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# ENVISAGING A SOCIAL PRESCRIBING FUND IN ENGLAND

**A report funded by the National Lottery Community Fund**

**The National Academy of Social Prescribing**
**January 2024**

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# 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