Lancashire and South Cumbria Integrated Care Partnership

Monday, 25th March, 2024 at 10.00 am in Committee Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

No.	Item	
1.	**Welcome and Apologies**	
2.	**Declarations of Interest**	
3.	**Minutes of the Last Meeting**	(Pages 1 - 4)
4.	**Lancashire Place Update**	(Pages 5 - 14)
5.	**ICP Development session update and next steps proposal**	(Pages 15 - 18)
6.	**Terms of Reference, Membership and Chairing**	(Pages 19 - 28)
7.	**AskSARA**	(Pages 29 - 36)
8.	**Accelerated Reform Fund**	(Pages 37 - 40)
9.	**National Academy Social Prescribing Share Investment Fund**	(Pages 41 - 76)
10.	**Date of Next Meeting** To be confirmed	

Lancashire and South Cumbria Integrated Care Partnership

Lancashire and South Cumbria Integrated Care Partnership

Minutes of the Meeting held on Monday, 22nd January, 2024 at 10.00 am via Teams

Present

County Councillor Michael Green

Angela Allen
Councillor Stephen Atkinson
Cllr Patricia Bell
Councillor Alistair Bradley
Councillor Neal Brookes
Victoria Ellarby
Tracy Hopkins
Dr Geoff Jolliffe
Kevin Lavery
Sue McGraw
Claire Richardson
Jo Rycroft-Malone
Karen Smith
Councillor Damian Talbot
Louise Taylor

In Attendance

Polly Patel, Chorley Council
Jane Cass, NHS Lancashire and South Cumbria ICB
Craig Harris, NHS Lancashire and South Cumbria ICB
Josh Mynott, Lancashire County Council

1. Welcome, Introductions and Apologies

All attendees were welcomed to the meeting, which, due to bad weather, was being held as an online meeting.

Apologies were received from Debbie Corcoran, StJohn Crean, Dr David Fearnley, Vicki Gent, Pete Murphy, Jane Scattergood and David Blacklock.

2. Declarations of Interest

None.

3. Minutes of the Last Meeting

Agreed as a correct record

4. Blackpool place-based partnership update

Councillor Neal Brookes, Cabinet Member for Adult Social Care, Blackpool Council, and Karen Smith, Director of Health and Care Integration (Blackpool), Lancashire and South Cumbria ICB, presented an update on the Blackpool place-based partnership.

The presentation reflected the challenges facing Blackpool, including high levels of deprivation, low life expectancy and high levels of both substance misuse and suicide, particularly in five wards in the borough. It was also noted that Blackpool experienced high levels of inward migration from other parts of the country, and a great deal of population "churn", and this led to disconnection from services and social isolation. Examples of the work being done by and through the place-based partnership were given, including the "Active into Autumn" project and work being done to address respiratory conditions, which is one of the areas of focus.

The presentation was welcomed by the partnership, and it was recognised that many of the issues faced existed elsewhere across the area. It was also recognised that Blackpool had a nationally high profile, which meant that it sometimes attracted unfair negative attention. It was noted that Blackpool was working to regain major conferences (including political party conferences) and was also seeking to bring in major employers including expanding the civil service base in order to create opportunities and aspiration. The work on the "multiversity" was also mentioned.

Resolved: That the presentation be welcomed

5. Population and Public Health update

Julia Westaway, Associate Director Population Health, NHS Lancashire & South Cumbria Integrated Care Board, and Rebecca Ramsay, Programme Manager, Cumbria & Lancashire Public Health Collaborative, attended to present an update on the development of health equity metrics.

It was noted that this was an ongoing piece of work, and that a working group had been established to take it forward. A set of draft indicators were presented, and it was agreed that these would be circulated after the meeting to members of the Partnership.

It was agreed that a pragmatic approach was needed, taking advantage of indicators that already exist and good practice elsewhere. It was also recognised that including comparators, such as national data would be helpful. The importance of engaging with residents and communities in identifying what matters to them was stressed, and that doing so would also help ensure the focus was on actions rather than simply measuring. It was recognised that there was a need to strike a balance between focussing on some key areas of activity, allowing place-based priorities and ensuring that the voice of communities was heard.

Resolved: That the presentation be welcomed and the approach outlined

endorsed

6. Work Well Vanguard programme bid

Andrew Bennett, Director of Population Health, Lancashire and South Cumbria ICB, presented a report seeking support and endorsement of a bid for "vanguard" status for the Workwell programme, an early-intervention work and health support and assessment service which aims to provide holistic support to address health related barriers to employment. The aim of the project would be to support 50000 residents across 7 pilot areas.

The partnership welcomed the proposal. It was noted that the outcome of the bid would likely be known in late February or early March and, if successful, would mean a two-year funding package starting in April 2024. It was noted that, if the bid was unsuccessful, alternative options would be explored to build on the work undertaken to date.

Resolved: That the Integrated Care Partnership endorsed the bid for Vanguard status for the WorkWell programme, and that an update on the outcome of the bid and next steps be reported to a future meeting

7. Delivering the Integrated Care Strategy

Criag Harris, Chief Operating Officer, Lancashire and South Cumbria ICB, provided an update on actions so far undertaken to deliver the integrated Care Strategy. It was confirmed that further information would come to the Partnership in due course after the planned workshop session.

It was confirmed that significant work was underway to deliver on the priorities agreed, at ICB, place and neighbourhood level. Areas of focus would be developed further, including at the workshop session, and this would contribute towards the refresh of the strategy.

Resolved: That the update be noted

8. Any other business

At the request of the partnership, Kevin Lavery, Chief Executive, Lancashire and South Cumbria ICB, gave an update on the OICB's financial position. He confirmed that the situation was a very challenging one. Demand for services generally was increasing, with a very significant increase in mental health issues being seen. National and local factors were also impacting, including the continuing impact of Covid and industrial action in the NHS.

Discussion were underway with NHS England on a three year recovery

programme to address the financial issues and look for innovation and transformation opportunities to address underlying issues at all levels, including in communities.

It was recognised that local authorities were also facing significant funding difficulties at this time and that this would have an impact on the work of all partners and the ICP.

The update was noted

9. Date of the next meeting

Monday 25 March at 10am at County Hall, Preston

Lancashire Place Update

Integrated Care Partnership - 25 March 2024

Living Better Lives in
Lancashire

The Lancashire Place – Key Challenges

The Lancashire Place is **vast** and includes both densely populated **urbanised cities** and expansive areas of **countryside.**

We operate within a **distinct 2-tier system** of local government of which there are **12 district councils** working alongside a **single upper tier authority.**

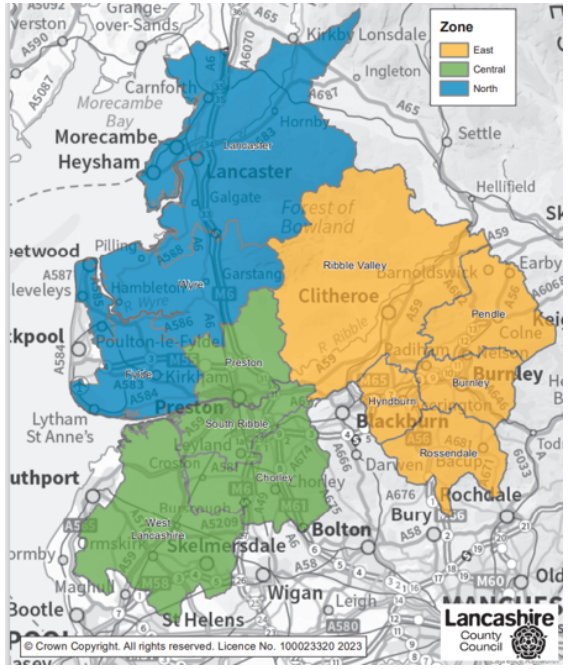
Lancashire has 28 Primary Care Networks with a potential to result in 20 Integrated Neighbourhood teams.

Large **health inequalities** exist throughout the county with **6 of the 12 districts** having neighbourhoods featuring in the **most deprived areas** in England.

Life expectancy has decreased overall in both the most and least deprived areas of the county.

The **cost-of-living crisis** and **housing** provide significant challenges throughout the county with many residents living in **overcrowded and poorly heated homes.**

The Lancashire Place



Due to the Lancashire Place being as big as some ICBs, we operate across three localities which are based upon the footprints of our district councils:

- **North**
- **East**
- **Central**

Our population size is 1.2m - over 65% of the total population across the Lancashire & South Cumbria ICB footprint

People aged **67+ to increase by 105k** in Lancashire by 2043

35% of over 65's assessd as being **'Frail'**

Prevalence of people living with **Dementia** is higher than the national average

15 Priority Wards in Lancashire where emergency Hospital admissions are higher than expected

Lancashire County Council supports around **250 people per week** to be discharged from hospital who need social care support (pathways 1-3)

Pan Lancashire Data

North Lancashire (c337 pop)

- Increase of 36k aged 67+ by 2043
- 30% over 65's Frail
- High no. of falls related admissions
- 25 lower super output areas in most deprived 10% of country
- High no. of single person households
- Low levels of physical activity (Fylde)
- Depression levels high in over 18's

Central Lancashire (c598 pop)

- 5 Priority wards
- 9k children living in poverty
- High levels of Homelessness
- High levels of Obesity (West Lancs)
- Smoking prevalence high
- Depression levels high in over 18's
- High levels of Tooth decay in under 5's

East Lancashire (c392 pop)

- 10 Priority wards
- Increase of 28k aged 67+ by 2043
- 42% over 65's Frail
- High no. of falls related admissions
- High obesity levels in Burnley
- 61 lower super output areas in most deprived 10% of country
- Low % children meeting expected standard in reading, writing and maths at end of KS2

Lancashire Place Foundational Year 2023/24 – Key Achievements

Living Better Lives in Lancashire

Lancashire Place Partnership (Board) operational and joint meetings with the Health and Wellbeing Board upon areas of mutual interest i.e. BCF and JSNA

Collaboratively **developed a vision, our delivery ambitions**, and our Lancashire Place **Delivery Plan** including plan on a page (slides 8 and 9)

Lancashire Place **Leadership Team** in post, including three Clinical and Care Professional Leads

Monthly Lancashire 'Place- Based **Newsletter**' sent to all stakeholders, staff and Partners working across Lancashire

Agreed to work through **10x District Level Health & Wellbeing Partnerships** tasked with development and delivery of local priorities

Ahead of any formal delegation, **Lancashire county council and ICB entered into a joint procurement of Living Well at Home Pseudo Dynamic Purchasing system** which enables purchase of services for individual adults to enable independent living

Established locality based **ICB Senior Delivery Teams** for all senior ICB staff who are place facing for Central, North and East, meeting monthly

Transforming Care in the Community Programme agreed. Tony McDonald as programme director and Louise Taylor as SRO. Three pan-Lancashire workstreams agreed of:

- Enhanced Care at Home
- Integrated Neighbourhood Teams
- Creating Healthy Communities

Brought together **ICB Population Health team and LCC Public Health team** who are working to a 100-day programme to establish a joint unit and work programme

Workshop with all 12 District Council CEOs collectively agreed two work programme priorities:

1.Housing (starting with Disabled Facilities Grants)

2. Leisure, Health and Activity

Two groups established to deliver Transforming Care in the Community programme across Lancashire:

- Senior Operational Delivery Group- Integration will support Enhanced Care in the Community and Integrated Neighborhood Teams.
- Senior Operational Delivery Group – Addressing Inequity will support Creating Healthy Communities

The focus of the Lancashire Place

Vision: Living Better Lives in Lancashire

Our ambition is to help the citizens of Lancashire to live longer, healthier and happier lives.

