ENVISAGING A SOCIAL PRESCRIBING FUND IN ENGLAND

A report funded by the National Lottery Community Fund

The National Academy for Social Prescribing
December 2024

Contents

Statement of Support from Partners ... **3**
Organisations Involved in the Co-design Process ... **5**
Executive Summary ... **6**
Introduction & Design Principles ... **8**
Purpose of this Report & Our Co-design Process ... 8
Context ... 12
Key Design Questions ... 18
Design Assumptions ... 18
Generating a Social Prescribing Fund ... **22**
Equal Local & National Contributions ... 22
Ambition Commensurate to Need ... 23
Local Investment Share ... 25
Adjusting for Local Needs Including Inequalities ... 27
The Matched National Contribution from Statutory Bodies ... 29
In-built Flexibility for the Future ... 30
Setting Up and Operating the Social Prescribing Fund ... **31**
Local by Default ... 31
Setting up Local Social Prescribing Funds ... 32
Honouring a 10-year Funding Guarantee ... 35
The Option of Local Demonstrator Systems Going First ... 36
National Arrangements & Support ... 37
Demonstrating Impact ... **38**
Augmenting the Case for Social Investment ... 38
Our Core Proposition on Evaluation & Data ... 43
A Long-term Vision for Evaluation and Data ... 44
Get in touch ... **48**

Figures

Figure 1. International Definition of Social Prescribing ... 9
Figure 2. Social Prescribing Activities ... 10
Figure 3. Conditions For Community-Led Initiatives That Support Health & Wellbeing ... 11
Figure 4. Green Social Prescribing ... 13
Figure 5. Community Wealth Fund in England ... 14
Figure 6. The Power of Music Fund ... 17
Figure 7. The Benefits of Multi-Year Funding ... 24

Tables

Table 1. Key Design Questions ... 18
Table 2. Declaration of Local Readiness ... 34

Text Boxes

Box 1. Using Wellbeing to Measure Economic Impacts of Social Prescribing ... 39
Box 2. Evidence on Social Prescribing ... 42
Box 3. Possible Metrics for Regular Analytical Reporting ... 46

Statement of Support from Partners

Our collective view, as independent partners, is that this report is both compelling and timely. That's why we've elected to come together, to add our signatures, as a visible mark of our collective endorsement.

Envisaging a Social Prescribing Fund has been developed through an extensive and open process. Its analysis and propositions bring together the views of national and local funders and leaders from right across the health, charitable, and voluntary sectors. We say with confidence that these ideas for a new Social Prescribing Fund enjoy an unusually wide and deep consensus, particularly the approach to long-term funding.

One of the most striking aspects of this report is how it joins up the dots, both conceptually and operationally, across the differing missions of so many disparate organisations—whether those whose prime dedication is to strengthen communities and civic society, or those most focused on arts and heritage, or on sport and nature, or on improving individual or population health and wellbeing.

Envisaging a Social Prescribing Fund charts a simple, precise, and practical approach to unlocking investment and value. Compared to more traditional one-off bid-grant investment approaches in community-based activities, it offers the promise of leveraging in disproportionately high levels of both investment and social value from each pound.

It brings the simplicity, clarity, and long-term certainty of a powerful new national investment framework to attract partners to the table. It recognises that the Social Prescribing Fund needs to be large enough to make a compelling prospect, able to achieve impact England-wide with no places left out. It brings a proven, practical focus of using social prescribing referrals to tackle inequalities in access to community activities—demonstrated through local case studies and evaluations. At the same time, the Social Prescribing Fund embeds local flexibility about most aspects of decision-making. It knits these different elements together, drawing on learning from past experiences, as well as published and emerging real-world evidence. The design of the Social Prescribing Fund is cognisant of current national and local contexts, and its focus on building social prescribing capacity by supporting the growth of existing social prescribing activities and services, together with widening provision through support for new organisations, is complementary to parallel community investments in infrastructure.

The National Academy for Social Prescribing (NASP) also explores innovative extra options to create what could become an extended set of nationally consistent data and a whole-system improvement support programme. Neither are essential features of the Social Prescribing Fund; but they offer the promise of further enhancing return on investment. They could also be of wider utility, even serving as exemplars for other National Lottery Community Fund activities.

