and leadership

To improve the scale and spread of social prescribing, the wider health workforce needs to be upskilled to understand the impact of the social determinants of health on their patients and the impact of social prescribing.

In particular, clinical leadership in primary and secondary care needs to recognise the importance of a social prescribing approach. This would enable link workers to receive referrals from all health professionals, as outlined in neighbourhood health guidance, ensuring that patients get the right help at the right time.

NASP has established a Social Prescribing Champions scheme and a Clinical Advisory group in order to address these challenges and increase wider understanding about social prescribing within the NHS.

Improving the national competency framework and strengthening joint workforce planning and commissioning models will also be key to success.

Improving referrals to VCSE groups

There is a need for consistent provision of community-based support; at the moment, VCSE groups report that funding is too often inconsistent and fragmented. NASP has proposed the establishment of a Community Health and Wellbeing Fund to address this challenge²⁵.

Further information related to training and productivity is available in Section 3.

²⁴ <https://bjgpopen.org/content/9/3/BJGPO.2024.0128>

²⁵ <https://socialprescribingacademy.org.uk/resources/towards-a-national-community-health-and-wellbeing-fund/>

Section 2: modelling assumptions

1. Introduction

Social Prescribing Link Workers have been recruited nationally since 2019, alongside complementary roles, including Health and Wellbeing Coaches and Care Coordinators.

As outlined in Section 1, there is now strong evidence for their effectiveness, both for patients and for the health system. But further investment is needed in the workforce to spread the benefits.

One of the key challenges facing social prescribing stems from caseloads above the safe maximum of 200-250, which can make it difficult for the workforce to operate according to NHS guidance¹. This means that there is a risk of patients failing to get an effective service. High caseloads are also a barrier to link workers innovating and proactively identifying and targeting those most in need (see Section 1).

For a workforce that is still in the establishment phase, but where there is increasing evidence of impact and need, there is a strong argument for ensuring that recruitment targets are explicitly included in the workforce plan. The number of link workers fell between March 2025 and June 2025². This coincided with changes to the ringfencing of Additional Roles Reimbursement Scheme (ARRS) funding; and with a significant reduction in national support from NHS England, where there is no longer a social prescribing strategy and policy development team.

2. Workforce planning and targets

In 2019, NHS England set at ‘achievable target’ of 1,000 link workers to be recruited by 2021 and 900,000 people to be referred by 2023/24, with a ‘maximum potential scale’ of around 5% of the population, or around three million people, benefitting from social prescribing per year³.

¹ <https://www.england.nhs.uk/long-read/workforce-development-framework-social-prescribing-link-workers/>

² <https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update/30-june-2025>

³ <https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf>

In 2023, the NHS England Long Term Workforce Plan set out the intention to expand the number of Social Prescribing Link Workers to 9,000 by 2036/37⁴. This target was also included in the Keep Britain Working review⁵.

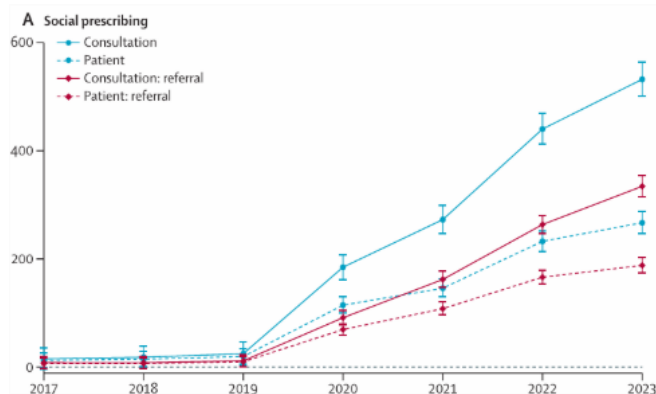
The story so far: exceeding targets

By the end of 2021, there were 2,229 NHS link workers. This rose to 3,713 in March 24. Numbers have since declined to 3,390 (June 2025)⁶.

Published analysis of CPRD data by UCL suggests that there were 5.5 million referrals to SP between 2019 and 2023. This included around 2,129,000 referrals for around 1,252,000 people in 2023⁷.

In other words, the number of patients referred to social prescribing services has far exceeded the initial targets, demonstrating very high levels of demand from GPs and patients.

UCL estimated an annual increase of roughly 81 referrals or 45 patients per GP practice between 2019 and 2023. This equates to annual increase of 283,955 patients a year (based on 6,311 GP practices).



Implications for caseloads

The recommendation for safe caseloads is a maximum of 200-250 people per year for each Social Prescribing Link Worker⁸.