We will do this by improving health and care services through integration and addressing health and wellbeing inequity across the Lancashire Place

Purpose of the Lancashire Place Partnership

Improving Health and Care services through Integration + Improving health and wellbeing outcomes through addressing inequity = Living Better Lives in Lancashire

The **Lancashire** Model

Healthier and Happier **Lancashire**

Transforming Care in the Community – The Approach

Enhanced Care in the Community

Supporting people to recover and increase independence through time limited enhanced support based on the person's needs to enable them to remain at home or as close to home as possible. – Brings together care teams to deliver Reablement, Crisis services, Home-based and Bed based support.

Integrated Neighbourhood Teams

Bringing together teams and professionals to improve care for neighbourhood populations. Primary, community, secondary and social care, domiciliary and care staff and VCSE partners. A team of teams, sharing information and resources to improve health and wellbeing and tackle health inequalities.

Creating Healthy Communities

Connecting residents to each other and services available from local partners and groups. Providing a forum for ideas to emerge from the community. Encouraging residents to take control of their health & wellbeing. Looking at aspects of day-to-day life such as education and training; job creation and economic development; the high street; leisure and tourism; etc.

Data as outlined in previous slides supports that these workstreams will achieve tangible results for Lancashire residents.

Vision: Living Better Lives in Lancashire

Our ambition is to help the citizens of Lancashire to live longer, healthier and happier lives.
We will do this by improving health and care services through integration and addressing health and wellbeing inequity across the Lancashire Place

Living Better Lives in Lancashire

ICB Transformation Priorities

	ACTIONS we will take:	OUTCOMES we will deliver:	
Enhanced Care in the Community (ECC)	**Implement the 'Lancashire Model of Intermediate Care' (step up and step down)** a) Integrated approach to Care Market management (Joint Strategic Integrated Commissioning Plans) b) Effective management of the Care Market (Integrated Brokerage Model) c) Strength based & outcome focussed 'Short Term Support' (optimum delivery model) alongside test of change	£ • **Cost savings** circa. £10m-£15m per annum (D2A/ new delivery model) • **Efficiency savings**- system efficiency and flow	↑ • **Increased** Direct Payments & Personal Health budgets • **Increased utilisation** of Virtual Wards , 2HUCR, LCC bed base • **Increased** service user voice • **Improved quality & outcomes**- personalised care • **Culture shift** to asset/ strengths-based care
	Manage demand for Care and Support Services across Lancashire (Virtual Wards, 2HUCR, Remote Monitoring & Advanced Care Plans)		
	Maximise the use of the Lancashire pound - full review of the Lancashire Better Care Fund	− • **No more than 5%** NMC2R • **Reduce** A& E attendance, admissions & avg. LoS • **Reduce** overall demand for care and support services	
	Identify Frailty earlier & provide proactive intervention		
The **Lancashire** Model	**Transform and transact new model of Community Services delivery in East and Central Lancashire**		
Integrated Neighbourhood Team Development (INT)	**Deliver Functioning Integrated Neighbourhood Teams** with integrated operational working and functioning MDT meetings	£ • **Cost savings :** no duplication of effort/ resources • **Efficiency savings**- system efficiency and flow	✓ • **Delivery** of joint asset utilisation plan • **Delivery** of agreed KPI's • **Children & young people's engagement** across system • **10 x Health & Wellbeing Partnerships** linked to INT's • **Parity of esteem** for mental health service users
	Co-produce the 'Lancashire Vision' for integrated working		
	Define the functions that will be delivered through integrated working at Neighbourhood, District and Place level		
	Agree principles for how we will integrate that are signed up to by all system partners		
	Jointly commission solutions that facilitate integrated working		
	Work collaboratively with system colleagues to: • Deliver integrated solutions to reduce health inequalities • Facilitate engagement with PCN's for INT development • Integrate processes/ clear interface between Mental and Physical Health	✓ • **Functioning** operational INT's across 12 Districts • **Integrate & strengthen** primary & community care at Place with partners & providers	
Healthier & Happier **Lancashire**	**Link effectively with** District Health and Wellbeing Partnerships & Integration Partnership		
Creating Healthy Communities (CHyC)	**Deliver a minimum of 10x health improvement actions across the 12 Districts of Lancashire using a data led approach**	− • **Reduce** health inequalities and prevent ill heath in priority/focussed wards • **Reduce** attributable risk factors across Districts	↑ •**Increased** Life Expectancy •**Improve** physical, mental & wellbeing health outcomes •**Maximise benefit of DFG's** & provide efficiencies •**Improve & integrate** leisure, health & activity
	Deliver 10 x evidence based, district level, longer term Health and Wellbeing 5–10-year Strategies		
	Deliver a pan Lancashire Disabled Facilities Grants Programme based on local need to maximise benefit and provide efficiency/ consistency		
	Improve and integrate leisure, health & activity offers through agreed way of working between NHS (via ICB) and L.A's	↑ • **Deliver world class care** for priority disease areas, conditions, population groups and communities	
	Create a joint unit between LCC Public Health & ICB Population Health focussed on reducing health inequalities and prevention		

*** We will support delivery of the Integrated Care Strategy and ensure delivery through the Lancashire Performance Dashboard**

Examples of Good Practice

- Undertaken **successful joint procurements** between LCC and the ICB worth £4.1billion over a twelve-year contract
- Brought together **ICB Population Health team and LCC Public Health team** to integrate programmes of work (such as health checks)
- Developed an **Integration and Transformation Programme for Community Health Services in Central Lancashire**
- Listened to our partners - Outputs from locality based **listening events have been** used to **shape and inform priorities** for the Lancashire Place
- Acted upon feedback from our communities - Hearing impaired coordinators have been appointed in adult social care and a contract review of BSL services in primary care has been instigated as a **direct result of engagement** with this community
- Improved access in deprived wards by listening to our communities - transport links and access to local community facilities improved across Lea and Larches (priority ward) in Preston as a **direct result of listening to this community via a population health approach to address inequalities**
- We are making our services seamless for residents and patients - LCC Council run care homes are supporting the reduction of out of area long stay placements for Mental Health Patients

Next Steps

- Continue to develop the Lancashire Place Partnership as an effective forum to bring both challenge and support to our Place

- Establish the two new Senior Operational Delivery Groups to develop the Lancashire Model and oversee delivery of our priority workstreams

- Finalise delivery targets for each Locality within Lancashire and use our developing Performance Scorecard to monitor performance through Lancashire Place Partnership

- Continue to develop meaningful co-production with our communities including a co-production processes and plan, ensuring that our work ties into community aspirations for their specific health and wellbeing needs

Questions and Feedback

Living Better Lives in
Lancashire

Lancashire and South Cumbria Integrated Care Partnership

Report Title	ICP Development session update and next steps proposal
Date of Meeting	25 March 2024
Agenda Item	

Lead Author	Claire Roberts, Associate Director, Health and Care Integration
Presenter	Cllr Michael Green & Angela Allen

Executive Summary

The Lancashire and South Cumbria Integrated Care Partnership (ICP) held a Development Session on 26th February 2024. The purpose of the session was to make progress on the following:

- **A stocktake of ICP successes (and missed opportunities) in 23/24.** What the ICP achieved as an Integrated Care Partnership, how it operates as a collective, how members feel about their individual roles and what the focus should be over the next 12 months?

- **Moving from 'developing a strategy' to 'ensuring it is impactful'.** How the ICP ensures and assures onward delivery of the strategy, what critical added value the ICP can bring, as the ICP, to enable successful delivery, and what measures can be used to understand success?

This briefing note provides a summary of the key themes to emerge from the session and proposes a number of actions that will help us to move forward recommendations.

Recommendations

ICP members are asked to endorse the recommended next steps as outlined in the paper

Summary of Discussions & Themes: ICP Development Session, February 2024

The Lancashire and South Cumbria Integrated Care Partnership (ICP) held a Development Session on 26th February 2024. The purpose of the session was to make progress on the following:

- **A stocktake of ICP successes (and missed opportunities) in 23/24.**
  What the ICP achieved as an Integrated Care Partnership, how it operates as a collective, how members feel about their individual roles and what the focus should be over the next 12 months?

- **Moving from 'developing a strategy' to 'ensuring it is impactful'.**
  How the ICP ensures and assures onward delivery of the strategy, what critical added value the ICP can bring, as the ICP, to enable successful delivery, and what measures can be used to understand success?

The session was attended by the majority of the regular ICP Board membership with 9 members completing the pre-work. This briefing note provides a summary of the key themes to emerge from the session and proposes a number of actions that will help us to move forward recommendations.

Key Themes

- Strengthening partnership working- a sense that the ICP provides 'a seat at the table' for a range of stakeholders, but there is much more we can do to strengthen collaborative working and lever the skills, experience and connections that members bring.
- The role and position of the ICP within our Integrated Care System- governance needs further clarity along with inter-connectivity between the ICP and other parts of the system such as Place Boards and Health & Wellbeing (HWBB) Boards.
- Understanding the unique role of the ICP- responsibilities, accountabilities, importance relevance and purpose?
- The Integrated Care Strategy was developed at pace but describes a set of collective priorities that still have resonance. The ICP needs to enable delivery and we now require a greater focus on implementation and action. Our role in driving and integrating the strategy in our own organisations and sectors.
- There is so much more we could do to collectively engage with local residents and communities. This includes understanding if our work is making a positive impact as well as talking to local people about our shared challenges and possible solutions.
- Defining the role of the ICP- thinking about how we use the time and structure agendas. Avoiding duplication and avoiding having the same conversations that are happening elsewhere. Creating the space for innovative thinking, challenge and learning.
- Thinking about the way we do business- more workshop style sessions, space for work in between meetings, support team to enable preparation for meetings, creating an 'engine room' for the ICP.