All of us can see significant potential in the Social Prescribing Fund to help strengthen communities and enable better health and wellbeing. For this reason, we can also imagine that once fully established, it could serve as a platform for subsequent sources of national investment; whether, for example, in health improvement or building healthy workplaces.

In our judgement, *Envisaging a Social Prescribing Fund* articulates an innovative opportunity to create a new sustainable funding model for community activities. By awarding NASP the initial development grant, the National Lottery Community Fund (NLCF) has revealed the support and enormous latent potential of prospective partners. What is now clear is that local systems will commit funds if there is equal commitment from a major national funding partner.

We should seize this opportunity for the benefit of all.

Kaveed Ali, COO and Director of Equity, Diversity & Inclusion

Amanda Craig, Director - People & Nature

Shane Devlin, CEO

Mike Farrar, Chair

Professor Kevin Fenton, President

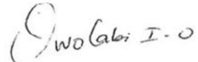
Mark Fisher, CEO

Michael Green, Chair

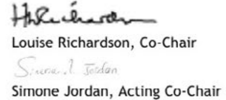
Professor Kamila Hawthorn, Chair of Council

Matthew Leach, CEO

Sarah Metcalfe, Managing Director



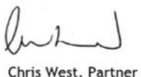
Dr Bola Owolabi, NHS England Director of Health Inequalities



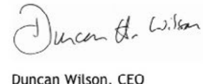
Louise Richardson, Co-Chair

Simone Jordan, Acting Co-Chair

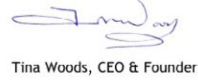
William Roberts, CEO



Chris West, Partner



Duncan Wilson, CEO



Tina Woods, CEO & Founder

Organisations Involved in the Co-design Process

The following organisations (listed alphabetically) provided insights into this work:

Alliance for Better Care

Arts Council England

Association of Charitable Foundations

Bedfordshire Rural Communities Charity

BPRCVS Lancashire Association of Community Voluntary Services

Bradford 2025

Brighton & Hove LGBT Switchboard

Brighter Living Partnership

Bristol, North Somerset & South Gloucestershire Integrated Care Board

Business for Health

Burnley Pendle & Rossendale Community Voluntary Services

CAM Medical Primary Care Network

Cheltenham Peripheral Primary Care Network

Croydon North Primary Care Network

Department for Environment, Food and Rural Affairs

Department of Digital Culture, Media & Sport

Department of Health & Social Care

Department of Work & Pensions

Edith Cavell Surgery

Elm Tree Surgery (Brunel Health)

Frimley Integrated Care Board

Firs House Surgery

Gloucestershire Integrated Care System

Gloucestershire Post-Covid Service

Greater Manchester Integrated Care Board

Greater Peterborough Network

Groundwork London

Hastings Voluntary Action

Healthbridge Direct (Redbridge GP Federation)

Herts and West Essex Integrated Care Board

Holderness Health

Historic England

Horsham Central Primary Care Network

Independent Age

Lancashire & South Cumbria VCFSE Community Futures

Leicestershire County Council

Leicester, Leicestershire and Rutland Integrated Care Partnership

Local Government Group

Local Government Association

Local Trust

London Councils

London Funders

Merton Connected

Mid-Chiltern Primary Care Network

Ministry of Justice

Money & Pensions Service

Movember

National Association for Voluntary & Community Action

National Council for Voluntary Organisations

National Lottery Community Fund

Natural England

NHS Charities Together

NHS Confederation (including 24+ ICP Chairs)