Based on UCL's analysis of estimated numbers of people referred in 2023 (around 1,252,000), and the number of link workers in December 2023 (3,664), we can

⁴ <https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/>

⁵ <https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report>

⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-workforce-quarterly-update/30-june-2025>

⁷ <https://www.thelancet.com/action/showPdf?pii=S2468-2667%2825%2900217-868266725002178.pdf>

⁸ <https://www.england.nhs.uk/long-read/workforce-development-framework-social-prescribing-link-workers/>

estimate that the average annual caseload was 341 people⁹. This highlights the level of demand and suggests that caseloads are exceeding the recommended maximum.

In our link worker survey, 37% of link workers said they see over 250 people a year, with 21% citing annual caseloads of over 300¹⁰. We hear from our Link Worker Advisory Group that many link workers have long waiting lists, and GPs tell us that sometimes they do not refer as they know there is not existing capacity.

To support the actual estimated number of people referred in 2023 (1,252,000 people), a link worker workforce of between 5,008 and 6,260 would have been needed to ensure caseloads of 200-250.

Implications for the future

The previous NHS Long Term Workforce Plan outlined a potential target to recruit 9,000 link workers by 2036/7¹¹. Based on the caseload figures above, this would enable link workers to reach 2,250,000 people a year. This is still below the maximum scale envisaged by NHS England in 2019 of reaching three million people each year.

The need for a workforce to address the holistic needs of patients is growing. The Ten Year Plan commits to setting a new standard so that, by 2027, 95% of people with complex needs will have an agreed care plan that will be co-created with patients and cover their holistic needs, as well as their treatment¹². Link workers already co-produce personalised plans with patients and could be a key role in achieving this.

As outlined in Section 1, employing link workers leads to an improvement in patient confidence in managing long-term conditions. With an estimated 14 million people in England living with multiple long-term conditions, and with the burden falling disproportionately on those living in areas of deprivation, an expansion of the workforce would have a significant impact.¹³

3. The need for link workers – in addition to other roles

As outlined in Section 1, there is strong evidence that social prescribing initiatives are reducing the demand on GPs and hospitals. Reducing recruitment and support for link workers would therefore impact on workforce requirements in other parts

⁹ Assuming all referrals are to ARRS-funded link workers

¹⁰ <https://socialprescribingacademy.org.uk/resources/link-worker-survey-2025-understanding-what-matters-to-social-prescribing-link-workers/>

¹¹ <https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report>

¹² <https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf>

¹³ <https://www.nihr.ac.uk/about-us/what-we-do/multiple-long-term-conditions>

of the system, as well as on high quality care and productivity if patients are not getting right care first time.

Link workers have a function that is distinct from other NHS roles. Other community-based staff may include an element of social prescribing (e.g. Community Health and Wellbeing Workers and Care Navigators) and can be supported by link workers as part of a multidisciplinary team. However, a workforce dedicated solely to social prescribing is essential, not least to support and map community assets and to meet the increasing demands of other Government priorities. For example, the Keep Britain Working report sets out the role that Social Prescribing Link Workers can play in Workplace Health Provision, increasing the economically active population, and refers to the target of 9,000 link workers.¹⁴

Digital transformation - for example, creating digital social prescribing tools - will not significantly reduce the need for link workers. The role of link workers goes far beyond signposting; staff need to be skilled in ensuring patient activation and building motivation, to ensure people and patients have the capacity to progress any referrals and practical and emotional support to take part.

Although not part of the NHS workforce, effective social prescribing relies on a network of voluntary groups and community assets. Volunteers and voluntary groups play a huge role in promoting health and wellbeing and in reducing pressure on the NHS - and complement the work of Social Prescribing Link Workers.

Without adequate funding and social finance models, increasing pressure will fall on link workers and Primary Care Networks to provide assets and groups directly. One of NASP's key roles has been to explore models for funding for community groups¹⁵. We also work closely with the VCSE sector to support their connections to the NHS. However, feedback from VCSE partners often highlights the difficulty of understanding NHS systems and receiving referrals for preventative programmes. Link workers play a vital role in bridging this gap.

¹⁴ <https://www.gov.uk/government/publications/keep-britain-working-review-final-report/keep-britain-working-final-report>

¹⁵ <https://socialprescribingacademy.org.uk/resources/towards-a-national-community-health-and-wellbeing-fund/>

Section 3: increasing productivity through social prescribing

1. Improving productivity through digital tools

In section 1, we set out how social prescribing projects have reduced demand on general practice and secondary care.