Emerging Work Plan

Participants were asked to think about a forward-facing outline work programme for the ICP and were invited to identify priorities for the year ahead. Some of the common themes emerging from this exercise included:

- A review of the Integrated Care Strategy (ICS) with a focus on what is currently being delivered and where in the system actions are being taken forward.
- Development of a position statement to describe the current baseline
- Agree a set of systemwide ICP priorities for 2024-25
- Connecting system leadership within and outside of the ICP to drive agreed priorities.
- Consider how the ICP achieves a strengthened emphasis on lived experience and community engagement.
- Work with Public Health and Population Health teams to understand changes in outcome metrics.
- Review ICP membership on the basis of agreed priorities - possible gaps in DPH, NWAS, LEP/ business leadership and NHS providers
- A mandate was given in the meeting for a small group or 'engine room' to be formed to make progress on reviewing the Integrated Care strategy, development of the Partnership and progress on delivery.

Proposed Next Steps

Further to the discussions that took place on the 26th February, the following are proposed as next steps:

Task	Who?	By When?
Working group to be convened to undertake a rapid review of the Integrated Care Strategy and current delivery mechanisms (place and thematic groups)	ICP Support Team to arrange date	April 2024
Rapid review used to produce a 'map' of current delivery mechanisms and explore how we achieve connectivity to the ICP	Working Group	April 2024
Development session in May to agree: • The role of the ICP and how we want it to operate • The role of ICP members		May 2024
Use review to identify potential areas of focus for the ICP during 2024-25. Proposals to be brought back to full ICP meeting for sign off	Working Group	June 2024
Working Group to develop proposals for ICP meeting arrangements, taking into account feedback from Development Session	Working Group	June 2024

Lancashire and South Cumbria Integrated Care Partnership

Report Title	Terms of Reference, Membership and Chairing
Date of Meeting	Monday 25 March 2024

Lead Author	Josh Mynott, Lancashire County Council

Executive Summary
The Integrated Care Partnership are invited to consider the Terms of Reference for the Partnership, the Membership of the partnership and to elect a Chair and Deputy Chair for the year ahead

Recommendations
The Integrated Care Partnership is asked to: i. Consider the Terms of Reference, as set out at Appendix A ii. Agree any changes to the Terms of Reference or Membership, taking into account the outcomes of the Development Session held on 26 February 2004 iii. Elect a Chair and Deputy Chair of the Partnership for the year ahead

Terms of Reference

The Terms of Reference of the ICP were agreed in April 2023. These should be reviewed on an annual basis to ensure they still reflect the aims and objectives of the partnership and allow it to operate effectively.

The Partnership is asked to consider whether it wishes to make any changes to the current Terms of Reference, presented at Appendix A

Membership

At the Development Session on 26 February 2024, there was discussion on the membership of the ICP and whether there was a need to review and refresh the membership. The Partnership is invited to consider whether any changes to the membership, as set out in the Terms of Reference, should be made.

Chair and Deputy Chair

The Terms of Reference set out that the Chair and Deputy Chair be elected annually. The Chair of the partnership will be one of the elected members from the Upper Tier Local Authorities represented on the ICP, and the Deputy Chair will be

from the VCFSE Sector. Members are invited to elect a Chair and Deputy Chair for the year 2024/25.

Lancashire and South Cumbria Integrated Care Partnership

Terms of Reference

Approved: ***17 April 2023***
Next Review due: ***May 2024***

1. Background and Context

1.1. Lancashire and South Cumbria Integrated Care Board (ICB) and Blackburn with Darwen Borough Council, Blackpool Council, Lancashire County Council, North Yorkshire Council, Westmorland and Furness Council and Cumberland Council have resolved to establish a committee known locally as the Lancashire and South Cumbria Integrated Partnership (referred to nationally as the Integrated Care Partnership), in accordance with section 116ZA of the Local Government and Public Involvement in Health Act 2007.

1.2. The Integrated Care Partnership, together with the Lancashire and South Cumbria Integrated Care Board, form the Lancashire and South Cumbria Integrated Care System (ICS).

2. Purpose

2.1. An Integrated Care Partnership (ICP), is a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. Locally, this is described as the **Lancashire and South Cumbria Health and Care Partnership (LSC HCP)** referred to as the Partnership.

2.2. National guidance outlines the following core purposes of an ICP;

- Achieve the four common aims of ICS;
  - Improve outcomes in population health and healthcare
  - Tackle inequalities in outcomes, experience and access
  - Enhance productivity and value for money
  - Help the NHS support broader social and economic development
- Build shared purpose and common aspiration across the whole-system to support people to live healthier and more independent lives for longer, as set out

in an Integrated Care Strategy. The strategy will be informed by both Health and Wellbeing Boards (HWB) and Joint Strategic Needs Assessments (JSNA) and is a statutory requirement.

2.3. The Partnership will focus on setting short, medium, and long-term priorities and agreeing intended outcomes that are aligned to our strategic aims (as above). It will seek progress on delivery of these outcomes from the relevant organisations/sectors/partnerships across the system to be certain that the Partnership is adding value and moving towards delivery of its ambitions.

2.4. The Partnership will support the development and maturity of placed based partnerships which are well placed to act on the wider determinants of health.

3. Scope

3.1. The Partnership will be a statutory component of the Lancashire and South Cumbria system and will provide a strategic, multi-sectoral perspective to the development of the strategy and ways of working of the health and care system, built upon existing partnerships and avoiding duplication.

3.2. The Partnership will focus on:

- Tackling the most complex issues that cannot be solved by individual organisations, and/or where the potential achievements of working together are greater than the sum of the constituent parts.
- Staying strategic and avoid being drawn into operational detail.
- A small number of key priorities as agreed within the strategy

3.3. It will provide oversight for all agreed Partnership priorities, and a forum to make decisions and recommendations together as partners on matters which do not impact on the statutory responsibilities of individual organisations and have been delegated formally to a collaborative forum.

3.4. The Partnership has no formal delegated powers from the organisations in the Partnership. It will work by building consensus with leaders across Partner organisations and local place based boards with delegated powers, when established, to oversee delivery of the Strategy.

4. Role and Functions

The Partnership will:

4.1. Develop an Integrated Care Strategy, setting the ambition across the system to tackle the broad physical health, mental health and social care needs of the population (both children and adults), including determinants of health such as employment, environment, and housing issues.

4.2. Plan for the future and develop proposals and recommendations for using available resources creatively in order to address the longer-term challenges which cannot be addressed by a single sector or organisation alone.

4.3. Ensure the right partnerships, policies, incentives, and processes are in place to

support practitioners and local organisations to work together to support people to live healthier and more independent lives for longer.

4.4. Complement place-based working and partnerships, develop relationships and tackle issues that are better addressed once within a larger geographical area.

4.5. Support broad and inclusive integration across places and drive meaningful improvements in cross-cutting health and care outcomes and experiences.

4.6. The Partnership will provide a forum for agreeing collective objectives, enabling place- based partnerships to thrive alongside opportunities for connected scaled activity to address health and care challenges. It will take account of the views of each Health and Well Being Board as statutory bodies.

4.7. The Partnership will continually develop its role and remit, along with optimizing ways of working with Place Based Partnerships, Health and Well Being Boards, and other existing Partnerships such as the Lancashire and South Cumbria Provider Collaborative and the Lancashire Enterprise Partnership.

5. Key Principles

5.1. Come together under a distributed leadership model and commit to working together as equal partners.

5.2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

5.3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.

5.4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.

5.5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.

5.6. Champion co-production with our residents and inclusiveness throughout the ICS.

5.7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).

5.8. Ensure place-based partnership arrangements are respected and supported.

5.9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.

5.10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

6. Membership and Chair

6.1. The membership of the partnership will consist of:

Sector	Organisation	Position
Local Government	Blackpool Council	Elected Member
Local Government	Blackburn with Darwen Borough Council	Elected Member
Local Government	Westmorland and Furness Council	Elected Member
Local Government	Lancashire County Council	Elected Member
Local Government	District Council (Lancashire) – urban	Elected Member
Local Government	District Council (Lancashire) - rural	Elected Member
NHS ICB	LSC ICB	ICB Chief Executive
Providers (Primary Care)	LSC ICB	Partner Member for Provider of Primary Medical Services
Providers (Mental Health)	LSC ICB Provider Collaborative	Clinical Representative for Mental Health Services
Providers (Acute and Community)	LSC ICB Provider Collaborative	Clinical Representative for Acute and Community Services
Place-based Partnerships	LSC ICB / Local Authority	Director of Health and Care Integration
Place-based Partnerships	LSC ICB / Local Authority	Director of Health and Care Integration
Place-based Partnerships	LSC ICB / Local Authority	Director of Health and Care Integration
Place-based Partnerships	LSC ICB / Local Authority	Director of Health and Care Integration
Voluntary, Community, Faith and Social Enterprise Sector	VCFSE	Representative
Voluntary, Community, Faith and Social Enterprise Sector	VCFSE	Representative
Public, Patients and Communities	Healthwatch	Representative
Public, Patients and Communities	LSC ICB Public and Patient Involvement Committee	Chair
Public, Patients and Communities	The Independent Race and Equality Panel (I-REP) for Lancashire	Representative
Business	Lancashire Enterprise Partnership Health Sector Board	Chair
Hospices	LSC Hospices Together	Representative
Higher Education	University	Vice Chancellor
Children's Services	Local Authority	Director of Children's Services

6.2. The members of the Partnership shall be jointly appointed with approval from the ICB and the upper tier Local Authorities

6.3. Members of the Partnership should aim to attend all scheduled meetings. The Chair of the Partnership will review any circumstances in which a member's attendance falls below 50% attendance over a 12 month rolling period.

6.4. The Partnership may co-opt additional members subject to the following terms:

- They have subject matter expertise required to support the Partnership in meeting its responsibilities
- They represent a community, place, or organisation required to support the

Partnership in meeting its responsibilities.

6.5. Partnership members may nominate a suitable deputy when necessary and subject to the approval of the Chair. All deputies should be fully briefed, and the secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.6. The ICB and local authorities will jointly select a Partnership Chair, appointed on an annual rotational basis, from each of the upper tier local authorities. The Lancashire County council representative will take the role for the municipal year May until May 2024.

6.7. The Deputy Chair will be a representative from the VCFSE sector, which will also rotate on an annual basis and this will align with the appointment of the rotated Partnership chair.

6.8. Membership may change as the priorities of the Partnership evolve and whilst the Partnership must engage with a wide range of stakeholders and understand the different viewpoints across the system and communities, membership should be kept to a productive level.

7. Quorum

7.1. The Partnership shall be quorate when at least 30% of Partners are in attendance. This must include:

- The partnership Chair or Deputy chair
- At least 3 of the founder members (including 1 local authority and 1 ICB representative)
- At least 1 Director of Health and Care Integration
- Two other partners

7.2. Where agreed in advance, virtual attendance via an appropriate remote access system will count as attendance for the purpose of quoracy and voting (see below)

7.3. At the start of the meeting, the Chair will confirm that the Partnership is quorate, after any actions have been taken to manage any declared conflicts of interest.

7.4. Nominated deputies attending ICP meetings, on behalf of substantive members, will count towards quorum.

7.5. If a meeting is not quorate, the Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary. The Chair will have the final decision as to their suitability.