NHS England

NHS Greater Manchester

NHS Lancashire and South Cumbria Integrated Care Board

NHS North Central London

NHS South Yorkshire Integrated Care Board

NHS Sussex Integrated Care Board

North Bucks Primary Care Network

North Central London Integrated Care Board

Nottinghamshire Integrated Care System

Pathways CIC

Robin Hood Foundation

Salford Community Voluntary Services

Sumarian Foundation

Severn Health Primary Care Network

Sirona Care & Health

Social Finance

Somerset Integrated Care Board

Southampton Central Primary Care Network

South Hardwick Primary Care Network

Southeast London Integrated Care Board

Southeast London Integrated Care System

Southmead Hospital Bristol

South Yorkshire Integrated Care Board

Sport England

St Helens South Primary Care Network

St Ives Primary Care Network

Streatham AT medics Primary Care Network

Think NPC

Taurus Healthcare

The Active Wellbeing

The Health Foundation

The Utley Foundation

Thomas Walker Westgage Healthcare

Transformation Partners in Heath & Care

UK Community Foundations

University of Central Lancashire Social Prescribing Unit

Villages Primary Care Network

We are Soda

Worwin UK Foundation

Executive Summary

In Autumn 2023, the National Lottery Community Fund awarded the National Academy for Social Prescribing (NASP) a grant to develop models of shared investment in social prescribing services. Nearly 100 organisations from different sectors contributed to this report. *Envisaging a Social Prescribing Fund in England* charts a way forward. It first sets the context, offers a diagnosis, and establishes design principles for an effective solution. Then, it explains how the fund is generated before moving onto the way it operates. It concludes by setting out evidence with a short and long-term approach to generating data and quantified analysis of impact.

There is nothing novel about either social investment or social prescribing. The innovative leap of the Social Prescribing Fund is to develop a new, England-wide mechanism for social investment in a way that also takes advantage of newly developed social prescribing systems to improve health and wellbeing outcomes, reduce inequalities, strengthen civic society, support economic growth, and moderate avoidable demand on the NHS.

For every pound the NHS invests in social prescribing link workers, we need at least as much investment to increase community capacity. Long-term investment would be more efficient and transformative. A nationwide approach is needed to ensure equity with no places left behind; allied, at the same time, to targeting neighbourhoods and people experiencing the greatest inequalities. The development of this report has revealed strong support and confidence that local partnerships, convened by the 42 Integrated Care Partnerships (ICPs), would find a way of investing a total of £500 million across 10 years, if this is matched by a national investment partner. Stakeholders are unanimous that a fund needs to be big enough to make a difference, with this as the minimum sum. In turn, a national investment partner unlocks a doubling of their own investment. Local partnerships would include the social finance and philanthropic sector, the NHS, and local government. The level of investment in each ICP area would be adjusted for local needs including inequalities by the most appropriate weighted capitation formula. Targeting of funds within places will be more important than the relative distribution across ICP geographies. Each area would decide the geographical footprint of its own fund(s) and governance arrangements. The fund can only buy additional capacity, not substitute existing funding, and could not be held by the NHS or local government.

Leadership from the Voluntary, Community, Faith, and Social Enterprise sector (VCFSE) together with Community groups would be essential. There is a need to enable and encourage comprehensive mechanisms at ICP level for empowering VCFSE organisations and community groups to develop community-led decision making in the fund management and deployment. Principles of co-production are essential to this process offering agency and control to local communities and helping community-led organisations to thrive.

The promise of long-term investment requires certainty of the Social Prescribing Fund's continued existence. A simple binding contract would provide for this—as opposed to the way in which the funds would then make local investments, most probably through simple grants.

As to how the funds should be established and operated, the evidence is clear: local by default. A limited number of systems could rapidly demonstrate their ability to establish the fund and help co-design arrangements for national roll-out. From recent single-sector programmes (for example, the Green Social Prescribing programme) we are confident that all parts of the country would want to take part in the national roll-out. Local readiness would be aided by a clear and timetabled development process.

Since 2019, social prescribing has snowballed from niche interest to mainstream activity. The NHS invests over £100m a year in over 3,600 FTE social prescribing link workers. Evidence of impact is also growing rapidly: on improvements in health and wellbeing, reductions in loneliness, on use of community infrastructure, and moderation of avoidable demand for GPs and hospital emergencies. Using HM Treasury methods we have demonstrated clear return on investment. NASP and partners have already initiated sufficient work to enable effective quantified evaluation from year one. A long-term plan would create national metrics across the benefit categories. An expert data and analysis hub would produce real-time data to support ongoing system improvement, as well as periodic reporting on impact.