We also highlighted the importance of collecting and harnessing data about social prescribing in order to help commissioners and employers understand the impact of different social prescribing innovations. The National Academy for Social Prescribing (NASP) has been working with Primary Care Networks (PCNs) and Integrated Care Boards to help them measure and track the impact of social prescribing - including of proactive social prescribing - and to evaluate return on investment. This type of modelling can help commissioners to allocate resources in a way that improves the productivity of the system as a whole²⁶.

2. Identifying and addressing gaps in training to support delivery of the three shifts

In Sections 1 and 2, we have outlined that Social Prescribing Link Workers require ongoing training and professional development and that annual caseloads are often high. Improved training and lower caseloads would be likely to increase overall productivity - through improved retention and job satisfaction, skills development and more face-to-face time with patients.

Our Social Prescribing Link Worker survey suggested that over 70% of link workers want to further develop their skills.²⁷ A lack of training and supervision and high caseloads were identified as key reasons why link workers might leave their roles.

The survey also outlined some differences in caseloads and training between link workers employed directly by PCNs and those employed through voluntary and community organisations (i.e. where an organisation is contracted to provide this service):

- Link workers employed directly by PCNs are particularly likely to report high caseloads: 46% of PCN link workers reported a caseload of 250+ (the maximum level set out in guidance), compared with 27% of other link workers.

²⁶ <https://socialprescribingacademy.org.uk/resources/exploring-the-financial-return-on-investment-of-social-prescribing-in-the-nhs/>

²⁷ <https://socialprescribingacademy.org.uk/resources/link-worker-survey-2025-understanding-what-matters-to-social-prescribing-link-workers/>

- Link workers employed directly by PCNs were less likely than other link workers to report:
 - Visiting activities in their community
 - Connecting people to activities, services and opportunities
- Link workers report that most of their contact with patients occurs over the phone (80%) rather than face to face. Link workers employed directly by PCNs are more likely to report this (85% compared to 73%).
- Link workers employed directly by PCNs were less likely than other link workers to report feeling confident in relation to NHS England competencies.
- Link workers employed directly by PCNs were less likely to ‘strongly agree’ that they enjoy their role - 53% compared with 62%.
- Nearly 4 in 10 SPLWs report that they have considered or might consider resigning in the next year, with SPLWs employed directly by PCNs being slightly more likely to report this (42% compared to 34%).

We also conducted a series of consultations to identify how link workers meet the competencies outlined by NHS England - identifying the key learning outcomes from entry level through to career progression. Through our Training Roadmap, we have developed a framework for link workers and training providers to develop future training and learning²⁸. We are also now supporting NHS England in the development of e-learning for health modules, which can aid productivity.

3. Policies and initiatives that have enabled the NHS to play a bigger role in local communities (for example, widening access, creating opportunities or supporting underserved groups).

As set out in Sections 1 and 2, link workers form a crucial bridge between the NHS and local communities. Under the Network Contract Directed Enhanced Service: Contract specification 2024/25, PCNs are required to:

Ensure that each Social Prescribing Link Worker has the following key wider responsibilities:

draw on and increase the strength and capacity of local communities, enabling local Voluntary, Community and Social Enterprise (VCSE) organisations and

²⁸ <https://socialprescribingacademy.org.uk/media/nzbfajb1/social-prescribing-link-workers-training-roadmap.pdf> link-workers-training-roadmap.pdf

community groups to receive social prescribing referrals from the Social Prescribing Link Worker;

work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners, local authorities and (where appropriate) VCSE infrastructure organisations.²⁹

This part of the link worker's role is particularly important in the move towards neighbourhood health and should be included in future contracts for PCNs. Caseloads need to be kept to a level that ensures they can do this effectively (see previous sections).

Proactive social prescribing approaches have also enabled link workers to identify and support underserved groups, widening access. See examples and evidence in Section 1.