8. Meetings

8.1. The Partnership will meet at least four times per year, or as determined by the Partnership, and have an annual rolling programme of meeting dates and agenda items.

8.2. There will be administrative support required for the meetings which will include:

- Giving notice of meetings (including, when the Chair of the ICP deems it necessary in light of the urgent circumstances, calling a meeting at short notice)

- Issuing an agenda and supporting papers to each member and attendee no later than 7 working days before the date of the meeting; and
- Ensuring an accurate record (minutes) of the meeting.
- Managing any questions posed to the Partnership

8.3. A record of the meeting will be presented at Board / committee meetings of the Founder members of the Partnership

8.4. Meetings of the Partnership will be held in public and agendas and papers will be published at least seven working days in advance of the meeting except where confidential or sensitive information is likely to be disclosed. This may include:

- information given to any of the partners in confidence,
- information about an individual that it would be a breach of the Data Protection Act to disclose, or
- information the disclosure of which could prejudice the commercial interests of any of the partners or third parties

9. Decision-making

9.1. The aim of the Partnership is to achieve consensus decision-making wherever possible.

9.2. Each voting member of the Partnership in attendance at a meeting shall have one vote.

9.3. If the Chair determines that there is no consensus or one member disputes that consensus has been achieved, a vote will be taken by the Partnership members. The vote will be passed with a simple majority the votes of members present. In the case of an equal vote, the Chair shall have a second and casting vote.

9.4. The result of the vote will be recorded in the minutes and a record will also be made of the outcome of the voting for the other ICB committees.

9.5. All decisions taken in good faith at a meeting of the Partnership shall be valid even if there is any vacancy in its membership or, it is discovered subsequently, that there was a defect in the calling of the meeting, or the appointment of a member attending the meeting

10. Sub Committees & Delegation

10.1. The Partnership may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are governed by Terms of Reference as appropriate, and reflect appropriate arrangements for the management of conflicts of interest.

10.2. The Place development Steering Group will provide progress updates to the Partnership as agreed.

11. Accountability/relationships/assurance/authority

11.1. National guidance provides the following detail on the status and establishment of an ICP:

- Will be established in law as a statutory committee of the ICS.
- Not a statutory body; therefore, members come together to take decisions on an integrated care strategy, but the committee does not take on functions from other parts of the system.
- Must be established locally and jointly by the relevant local authorities and the ICB as equal partners.
- Local authorities and designated ICB chairs and Boards should meet in the Partnership as co-owners and equal partners of that committee.
- Should evolve from existing arrangements, with mutual agreement on terms of reference, membership, ways of operating and administration.
- To facilitate broad membership and stakeholder participation, Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in the shared strategy.

12. Code of conduct/managing conflicts of interest

13.1 Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.

13.2 Conflicts of interest will be included as a standing agenda item at the beginning of each meeting, where the chair will invite any members to declare any interests in connection to the business of the meeting.

Lancashire and South Cumbria Integrated Care Partnership

Report Title	AskSARA
Date of Meeting	25th March 2024

Lead Authors	Deborah Gent and Kash Ahmed

Our Vision	
To be healthier, happier and wealthier.	
The items in this paper contribute to the following Integrated Care Partnership priorities:	
	Please ✔ all applicable
1. Start well - give our children the best start in life, supporting them and their families with problems that affect their health and wellbeing, and getting them ready to start school.	
2. Live well - reduce ill health and tackle inequalities across mental and physical health for people of all ages by understanding the cause of these unfair differences.	✓
3. Work well - increase ambition, aspiration and employment, with businesses supporting a healthy and stable workforce and employing people who live in the local area.	
4. Age well - support people to stay well in their own home, with connections to their communities and more joined up care.	✓
5. Die well - encourage all our residents to feel comfortable in talking about planning for dying, and to be well-supported when a loved one dies.	✓

Executive Summary

- Originally supported by the Department of Health in 2009, the Disabled Living Foundation's (DLF) AskSARA online guided advice tool provides 'self-assessment, rapid access' (SARA) to help direct older and disabled people to impartial advice about aids and adaptations to help with activities of daily life. Most importantly, it is anonymous and free to use – factors that DLF believes contribute to its popularity.

- The dynamic question streams and resulting advice in AskSARA are devised and revised by occupational therapists and the tool is regulated by The

Information Standard https://www.england.nhs.uk/tis/, which gives further assurance of quality.

- Users of AskSARA can link to over 10,000 products in the Living Made Easy marketplace many of which can be immediately purchased from online retailers and delivered to their door.
- With almost a thousand retailers, it is the largest database of its type in Europe.
- The AskSARA application is available through local licensed versions which allow further signposting and advice, directing users to useful resources within their local area.
- Other councils report that when the tool is offered as a 'front door' service, it can help residents quickly find low level solutions for themselves that they are often happy to self-fund. This allows those with more complex needs to access formal assessments more quickly and efficiently.
- AskSARA can be used as the basis for a 'good conversation' about equipment that might help. It enables faster provision of small aids to daily living (SADLs) to many individuals as part of the Living Better Lives in Lancashire delivery model.
- AskSARA's user analytics provide useful demand data.
- Lancashire County Council is proposing to purchase the tool on behalf of all Lancashire and South Cumbria local partners, with weblinks available on all relevant ICB and Local Authority webpages.

Recommendations
Members are asked to: Approve the use of ICP branding on a Lancashire and South Cumbria AskSARA tool, for regional use. As per the themes that support delivery of our ICP priorities, AskSARA is a digital resource that provides information and advice in a timely way. The tool will support our residents with their health and wellbeing, and to make sure we make a difference where it is most needed.

AskSARA

Appendix A

Lancashire County Council

What is AskSARA?

- Originally supported by the Department of Health in 2009, the Disabled Living Foundation's (DLF) AskSARA online guided advice tool provides 'self-assessment, rapid access' (SARA) to help direct older and disabled people to impartial advice about aids and adaptations to help with activities of daily life. Most importantly, it is anonymous and free to use – factors that DLF believes contribute to its popularity.
- The dynamic question streams and resulting advice in AskSARA are devised and revised by occupational therapists and the tool is regulated by The Information Standard https://www.england.nhs.uk/tis/, which gives further assurance of quality
- Users of AskSARA can link to over 10,000 products in the Living Made Easy marketplace many of which can be immediately purchased from online retailers and delivered to their door
- With almost a thousand retailers, it is the largest database of its type in Europe

Why buy AskSARA?

- The AskSARA application is available through local licensed versions which allow further signposting and advice, directing users to useful resources within their local area
- Other councils report that when the tool is offered as a prevention service, it can help residents quickly find low level solutions for themselves that they are often happy to self-fund. This allows those with more complex needs to access formal assessments more quickly and efficiently
- Reduces demand on occupational therapy assessments
- AskSARA can be used as the basis for a ‘good conversation’ about equipment that might help. It enables faster provision of small aids to daily living (SADLs) to many individuals as part of the Living Better Lives in Lancashire delivery model
- AskSARA’s user analytics provide useful demand data

Lancashire County Council

Procuring AskSARA

- The cost for a LCC portal, is the same as it is for one that covers the whole integrated care system
- LCC will therefore commission a 5 year licence agreement on behalf of all Lancashire and South Cumbria local partners – linking in with the four upper tier Local Authorities, the ICB, the retail sector and the VCSE
- A link and information about AskSARA will be put on each organisation's landing page for equipment and OT support, alongside inclusion in the new digital directory, on intranet sites and as widely as possible.
- Our front door services will target the site at people who:
  - Are able to self-assess using an online portal
  - Would like to avoid the long wait for an OT assessment
  - Want guaranteed new equipment (not recycled) and
  - Are prepared to pay
- As part of the contract, the Disabled Living Foundation will provide monthly usage reports that will enable all partners to evaluate the return on investment. Reports will give data on the impact AskSARA has had in terms of reducing the number of contacts/ requests via email/ online forms/ telephone contacts etc. to our first points of contact teams, alongside information on private online equipment sales.
- The data will show if there has been any reduction in SW Assessments and/or OT Assessments due to its introduction.

Links to the Integrated Care Strategy

Age Well	**Integrated support for older people -** providing joined-up support for our most vulnerable and frail residents, their families and their carers	Plan and deliver joined up services and teams that meet our residents' needs and provide care designed for each person, supporting their physical and mental health and wellbeing and helping people to stay in their own home.
	Choice and control - making sure support is in place when circumstances change for an individual or their carers, supporting individuals to be as independent as possible	Help older people to use technology to support their health and wellbeing.
		Make sure that we know who is at risk of becoming frail and support a range of community activities to meet different needs and interests, encouraging self-care through better understanding, and developing and maintaining people's skills.
	Healthy ageing - keeping our maturing population mentally and physically active as well as involved in and contributing to their communities	'Live longer better' - supporting residents to access information and support to maintain and make the most of their own health and wellbeing
		Connect residents, their families and their carers to lead active, healthy and positive lives, to plan for old age and think about things that can be arranged in case their needs change or their health gets worse

AskSARA can be accessed by residents of any age in all of our places and communities
It provides guidance for people to self-serve and implement low level preventative measures in their own homes

Lancashire County Council

Next steps

- Submit the Procurement Waiver to allow deviation from the standard competitive process
- Seek approval from the Integrated Care Partnership (ICP) to use the jigsaw brand, guidelines and pantone references
- Complete the DLF Workbook to establish the local design concepts and ICP aesthetics
- Specify all technical website details, such as local equipment supplier databases and hosting
- Thoroughly test the website for functionality and compatibility
- Upload the website link onto the ICB and Local Authority webpages
- Provide necessary training

Lancashire County Council

Lancashire and South Cumbria Integrated Care Partnership

Report Title	Accelerated Reform Fund
Date of Meeting	25 March 2024
Agenda Item	

Lead Author	Victoria Tomlinson

Executive Summary

Links to ICP Priorities

Life Course	Theme	Action
Living Well	Supporting people who are already mentally or physically unwell - taking action on earlier diagnosis, providing better support to people living with their conditions and stopping them from getting worse, especially those people who have the greatest inequalities in access, experience and outcomes	Make it easier to know who our unpaid carers are, better understand their roles, and give better support for carers of all ages
Working Well	Wellbeing at work - creating workplaces and cultures that encourage good health and wellbeing, identifying the signs of ill health and wellbeing early and offering support where needed	Working carers are supported to balance work with their caring responsibilities.
Ageing Well	Integrated support for older people - providing joined-up support for our most vulnerable and frail residents, their families and their carers.	Make sure people know about all of our services that can support residents, their families and their carers
Ageing Well	Choice and control - making sure support is in place when circumstances change for an individual or their carers, supporting individuals to be as independent as possible	Provide accessible information about what care is available, when and how to access this, including details about costs and funding options that are easy to understand and follow Help older people to use technology to support their health and wellbeing
Ageing Well	Healthy ageing - keeping our maturing population mentally and physically active	Connect residents, their families and their carers to lead active, healthy

	as well as involved in and contributing to their communities	and positive lives, to plan ahead for old age and think about things that can be arranged in case their needs change or their health gets worse

Background

The Department for Health and Social Care (DHSC) launched a £42.6 million Accelerating Reform Fund (ARF) to boost the quality and accessibility of adult social care by supporting innovation and scaling, and kickstarting a change in services to support unpaid carers.