Introduction & Design Principles

Purpose of this Report & Our Co-design Process

1. **The National Lottery Community Fund (NLCF) is the biggest single funder of community activity in the UK**, awarding £615 million in 2022/2023 in 13,858 grants of which 8,931 supported health and wellbeing[1]. The NLCF has been and continues to be a significant investor in social prescribing. The international definition of social prescribing agreed last year by 26 countries is set out in *Figure 1*. Strategic programmes such as *Ageing Better* (£87m programme over seven years)[2] [3] and *HeadStart* (£67.4 million programme over six years)[4] are in part adopting social prescribing approaches. The NLCF has also been directly investing in social prescribing activities (*Figure 2*) including over £60 million in the five years prior to the NLCF's 2019 report *Connecting communities and healthcare: making social prescribing work for everyone*[5] and more recently the £3 million *Healthy Communities Together* partnership with the King's Fund[6] and £5 million in phase two of the *Health Equality* programme[7]. The NLCF further made a £200 million investment in neighbourhoods through the Big Local programme led by the Local Trust, which is now drawing to a close after more than a decade[8]. Learning from this innovative, decade-long programme identified four key conditions for community-led initiatives to support health and wellbeing, summarised in *Figure 3*.

2. **Building on these previous investments in social prescribing, the 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 building social prescribing capacity.

1 *The National Lottery Community Fund, Annual Report and Accounts 2022-2023*.
2 McKenna K, Williams J, Humphreys A, Campbell-Jack D, Whitley J, Cox K. (2022). *The Ageing Better Programme: Summative Report*. Ecorys.
3 *Social prescribing for children and young people Headstart* (2023). *National Children's Bureau*.
4 Holland M. (2023). *HeadStart national evaluation final report. Supporting the mental health and wellbeing of children and young people: the role of HeadStart*. Evidence Based Practice Unit.
5 Davison E, Hall A, Anderson Z, Parnaby J. (2019). *Connecting communities and healthcare: Making social prescribing work for everyone*. The National Lottery Community Fund. Version 1. Reference: KL19-03.
6 Maybin J, Fenny D, Chauhan K. (2023). *A Reflective Learning Framework for Partnering*. The King's Fund.
7 Langdale E, O'Flynn L, Jackson-Harman K. (2022). *Learning From Phase 2 of the Place Based Social Action Programme*.
8 *The Halfway Point. Reflections on Big Local*. (2019). Local Trust.

Figure 1. International Definition of Social Prescribing

Social Prescribing

Social prescribing is 'a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and well-being and to strengthen community connections.'