Social prescribing is effective at tackling health inequalities and supporting underserved groups:

- A 2025 [study by UCL](#) in 2025 showed that year on year, there was an increase in GP referrals to social prescribing among people in the most deprived areas³⁰. Representation from patients in more deprived areas increased from 23% prior to the 2019 national roll-out to 42% in 2023. [Previous research from UCL](#), which looked at referrals not just from GPs but from social care, voluntary organisations and other sources, showed that people from the most deprived areas were accessing social prescribing far more than people from more affluent areas³¹.
- The same UCL study showed that 23% of people who are referred to social prescribing are from ethnic minority groups³². This supports [previous research from the Race Equality Foundation](#), which showed higher proportions of social prescribing referrals for those from Black, Asian and minoritised ethnic communities compared to their population.³³

²⁹ <https://www.england.nhs.uk/publication/network-contract-des-contract-specification-2024-25-pcn-requirements-and-entitlements/>

³⁰ <https://socialprescribingacademy.org.uk/resources/new-study-tracks-five-years-of-social-prescribing-growth/>

³¹ <https://socialprescribingacademy.org.uk/resources/is-social-prescribing-reaching-people-in-the-most-deprived-areas/>

³² <https://socialprescribingacademy.org.uk/resources/new-study-tracks-five-years-of-social-prescribing-growth/>

³³ <https://socialprescribingacademy.org.uk/resources/is-social-prescribing-reaching-black-asian-and-minoritised-ethnic-communities/>

Section 4: culture and values

1. Introduction

In Section 1, we set out the benefits of social prescribing for patients: the personalised approach that Social Prescribing Link Workers take enables patients to have more control over their own health and improves their overall experience of primary care.

In Sections 2 and 3, we also set out some of the challenges that can affect retention and job satisfaction of link workers - including high caseloads and a need for ongoing training and supervision.

In this section, we will focus how to achieve positive changes in culture and values.

2. Workforce development framework

A positive intervention - introduced after the roll-out of Social Prescribing Link Workers - was the publication by NHS England of a detailed workforce development framework for Social Prescribing Link Workers³⁴. This set out to:

- Provide clear and consistent standards for link worker practice, including their knowledge, skills and behaviours
- Provide guidance on the support, supervision, and learning and development offer required from employers to support link workers
- Promote the development of a strong and capable workforce of link workers and their future development
- Support improved quality and consistency of social prescribing and reduced variation in outcome and access standards
- Demonstrate the benefits of link workers as part of a multidisciplinary team (MDT).

The framework has helped to set the standard for social prescribing, enabling a rapid and successful roll-out of link workers across the country and supporting a reduction in variation across Primary Care Networks.

However, we know through consultations and our link worker survey³⁵ that adherence to this framework is inconsistent; this leads to ongoing inconsistency in high quality social prescribing service provision.

³⁴ <https://www.england.nhs.uk/long-read/workforce-development-framework-social-prescribing-link-workers/>

³⁵ <https://socialprescribingacademy.org.uk/resources/link-worker-survey-2025-understanding-what-matters-to-social-prescribing-link-workers/025>

Though guidance is welcomed and encouraged, a reduction in mandatory requirements and metrics have led to decline in adherence and awareness.

The ongoing implementation of this framework is crucial and NASP is in discussion with the Department of Health and Social Care about how to support this implementation, given the recent reduction in NHS England staff members focused on social prescribing strategy and policy.

3. How the workforce plan can improve culture and values

We recommend that the following culture and values should be set out in the workforce plan:

- Enabling a culture that recognises the social determinants of health as part of addressing health and wellbeing of the population.
- Ensuring that the wider workforce recognises the value of community assets, recognising the need to map and support voluntary sector provision.
- Ensuring that the wider workforce understands the purpose, role and evidence base of social prescribing.
- Valuing patients and putting them at the heart of neighbourhood health. Genuine engagement is required, not just to develop component services and training of staff, but also to ensure that the priorities of patients underpin neighbourhood health.
- Creating a culture that enables and rewards innovation that can increase the impact of social prescribing, particularly in priority populations.

Section 5: any additional comments

Our response sets out evidence and examples that demonstrate the value of Social Prescribing Link Workers across the health system, and their key role in the Government's ambition for neighbourhood health and holistic care planning.

Our comments about the need for increased recruitment of link workers should also be considered in the context of the objectives of other Government Departments. For example, the Keep Britain Working report highlighted the role link workers should play in workplace health provision and cited the ambition for 9,000 link workers to be in post for 2036/7. DEFRA's current Environment Improvement Plan cites Green Social Prescribing, and this is expected to have greater prominence in the next plan. Social prescribing has also been discussed in the context of the development of DCMS' Youth strategy.

The National Academy for Social Prescribing is the national organisation leading social prescribing policy, practice, evidence and education, enabling services to adopt, scale and evaluate social prescribing effectively. Funded by an initial core grant from the Department of Health and Social Care, we have enabled the successful roll out of link workers and supported local opportunities, services, activities and advice that enable communities to thrive.

With further funding from the Department of Health and Social Care, we could lead on workforce support for Social Prescribing Link Workers over the course of the new plan.