The ARF will focus on embedding and scaling approaches to transform care and support including for unpaid carers, who play such a vital, selfless role in our society. This will accelerate progress towards the government's social care vision where people have choice, control and support to live independent lives, and where care and support is of outstanding quality and is provided in a fair, accessible way. The ARF provides 12 month project funding from April 2024.

Expression of Interest

We have agreed an approach as a collaboration between Lancashire County Council, Blackburn with Darwen Council, Blackpool Council and Westmorland and Furness Council to work on the following priorities and projects across the Councils with Westmorland and Furness Council acting as the lead:

- Priority 3: investment in local area networks or communities to support prevention and promote wellbeing, enabling people to age well in their communities
    - Information and Advice Offer (Including Digital offer)
    - Co-Production and Engagement with Communities
    - Identifying and Strengthening Community Support
    - Connecting People to Community Support
    - Impact, Evaluation Sharing and Scaling

These workstreams will be looking to target areas of demand for non-regulated care tasks, such as social interaction and household tasks. This will be achieved through the development of the VCFSE across the ICB footprint

- Priority 12 (focusses on unpaid carers): ways to encourage people to recognise themselves as carers and promote access to carer services
    - Identifying Unpaid Carers (At home and during hospital stays)
    - Shared Lives (Westmorland and Furness)

- Carer's Support and Respite
- Digital Support for Carers
- Mutual Support for Unpaid Carers

These worksteams will build on the areas identified as shared priorities for the Local Authority partners for further investment and dedicated resource. The ARF funding enables joint working across the Lancashire and South Cumbria ICB footprint to accelerate the workplan which is being developed as part of the Carers Strategy and work with the VCFSE alliance around Early Intervention and Prevention. These include improving the information and advice for carers and supporting carers to better health and wellbeing in order to live a fulfilling life.

Funding

Initial £300k start up funding to be provided to all accepted bids and shared across partner organisations as set up costs and infrastructure support			
Local Authority	**2023 to 2024 indicative LA level top-ups to consortium funding - assuming all LAs participate and all ICS have a consortium (excluding consortium floor funding)** **(£)**	**2024 to 2025 indicative LA level top-ups to consortium funding - assuming all LAs participate and all ICS have a consortium (excluding consortium floor funding)** **(£)**	**Combined 2023 to 2024 and 2024 to 2025 indicative LA level top-ups to consortium funding - assuming all LAs participate and all ICS have a consortium (excluding consortium floor funding)** **(£)**
Blackburn with Darwen	23570	71983	95553
Blackpool	27864	85097	112961
Lancashire	170143	519626	689769
Westmorland and Furness	35271	107721	142992

Proposed governance:

Role	Name of Group	Description
Assurance	Department of Health and Social Care Social Care Institute of Excellence (SCIE)	Funding Source and National Reporting required around the fund to provide assurance.
Decision Making (Strategic) Group	Social Care and Health Partnership Board	Combined Local Authority Group with Director of Adult Social Services from each local authority across Lancashire and South Cumbria in attendance to provide oversight and decision making.
Decision Making (Tactical) Group	Accelerated Reform Fund Project Group	Project Group with leads from each local Authority which will be responsible for delivery at place
Delivery	Workstream Groups	Individual Project Delivery Groups

Recommendations

ICP members are asked to;

1. Note the update.
2. Support the approach to collaborative working in the ARF priority areas

Lancashire and South Cumbria Integrated Care Partnership

Report Title	National Academy Social Prescribing Share Investment Fund
Date of Meeting	25th March 2024

Lead Authors	Claire Niebieski – Head of Population Health, Lancashire & South Cumbria ICB

Our Vision	
To be healthier, happier and wealthier.	
The items in this paper contribute to the following Integrated Care Partnership priorities:	
	Please ✔ all applicable
1. Start well - give our children the best start in life, supporting them and their families with problems that affect their health and wellbeing, and getting them ready to start school.	✔
2. Live well - reduce ill health and tackle inequalities across mental and physical health for people of all ages by understanding the cause of these unfair differences.	✔
3. Work well - increase ambition, aspiration and employment, with businesses supporting a healthy and stable workforce and employing people who live in the local area.	✔
4. Age well - support people to stay well in their own home, with connections to their communities and more joined up care.	✔
5. Die well - encourage all our residents to feel comfortable in talking about planning for dying, and to be well-supported when a loved one dies.	✔

Executive Summary

Population Health are leading a review of social prescribing across Lancashire & South Cumbria. As part of the review the Voluntary Community Faith Sector & Enterprise (VCFSE) has been extensively engaged. The emerging picture is that whilst there has been significant investment in social prescribing link workers (SPLW) in each Primary Care Network (PCN) from various funding sources; the investment into VCFSE to support onward referrals from social prescribing (SP) has not had investment at the same level. The VCFSE sector are reporting that they are reaching crisis point in

managing the workload that is received through SP and are using other organisational resources to prop this up.

This too has been recognised by National Academy of Social Prescribing (NASP) and as such they have been working closely with government and The National Lottery Community Fund (NLCF) to develop a longer term more sustainable solution for the VCSFE. NLCF awarded NASP a six-month grant, running from October 2023 to March 2024, to explore new models of shared investment funds for social prescribing activities. As a result, by the end of March 2024, NASP expects to be in a position to submit proposals that have been widely tested and enjoy a clear consensus across national and local organisations in health, healthcare, local government, the VCFSE, the arts, sports, leisure and the natural environment. NASP are now looking to work closely with interested Integrated Care Systems (ICS) and Integrated Care Boards (ICB) to progress solutions in line with the above. NASP have developed a proposal to be able to further develop a 'shared investment fund' with interested ICS's over the next 12 months. NASP are supporting the development of a model where the SIF could eventually comprise of funding from weighted per population at £1.80 per person (90 pence per person from Big Lottery with a potential 90 pence per person matched investment from partners). The SIF would provide a shared and structured funding framework in which this funding will be disseminated across LSC to the VCFSE.

It is important to note that neither NASP nor the co-production partners are asking specific ICPs, philanthropists or national investors such as NLCF or HM Government to commit to making an investment. The status of the report at Appendix 1, that accompanies this paper is not a bid application, seeking a yes/no decision. Instead, this report is a shared exercise in envisaging what could come to pass. With wider partners NASP have developed ideas into concrete proposals set out in the report, purely for the purpose at this stage of making a shared vision as tangible as possible, to show it is properly thought through, and to demonstrate practicability.

Please see Appendix 1 for the report and Appendix 2 for a slide deck for further detail relating to this.

Recommendations

Agreement for a decision:

The ICP Board to agree to work with NASP to progress proposals to become an early demonstrator site understanding that there are no concrete commitments at

this stage and further developments would be brought back for update / decision / commitment.

EARLY DRAFT version 1.4 ID 25/01/24

ENVISAGING A SOCIAL PRESCRIBING FUND IN ENGLAND

A report funded by the National Lottery Community Fund

The National Academy of Social Prescribing
January 2024

Contents

A. Introduction and design principles

Purpose of this report and our co-design process

1. **The National Lottery Community Fund (NLCF) awarded the National Academy of Social Prescribing (NASP) a six month grant, running from October 2023 to March 2024, to explore new models of shared investment funds for social prescribing activities.**

2. **To help in our task, many national and local organisations and individual experts have volunteered their time**. This report has been shaped by their creativity and wisdom. An advisory group guided our process. It had representation from the private, public, charitable, and philanthropic sectors. It included senior experts from NHS England, Integrated Care Boards (ICBs), the Local Government Association, the NHS Confederation, Business for Health, the National Association for Voluntary and Community Action (NAVCA), the Department for Communities Media and Sport (DCMS), the Department for Health and Social Care (DCMS), the Department for the Environment Food and Rural Affairs (DEFRA) and NHS Charities Together, as well as independent consultants with extensive experience of the health system and strategic transformation. NASP held roundtable discussions with a wide range of funding organisations across the arts, sports, leisure and natural environment. Working with the NHS Confederation, we benefitted from discussions with chairs of Integrated Care Partnerships (ICPs). We engaged national arm's length bodies such as the Arts Council, Sport England and Natural England, as well as voluntary community faith and social enterprise (VCFSE) provider organisations. Bilateral discussions with ICPs explored how a new shared investment model could work in their specific geographies. We worked with think-tanks, and through desk research, we analysed the lessons learnt from previous relevant programmes.

3. People have been enthusiastic about engaging with the co-design process and see the huge potential for this work. As a result, **by the end of March 2024, NASP expects to be in a position to submit proposals that have been widely tested and enjoy a clear consensus across national and local organisations** in health, healthcare, local government, the VCFSE, the arts, sports, leisure and the natural environment, [as will be demonstrated in the foreword collectively signed by national stakeholders].

4. **The NLCF is the biggest funder of community activity in the UK,** awarding £615m in 2022/23 in 13,858 grants of which 8,931 supported health and wellbeing. The NLCF has been and continues to be a significant investor in social prescribing. Strategic programmes such as Ageing Better (£87m programme over seven years), and HeadStart (£67.4m programme over 6 years) are in part adopting social prescribing approaches. The NLCF has also been directly investing in social prescribing activities including over £60m in the 5 years prior to the NLCF's 2019 report, *Connecting communities and healthcare: making social prescribing work for everyone,* and more recently the £3m *Healthy Communities Together* partnership with the King's Fund, and £5m in phase two of the *Health Equality* partnerships.

5. **This work is intended to assist NLCF's framing of its own potential future investment in relation to social prescribing, in line with its 2023-2030 strategy *It starts with community*.** NLCF has set four main missions (come together, be environmentally sustainable, help children and young people thrive, and enable people to live healthier lives). Rather than addressing just one of these goals, local social prescribing systems bring these goals together operationally, by focusing on improving health and wellbeing through the specific means of community connection, for all ages including children and young people, and by moderating avoidable NHS activity and the associated carbon emissions. There is an opportunity for us all to unlock stronger synergies, nationally and locally.

6. **It is also important to note that in producing this report, neither NASP nor our co-production partners are asking specific ICPs, philanthropists or national investors such as NLCF or HM Government to commit to making an investment. <u>The status of this report is not a bid application, seeking a yes/no decision. Instead, this report is a shared exercise in envisaging what could come to pass</u>. With our partners we have developed our ideas into concrete proposals set out in this report, purely for the purpose at this stage of making our shared vision as tangible as possible, to show it is properly thought through, and to demonstrate practicability.**

Context

7. In recent years social prescribing has expanded dramatically in England, with over 2.5 million referrals by Social Prescribing Link Workers. The stories are compelling, and the evidence base is increasing. Social prescribing enjoys tremendous grass-roots, cross-sectoral and cross-party political support. From being a niche interest, it has become a mainstream, UK-wide activity. NASP is also supporting its global development, working with the World Health Organisation. We now host an international network of over twenty countries.