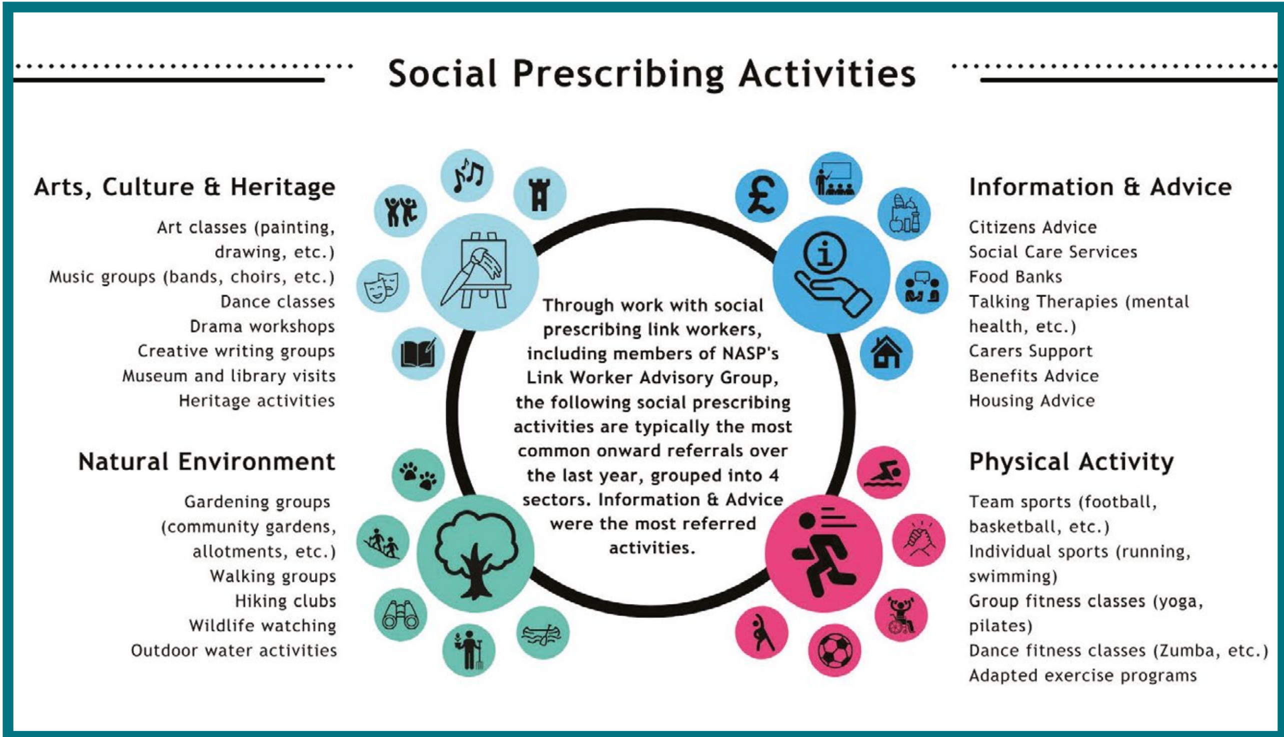
Muhl C, Mulligan K, Bayoumi I, Ashcroft R, Godfrey C. (2023) Establishing internationally accepted conceptual and operational definitions of social prescribing through expert consensus: a Delphi study. BMJ Open. Jul 14;13(7)

3. **The purpose of this report is to set out options for establishing new models of shared investment funds to build social prescribing capacity.** That would: (i) support the additional growth of existing social prescribing activities and services; (ii) widen the reach and range of activities and services through support for new organisations to address gaps in provision and improve access for all social groups in all parts of the country; (iii) empower local VCFSE organisations and community groups to develop greater community-led decision making and agency in the fund management and deployment through co-design and production processes; and (iv) tackle inequalities through effective targeting and distribution of funds through means 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, heritage and the natural environment (see section below on *Adjusting for Local Needs Including Inequalities*).

4. **The report is also intended to assist NLCF's own future investment plans in line with its 2023-2030 strategy *It starts with community*[9].** NLCF has set four main missions: connected communities; environmentally sustainable communities; help children and young people to 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 better community connection for all ages, including children and young people, and by moderating avoidable NHS activity and the associated carbon emissions. **This report also addresses the clear untapped opportunity for national and local investors to unlock stronger synergies and benefits in a way that addresses inequalities.**

9 *It starts with community. The National Lottery Community Fund Strategy 2023-2030*