8. NHS funding for existing NHS social prescribing link workers (SPLW) currently operates well, through the system of legal entitlements in the 2019 five-year update to the national GP contract. Primary Care Networks are choosing to spend over £100million each year of their funding on over 3,600 FTE link workers. The recent NHS Long Term Workforce Plan includes a target to recruit 9,000 Link Workers by 2036/7.

9. **Looking beyond the NHS, there is vast untapped potential to expand beyond NHS referrals.** Three spheres seem most obvious:

   (i) **to help employers proactively support the health and wellbeing of their workforce** and connect with local communities at the same time. NASP sees potential for a new national programme here sponsored by employers, backed by Government, with a contributing national investor;

   (ii) **to help people get back into work**. The new DWP *WorkWell* programme intends to use social prescribing approaches. Operationally, NASP sees this working best if

the additional dedicated link workers that will be required are integrated with the existing NHS link workers, as part of a coherent local approach; and

(iii) **to support self-referral, by friends and family, or by local community.** 85% of the referrals in the *Thriving Communities* social prescribing programme were from outside the healthcare link worker system. Social prescribing systems have the potential to become the main at-scale, umbrella means to unlock health improvements in local populations, because of their ability to reach people with the greatest health and wellbeing needs, and help individuals with what works best for them.

10. **Multiple Government Departments and additional Arms' Length bodies have recently made a number of standalone investments in social prescribing activities typically through short-term pilots**, for example: (i) DEFRA, NHS, Sport England and NASP through the Green Social Prescribing Programme aimed at tackling mental health needs; (ii) DCMS through its Power of Music strategy; (iii) Arts Council England, Natural England and Historic England through its funding of the *Thriving Communities* programme, and the Office of Health Improvement and Disparities (OHID) work on health promotion, and (iv) DfT through its Active Travel Social Prescribing Pilots.

11. **The biggest challenge in social prescribing is the severe constraint on supply-side capacity, which has not kept pace with the demand revealed through the increase in referrals.** Prior even to the huge growth of link workers from 2019, this issue was already identified back in NLCF's excellent report *Connecting communities and healthcare: making social prescribing work for everyone*: it concluded that we need "a systematic approach to funding that nurtures and enables collaboration between statutory and community providers and ensures that money reaches all parts of the system". The lack of sustainable investment in social prescribing activities to which people are referred now serves as the biggest brake on its potential to improve health and wellbeing, moderate avoidable demand on the NHS, strengthen civic society, and support economic growth. Many social prescribing activities are now running at maximum capacity, with limited scope for further expansion (as for example envisaged under *WorkWell*) without relatively modest levels of additional sustained investment. Voluntary sector organisations have also experienced major funding difficulties in recent years, given real-term cuts to Local Authority budgets, the COVID pandemic, and the cost-of-living crisis.

12. **There is a clear consensus that the inadequate, fragmented, short-term funding of social prescribing activities is the core problem which between us we must solve. Of course, there will always be value and interest in one-off, pump-prime funding for specific activities or client groups. But we also need *bigger*, more *certain*, *longer-term, joined-up, repeat investment* to support the kaleidoscope of social prescribing activities needed to meet revealed and emerging extra demand.**

13. **We think this challenge ought to be readily addressable, not least given the widespread interest of many different funders in developing innovative models of investment.** At NASP, unlocking a solution is a top priority. In December 2023 we published our *Vision for the Future of Social Prescribing in England*. This sets out the five

inter-linked actions needed to accelerate the scale and impact of social prescribing. Centre-stage is the need to create new shared investment models for social prescribing activities, taking a holistic approach across multiple sectors and client groups. We draw upon analysis and recommendations from a variety of sources, including but not limited to the King's Fund, the National Association for Voluntary and Community Action (NAVCA) and National Voices.

14. **Our vision of shared investment funds is not just an aspiration.** Some early progress is happening. We are seeing models such as community chests being successfully rolled out in some London Boroughs, investing more than £500,000 to date in 83 different VCFSE organisations providing social prescribing activities.

15. **The process undertaken through this NLCF development grant has revealed that the appetite exists in myriad organisations to attempt a far more ambitious approach. This paper describes what a new investment model could look like that unlocks and marries up local with national funding, and bridges across the statutory and VCFSE sectors. For simplicity, we are calling this model "The Social Prescribing Fund".** NASP is being approached by local areas keen to go first and willing to commit to their part, if there is a national investment partner.

Four key design questions

16. Our design process is being structured around answering the following questions:

Q1. **Fund generation** – what is the best way of maximising investment levels from diverse investors?

Q2. **Fund operation** – what are the options for the investment pot, and at what geographical level? Who will be making the decisions about grants? What activities will it buy?

Q3. **Learning and impact** – what information will be collected, in order to know what the Social Prescribing Fund will be buying and with what effects?

Q4. **Phasing** – how might rapid progress be made in implementing the Social Prescribing Fund as part of a commitment to national roll-out?

Design assumptions

17. Through our discussions so far, and analysis of lessons from other programmes, we have been iterating a set of design assumptions. We have paid particular attention to understanding and differentiating between what would optimally be decided and done locally and nationally:

I. **Adopt a clear model for a Social Prescribing Fund based on shared investment**. The power of the Fund would be by generating financial commitment from multiple sources - local statutory partners, businesses, employers and philanthropists, and national funders.

II. **Aim to unlock ambitious levels of investment**, that are commensurate to the scale of the funding challenge, as revealed by demand**.**

III. **Incentivise contributions through nationally-set matched funding rules.** National matched funding rules would be a powerful way of providing clarity and certainty, incentivising significantly more investment in social prescribing activities, and reducing transaction costs. It would be more attractive to many investors than the current fragmented approach.

IV. **Adopt a long-term approach to fund generation and grant-making.** The matched investment rules should be set up to run over a long-term period, e.g 10 years. The local operation of the Fund should enable multi-year commitments to be made to some providers, to promote innovation, generate scale, and provide financial stability.

V. **Centre the approach on existing local partnerships.** In particular, the 42 Integrated Care Partnerships in England would be key actors in this space, as well as for example Community Foundations, as a way of helping with health generation and community development, across NHS, LAs, and VCFSE partners.

VI. **Enable and encourage comprehensive England-wide participation.** Whilst it must be a matter of local choice for ICPs to take part, we should encourage participation from all 42 ICPs, so that no part of England is left behind. Otherwise, we risk exacerbating relative inequality and continuing the current piecemeal approaches.

VII. **Reflect additional needs for inequalities in the design of investment arrangements.** National rules around matched funding arrangements should take account of additional needs, for example by using the relativities in the NHS ICB allocation formula as the likely best available tool.

VIII. **Leave alone the NHS mechanism for investment in Social Prescribing Link Workers**, through the Additional Roles Reimbursement Scheme (ARRS) in the Primary Care Network (PCN) Directed Enhanced Service (DES) in the national GP contract. It works well and is effective. We should complement it, by focusing investment on social prescribing activities and supporting infrastructure.

IX. **Maintain clear operational separation of the Social Prescribing Fund from NHS and LA funds.** Social prescribing is much wider than the statutory sector, and health and healthcare. Governance over spending decisions should reflect expertise from both funders and the sectors into which investment would be made.

X. **Operate the Social Prescribing Fund at ICP level or place footprint, rather than try to hold and manage the money in one big national pot.** The footprint for any national matched funding rules might best be ICP level, but that could be different to the footprint for holding and distributing the funds. In large ICPs e.g. Northeast and North Cumbria, West Yorkshire and Harrogate, there might be a stronger focus on place than in smaller ICPs such as Dorset. The design of the funds should allow for flexibility to promote place-based models.

XI. **Embrace local fundraising and local governance**. We are not making any national assumptions about which organisations or partnerships are best placed to hold the fund, lead on local fundraising from employers and philanthropists, or be the grant-making body for the fund. This would be determined by local partnerships.

XII. **Allow local flexibility about how the Fund is spent within broad guiding principles.** The Fund would only be investing in *additional* activity and extra *non-clinical community services*, rather than substituting for what already exists. It should never replace NHS funding of NHS clinical services, or other national statutory bodies funding services such as *WorkWell* assessments and personalised support. NASP's experience is that services should include local community enterprises, the arts, sport and leisure, heritage, and the natural environment. The fund should be about generating value aligned with local social prescribing strategies, including additional demand revealed by link workers referrals.

XIII. **Generate regular systematic data.** We would leverage the creation of the Fund as a stimulus to fill existing data and analysis gaps, with relevant support from national organisations including DHSC, NHSE and DCMS. The development of regular, systematic and aggregable data across England would enable clear demonstration of value to providers and investors alike. Data and analysis needs to cover what is being bought (spend and activity levels), for whom, and with what effect (improvements in self-reported satisfaction, health and wellbeing status, reductions in loneliness, moderation of avoidable NHS utilisation, and potentially improvement employment status). For some of these metrics, a segmented approach is needed, rather than all applying equally to everyone.

XIV. **Commit to an England-wide programme, making early progress through demonstrators.** A number of ICPs are enthusiastic to apply this Social Prescribing Fund model now. They could (i) rapidly demonstrate the viability of the matched investment model; (ii) illustrate different types of operational arrangements and expected investment priorities; (iii) help co-design and start operating the enhanced data flows, working with national partners; (iv) work together as a community with NASP to help identify good practice. A Demonstrator programme could also be used

for a national funder to develop an agreement with a partner body such as NASP in overseeing the overall operation of the model, including conditional release of national contributions, and reporting arrangements, in line with the agreed framework.

18. The following sections of the report flesh out how these design assumptions should be put in practice.

B. National rules for The Social Prescribing Fund

19. This section describes our simple but ambitious model for generating a Social Prescribing Fund. Our intention is to replace fragmented funding with a new integrated approach, that unlocks and marries local with national investment, and builds bridges across the statutory sectors and the VCFSE.

Equal local and national contributions

20. **A powerful new incentive effect would be generated by *fixing requirements,* for *guaranteed equal* new *investment contributions,* from two *essential sets of contributions*: (i) local Integrated Care Partnerships (ICPs) working together with local businesses, and philanthropists; and (ii) one or more national investor(s).**

21. **We have heard that parties would be much more willing to commit, if they knew that their contribution was a critical part of the trigger for the generation of a much bigger Social Prescribing Fund.** Each commits their £1 only conditionally, on the basis of it becoming £2 of actual investment. That result is true for everyone: the ICP and its partner local contributors, as well as the national investor(s).

22. **We have designed this "buy one get two" model in order to create a highly attractive investment vehicle for all parties including any potential national investors.** It will leverage a bigger effect than a more traditional investment model. It demonstrates you are not alone (sharing benefits and risks); there is equal commitment of local partners to the investment proposition. And furthermore, by building mutual interdependence in fund generation, this model should also help cement stronger partnership working across sectors and all contributors.

23. **All investors will want to know that their contribution is going to lead to improvement, rather than be used as an excuse to withdraw existing funding.** The Social Prescribing Fund is not intended purely as way of brigading together pre-existing investment in services. Instead, it is about securing additional capacity and impact, which would be demonstrated by our proposals in part D of this report for systematic and regular data. It is also important to note that whilst the Fund is intended as an attractive means of increasing the funding for social prescribing services, it is not purporting to be the sole and exclusive way of funding the future expansion of services. Additionally, the Fund should never replace NHS funding of NHS clinical services, or core funding by other statutory bodies.

Ambition commensurate to need

24. **As the NHS continues to invest in link workers and referrals, so there needs to be commensurate investment in activities for those referrals. One simple rule of thumb is that for every £1 spent annually on link workers, so we should aspire to see the Shared Investment Fund bringing in *at least* the same for social prescribing activities**

to which people are referred. This would only form a contribution to the actual costs of the activities. It would point to an England-wide fund of at least £100 million per annum at today's prices, rising according to referral flows.

25. **To enable longer-term commissioning, and to scale up services showing the greatest promise, we propose that the investment in the fund should run for an initial 10 year period,** similar to the design of the *Big Local* project, which gave 150 places about £1m over 10 years to improve health and wellbeing. Its recent evaluation report was able to show statistically significant improvements in health and wellbeing compared to comparator areas, using national Census data.

26. **Ten years of £100m per annum would generate a £1bn Social Prescribing Fund over 10 years at today's prices.**

27. We also propose to embed the principle that investment requirements would logically be uprated in line with CPI, in the design of the Fund, in order to maintain purchasing power.

The local investment share

28. The implication of the scale of our ambition is to **establish a fixed investment requirement across all 42 Integrated Care Partnerships who choose to participate.** In designing the scheme, we recognise that Local Authority and NHS partners are all under unprecedented financial pressure, and many will find it impossible to contribute to the local investment share, unless there is a guarantee of generating matched national funding which they would otherwise forego. A fixed requirement generates certainty of the scale of the total prize. It promotes equity nationwide. It also takes away what would otherwise be a difficult and time-consuming local debate about how much to invest: the national rules are the rules, with no exceptions. It also removes the risk for national investors of having to match higher than expected local contributions.

29. **We propose that the local investment level would be set at 90p per annum per head of ICP population** (i.e. about £50m nationally if all ICPs participated), uprated each financial year in April by the annual CPI figure from the preceding September.

30. **We have heard that funding must take account of relative needs and health inequalities. The mean level per ICP would be adjusted up and down by weighted population.** As the best readily available proxy for relative population need, we propose to do this according to the NHS ICB allocation formula, which takes into account deprivation and inequalities.

31. **We have heard from ICP chairs, the NHS Confederation, the Local Government Association and NHS England that the ICP is the right vehicle to galvanise this endeavour across and on behalf of NHS and LA partners.** ICPs do not act as the NHS or LA budget holders and Accountable Officers or have a role in wider local fundraising. They do not represent the VCFSE. But they do have a critical role in promoting action and investment to improve health, and partnership working across sectors including the VCFSE.

They are ideally placed to lead the conversation and broker an ICP contribution, as a core part of the local investment share.

32. There is no obvious reason why we should seek to decide at national level any relative proportions of contributions to be generated from different local sources, and thereby constrain local decision-making. **Local systems would have almost total flexibility as to how they source their local investment share. We propose one requirement only: that it must include contributions from at least three separate sources: (i) the NHS, (ii) local government, and (iii) local employers and/or philanthropists.** The balance of contributions is entirely a local matter. We propose that the commitment would need to be for the entire duration of the Fund, i.e. over a 10 year period.

33. **The Fund is intended to provide an attractive investment vehicle for local communities, including businesses, and philanthropists.** From philanthropic investors we have heard clear enthusiasm, subject to certain assumptions. Any arrangements need to (i) remove uncertainty about there being some commitment from statutory partners; (ii) enable rapid decision making, with low transaction costs for investors and providers alike; (iii) promote a long-term approach, and (iv) give them a voice, so that their interests can be heard and their expertise effectively deployed. The ICP geography would need to demonstrate that the local investment share includes some contribution from non-statutory organisations. The ICP itself might not be the vehicle for organising these, but it would need to be sure that an effective and appropriate arrangement is in place. The question of who and how local fundraising occurs will be entirely a matter for local determination, and will need to command the confidence of the VCFSE sector locally.

34. **Some philanthropic organisations have told us that they - and potentially large employers - may be interested in investing on a multi-geography or even national basis.** To address this opportunity, NASP could offer a free "brokerage" service to possible philanthropic investors who are interested in exploring a multi-geography approach. We envisage they could take advantage of three options:

    (i) *comprehensive*: a simple 'tracker' investment model, where their investment is spread equally across the ICBs who are participating according to weighted population;

    (ii) *targeted*: the opportunity to focus on particular geographies of greatest salience to them (e.g. regionally, or the areas with highest levels of deprivation); or

    (iii) *dialogue*: the opportunity to post their interests with geographies and see where the ensuing conversation leads.

35. Our thinking is that such investments would best count towards the meeting the local investment share. Timing is probably too constrained for this arrangement to work well for any local demonstrators, as opposed to wider national roll-out.

Matched national contribution from statutory bodies

36. **Our proposal is that following confirmation of the local investment share of 90p per head of population, it is then matched nationally with an additional national 90p.**

37. **We have designed the proposals for the Social Prescribing Fund to include at least one core national investment partner from the statutory sector**, for example an organisation such as the National Lottery Communities Fund; or Government; or both working together.

38. **The Social Prescribing Fund has the potential to serve as a more powerful, new overarching vehicle for future national investment in health and wellbeing and community development.** The first section of this report outlined some of the investments that the National Lottery Communities Fund (NLCF) and different Government departments have previously made in health and wellbeing, and social prescribing activities specifically, without matched funding, and not explicitly connected to the newly established NHS social prescribing system.

39. **We are optimistic that our investment proposition will be attractive for a national investor, for three significant reasons:**

    (i) many national investment opportunities do not guarantee any matched local funding. Under this model, the **national investor achieves disproportionate leverage;**

    (ii) although the Social Prescribing Fund is only buying supply-side activities, **it also gets free access to the wider system of social prescribing paid for by others including NHS investment in link workers.** It benefits from being part of a systemic approach, already in existence, that involves connecting targeted demand to supply, in a personalised and light-touch way;

    (iii) with the proposal on standardised nationally aggregable data flows set out in section D of this report, there will be a **high level of transparency and clarity about what is bought, and with what quantified impacts.**

    For these reasons, the Social Prescribing Fund should prove a far better value proposition than the many opportunities for standalone investment in community activities for example through traditional grant-making processes.

40. **Under the rules of the fund, the national contribution would only be triggered when the local investment requirement has been met.** Whilst participation is voluntary, we would encourage nationwide coverage, to avoid some communities being left behind and thereby exacerbate inequalities. The Government, NHS England, and the LGA could assist by advocating full participation in communications with local systems.

41. **One option to simplify operations for the national investor is that they could develop a strategic partnership with NASP, and we could oversee the operation of these rules including transfer of funds and regular reporting arrangements**. Such an arrangement also has the potential to reduce transactional burdens for local systems and the national investor alike, and is explored more fully in section E.

Flexibility for the future

42. **The Social Prescribing Fund has been designed with scope for future expansion in mind. For example, if in future years additional national investors sought to participate, NASP would co-design further matched investment tranches**. Individual Government departments or NDPBs may wish to use it as an investment vehicle; or even more powerfully, different Government programmes could choose to work together as one. NASP can confirm that the operational framework for deploying the fund on social prescribing activities, and the data flows, would maintain focus onto the priority areas of national investors.

C. Local operation of the Fund

Section C to be written following discussion with stakeholders and in particular individual ICBs.

In outline:

Flesh out the relevant design principles

A simple permissive national framework, which maximises local flexibility, and a few national guard rails

Additionality; not replacing funding for statutory services; NHS link worker funding is separate

The Social Prescribing Fund is an overarching label and set of rules. It also becomes a set of separate locally determined legal vehicles ("the Manchester Social Prescribing Fund", "the Dorset SPF" etc), that is not the ICB or LA. It could be held at a smaller geographical footprint than the ICB: footprint is a matter entirely for local decision-making.

Practical arrangements about funds flow. Local investment share transferred in either annually or flexibility for multiple years in advance. National matched funding likely to be transferred annually, upon confirmation of local investment funds transfer, but with flexibility for national investor to transfer funds for multiple years in advance. One further option is NASP could hold national funds as an endowment

Locally determined governance of the Fund in line with legal form.

Complete flexibility about the distribution of the spend across 10 years

Must have a full record and transparency about funding decisions, and arrangements for reporting on spend on a [quarterly] basis, and in line with legal form.

Requirement to use national data collection tools and information standards. Where these tools are not provided, no obligation for local systems to establish their own. Comparative data and analysis to be provided nationally for free, for local use, learning and benefit realization.

This section illustrates the diversity of approaches that are likely – with practical local examples of how different parts of the country see it operating. Peppered with local investment priorities & some of the sorts of things it would buy.

D. Learning about impact

The positive impacts of social prescribing are clear in stories, experiences, and local evaluations. These have fuelled the tremendous growth in numbers of link workers and referrals since 2019. [DN: expand with NASP's summary of best available positive evidence].

At the same time, national data on the quantified benefits remain a work in progress. **The establishment of a Social Prescribing Fund is a golden opportunity to fill the data and analysis gaps** that could otherwise serve as a drag on the future expansion of social prescribing. Our purpose is threefold. First to do justice to what is being achieved. Second, to help investors understand more fully the impacts they are making. And third, to enable local referrers and providers to optimise how they work.

A step change is readily and rapidly attainable, through a concerted, coordinated, but relatively modest national drive. This forms the third critical action in NASP's December 2023 vision *The Future of Social Prescribing in England.*

Inspired in part by this development grant from NLCF, NASP is now working with national bodies in particular on a **small and rapid joint piece of work to developing the actions required to solve the data and analysis gaps.**

Together we are seeking to answer the following **six questions:**

1. **What key simple *national metrics are needed to demonstrate the expected quantified benefits*** (populated by standardised data that are aggregable from local to national, and national analysis of disparate data sources)?

2. **What are the *means* by which the *data required to fill gaps* now can be captured**?

3. **How best can *disparate data, new and existing, be brought together and analysed***?