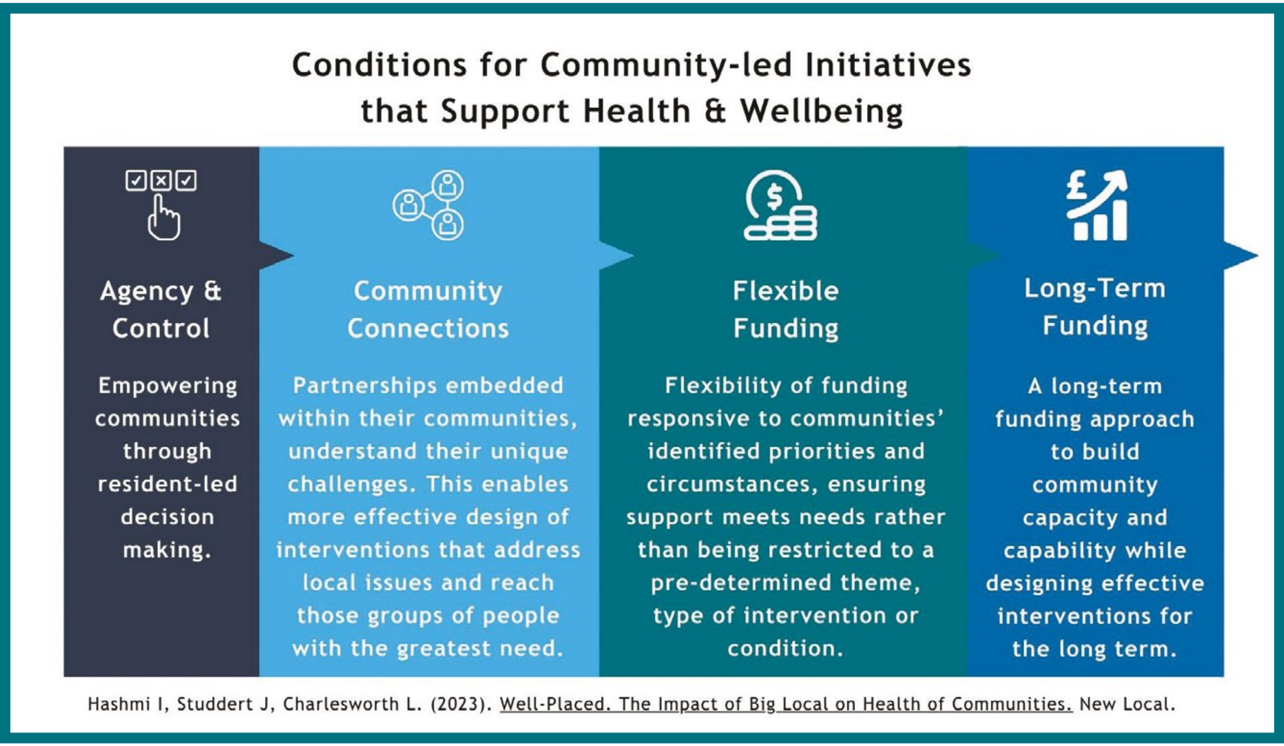
Figure 2. Social Prescribing Activities



5. **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 the process including 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 Digital, Culture, Media & Sport (DCMS), the Department of Health and Social Care, 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 from across the arts and heritage, sports, and natural environment. Working with the NHS Confederation, we benefitted from discussions with chairs of Integrated Care Partnerships (ICPs). NASP engaged national arm's-length bodies such as Arts Council England, 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. In total nearly 100 stakeholders from a wide range of organisations have been engaged in the co-design process, as listed earlier.

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. **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.** With our partners we have developed our ideas into concrete proposals, 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. Beyond NLCF and Government, it may also be useful for the wider social finance sector.

Figure 3. Conditions for Community-led Initiatives that Support Health & Wellbeing



Context

7. In recent years, social prescribing has expanded dramatically in England, with over 2.6 million referrals by Social Prescribing Link Workers. The stories are compelling, and the evidence base is increasing (*see Box 2: Evidence on Social Prescribing*). Social prescribing enjoys tremendous grassroots, cross-sectoral and cross-party political support[10] [11] [12] [13]. From being a niche interest, it has become a mainstream, UK-wide activity. NASP is also supporting the global development of social prescribing[14], and is on course to become the first World Health Organisation Centre of Excellence for Social Prescribing, working with an international network of over 30 countries[15].

8. NHS funding for existing NHS social prescribing link workers (SPLW), currently operates through a system of legal entitlements in the 2019 five-year update to the national GP contract[16]. Primary Care Networks are choosing to spend over £100 million each year of their funding on over 3,664 full-time equivalent (FTE) link workers[17] [18]. The recent NHS Long Term Workforce Plan anticipates that the NHS will reach 9,000 link workers by 2036/2037[19].