4. **What *query functionality and standard reporting* would be most useful for investors, referrers and providers of services and activities**?

5. **What *ongoing infrastructure* is required?** What the are competencies required and who might commission or provide it?

6. **What are the *practical next steps* can be taken, by whom, and in what order?**

A first cut of an **emerging end-state vision, to which we could build over time,** is for

… *near-real time data*

… on the *current actual quantified impacts* of social prescribing (and over time historical impacts), for example on

- whether it is *helping clients meet their particular addressable need* (captured on a simple scale, drawing from current best practice)
- self-reported *health and wellbeing status* (going further than the SP Information Standard proposals)
- self-reported *loneliness* (where appropriate for clients)
- *moderation of avoidable NHS demand* including appointments with primary care clinicians, overprescribing of certain medicines like opioids, and anti-depressants, A&E attendances (by big data analysis, possibly using synthetic control methods)
- social prescribing link worker *referral activity* and on *expected unmet need* and gaps in referrer coverage (the SP Observatory does this)
- the volume of *provider activity levels* and by provider category (the former cannot be captured by the NHS alone, but is key for investors; the SP Information Standard will help with the former)

… with the *ability to conduct queries and comparative analysis* across data categories to understand variations and spot patterns (also invaluable for future research studies; and the fruitful application of AI tools)

… *across multiple geographical footprints* (e.g. national, regional, ICB, place, LA, ward, PCN, practice)

… *to be readily available to anyone interested in social prescribing* (i.e. not just the current SP Observatory users)

… by means of an *easy-to-use digital interface* (bearing in mind existing software suppliers)

… with *high footfall* from a *thriving and growing user community*.

We are learning from the progress already made. We are not starting from scratch. The Royal College of GPs (RCGP) Research and Surveillance Centre (RSC) has recently set up and runs the excellent Social Prescribing Observatory service jointly with Oxford University. For primary care staff only, it provides data and insights mainly about referrals and client characteristics. And NHS England is about to launch a new Social Prescribing Information Standard. This is seeking to help improve NHS data quality and comprehensiveness.

Co-production is essential to gather inputs and insights from data and analytical experts (e.g. from NHS England, the DHSC's Office of Health Improvement and Disparities who lead on health generation and tackling health inequalities, NHS commissioning support units and data services), academic researchers (e.g lead researchers for NIHR projects), as well as investors, social prescribing service providers and users. We are planning to hold an expert roundtable in early 2024, ideally as a three-way endeavour sponsored by NASP, Government, and NHS England.

We expect to have concrete proposals for inclusion in the report for March 2024.

The proposals will include specific information requirements, data collection tools, and the outline specification for a national data and analysis hub. We then propose to work with interested national stakeholders (and potential demonstrator systems of the Social Prescribing Fund) to finalise the proposals. Our intention is that the data and analysis infrastructure would be in place in time for national rollout of the Social Prescribing Fund.

E. National roll-out, with potential early demonstrators

This section to be co-produced following discussion with national stakeholders and local ICBs

In outline:

Proposal is for clear commitment to a national model, not pilots. But early progress could be made with a set of 6-8 demonstrator systems, should that be preferred by a national investor.

The purpose would be purely to confirm the viability of the matched funding model, and offer concrete examples of how the fund will actually operate, going beyond the illustrations in section C of this report. It is also an opportunity to create a learning community.

We do not propose that evaluation of impact precedes wider national roll-out because (i) it is unlikely to be informative. The key to understanding impact is to solve the data and analysis gaps set out in section D, not yet further qualitative evaluation; and (ii) it would introduce significant delays.

To ensure fairness, NASP would run a very simple and rapid open application process across all ICPs, seeking formal confirmation (i) that they intend to meet the local investment share, (ii) of ICP and wider local support, (iii) that they agree to abide by the arrangements set out in this proposal (or as subsequently iterated following discussion with a national investor). Applicants would also be free to provide a brief (e.g no more than 2 pages), open text supportive statement should they wish. NASP would convene a group, to be constituted, to decide on applications.

We envisage that the demonstrators would run for a fixed time period [to be determined] prior national roll out the following April.

If NASP were the core national partner overseeing the operation of the Fund, it would develop a core binding agreement document – whether an MOU or a contract – with local systems. This would include reporting arrangements and need to be signed prior to the transfer of any funds. NASP could provide at least quarterly updates on progress. A full annual report to the core national funder could include quantitative data on spend, grants made/services commissioned, activity, and impact.

F. Conclusion and next steps

National Academy for Social Prescribing

Developing Shared Investment Funds for social prescribing

30th January 2024

Appendix B

National Academy for Social Prescribing

What is Social Prescribing?

"A means for trusted individuals in clinical and community settings to identify that a person has nonmedical, 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."

Global conceptual definition, 2023

National Academy for Social Prescribing

Understanding the need

- Inequitable funding landscape across SP system
- Diverse, stable provision of SP activities, advice and info are completely central to any SP offer
- Often provided by VCFSE sector, supported by community infrastructure
- Short-term, piecemeal funding from wide variety of sources puts provision and sector at risk
- Commitment to triple SP link workers, without wider investment in VCFSE provision risks demand outweighing supply

Health setting
Funded through GP contract

Community setting
Unstable funding

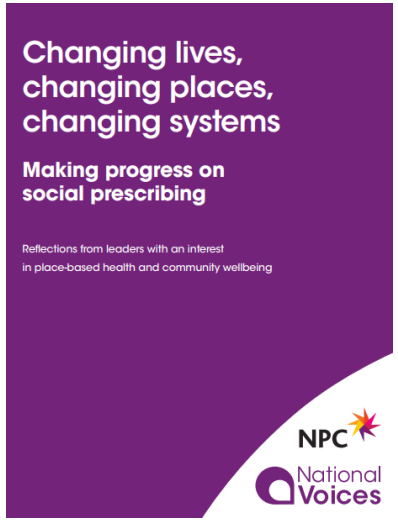
National Academy for Social Prescribing

What does the evidence say?

Encourages ICSs to move from providing one-off funding of VCSE orgs to longer term investment in the sector

navca
local focus national voice

Calls for continued national funding at ICS level until local systems and leaders are more established. Need for legacy building element.



Says all stakeholders recognise the need for cross-sector funding for social prescribing, but shifting from this recognition to a commitment of funding remains the challenge.

The National Academy for Social Prescribing (NASP) commissioned its Academic Partners to review and summarise the evidence on funding models for social prescribing, and any insights into their financial sustainability.

- The current evidence shows a range of different funding models for social prescribing, which include a diversity of funding sources such as private, public and charitable.
- Regardless of the funding model used, the evidence suggests that the most effective models and approaches are those where a range of local partners work together, and that it is important to recognise the challenges in doing this

National Academy for Social Prescribing

Designing a solution

- We now have a unique opportunity to shape better investment in social prescribing
- Co-develop a ringfenced Shared Investment Fund from public, private, charitable and philanthropic sectors aligned to Integrated Care Systems
- Development grant to scope, engage partners and co-design a solution addressing these challenges and barriers facing community organisations providing SP activities

COMMUNITY FUND

November 2023
Strategic Advisory Group
Engagement with provider organisations
Funding organisations round table
ICP & System Level VCSE Alliance round table

December 2023
Design Assumptions

January 2024
Further ICP and Link Worker engagement
Multi-agency co-design session
Develop framework

February 2024
Strategic Advisory Group test & challenge

March 2024
Report to NLCF with proposed SIF framework & go-early sites

National Academy for Social Prescribing

Design Assumptions

A Shared Investment Fund model should:

1. Generate financial commitment from multiple sources & unlock ambitious levels of investment
2. Incentivise contributions through nationally-set matched funding rules
3. Adopt long-term approach to fund generation and grant-making
4. Be locally driven and nationwide
5. Reflect additional needs for inequalities (e.g. by using relatives in the NHS ICB allocation formula)
6. Not disrupt or substitute current funding for Link Workers or NHS funding of NHS clinical services
7. Be separate from NHS & LA funds
8. Operate locally (ICP or place level) rather than from one large national pot
9. Embrace local fundraising, governance and spending flexibility within broad guiding principles
10. Generate data to drive improvement and impact
11. Commit to being England-wide with early demonstrators

National Academy for Social Prescribing

Proposal: equal local & national contributions

For every £1 spent annually on link workers,

SIF should contribute *at least* the same for SP activities

- Total fund of at least £100 million per annum for 10 years (total of £1bn)
- £1.80 per capita per annum approx
- Fixed annual contribution from ICPs of 90p per capita **matched** by national pot from core national investor
- All contributions are mandatory components with a 10-year commitment
- ICP convenes local contributions which must include NHS, LA and private/philanthropic partners
- Local flexibility on holding the fund, at what geographical footprint and how to spend it.

Local operation of the fund

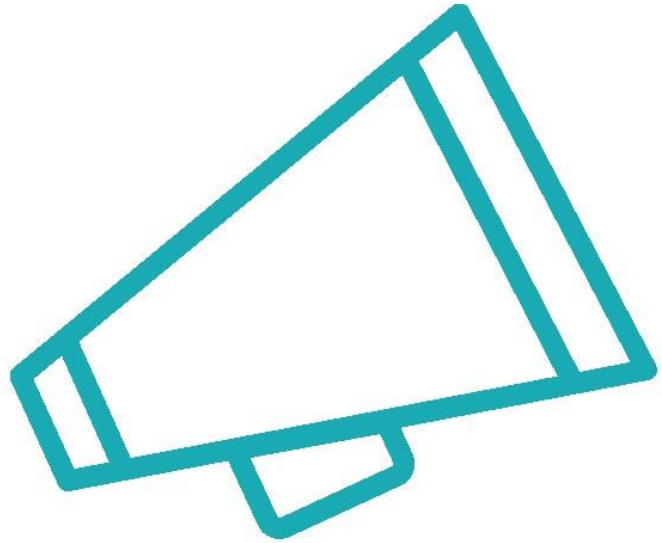
Aspiration is for all ICPs to choose to take part.

- Maximum local flexibility within a national framework
- Not replacing funding for statutory services; NHS link worker funding is separate
- ICP convenes local partner contributions
- Locally set, transparent governance arrangements
- Local flexibility on spend over 10 years
- Use national data collection tools and standards
- Create a stable, strong and sustained SP system

National roll-out

Clear commitment to a national model, not pilots.

- Option for a number of ‘go-early’ sites to illustrate, learn and create confidence in the model
- Simple, rapid application and selection process
- National org overseeing operation of fund
- Core binding agreement
- Agreed reporting arrangements
- Full national evaluation



Learning about impact

Opportunity to fill the data and analysis gaps to drive and scale intelligent commissioning.

- Discrete, separate proposal to capture near-real time data on impacts of SP
- Referral activity, provided activity levels, reduced NHS demand, self-reported health, wellbeing and loneliness status, helping clients meet their needs

National Academy for Social Prescribing

Reflections and Discussion