9. **Furthermore, there is vast untapped potential to expand beyond NHS referrals, especially in three spheres:**

(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[20];

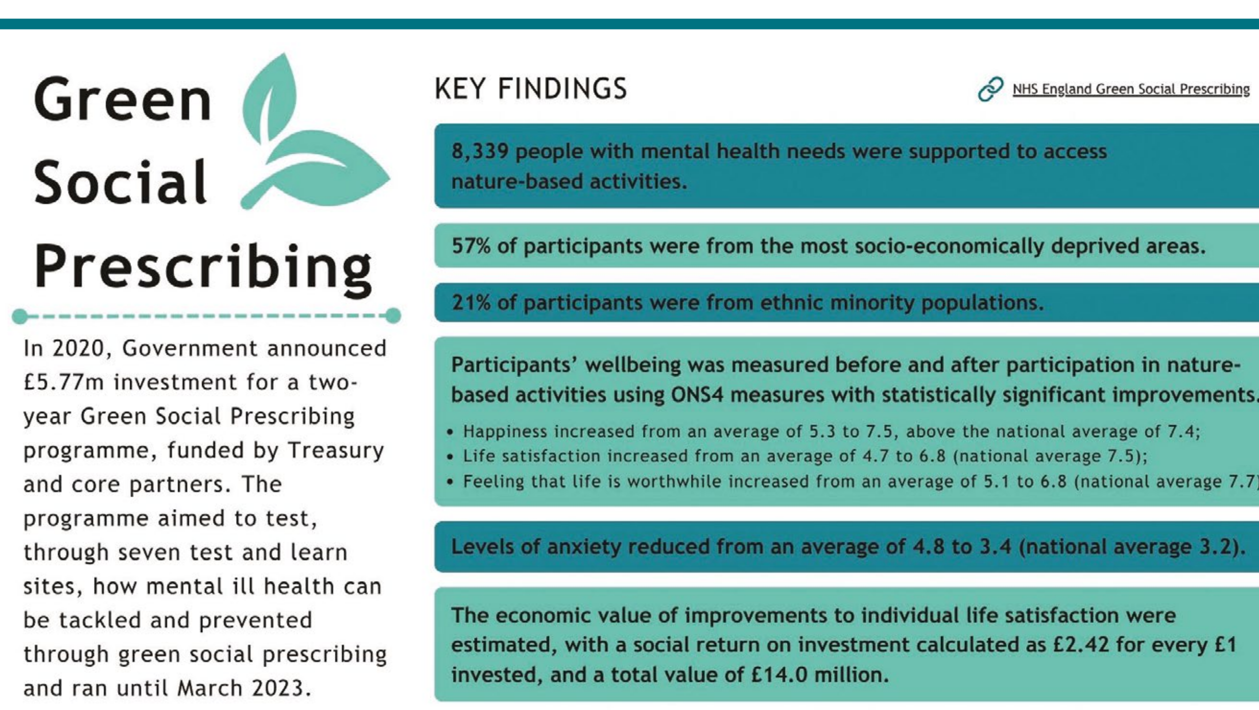
(ii) **to help people get back into work.** The new Department for Work & Pensions (DWP) *WorkWell* programme intends to use a social prescribing approach[21]. Operationally, NASP sees this working best if the additional dedicated connecting roles that will be required for the Programme are integrated with the existing NHS link workers, as part of a coherent local approach. Otherwise, *WorkWell* staff may lack both the skills about what works, and the knowledge of local activities and services available; and

(iii) to support self-referral, by friends and family, or by local community. 85% of the

10 *The NHS Long Term Plan*. (2019). NHS.
11 *Exploring perceptions of green social prescribing among clinicians and the public* (2023). Department of Health and Social Care.
12 *Social prescribing: applying All Our Health*. (2022). Office for Health Improvement and Disparities.
13 *Social prescribing*. National Association for Voluntary and Community Action (NAVCA): online reports, learning, and case studies.
14 Morse DF, Sandhu S, Mulligan K, et al.(2022). *Global developments in social prescribing*. *BMJ Global Health* 2022;7:e008524.
15 *Social Prescribing Around the World*. National Academy for Social Prescribing (NASP). International Programme.
16 *Workforce development framework: social prescribing link workers*. (2023). NHS England
17 *Primary Care Workforce Quarterly update, 31 December 2023*. (2024). NHS England.
18 *Network Contract Direct Enhanced Service: Additional Roles Reimbursement Scheme Guidance*. (2019). NHS England
19 *NHS Long Term Workforce Plan*. (2023). NHS England
20 *The Future of Social Prescribing in England*. (2023). National Academy for Social Prescribing.
21 *WorkWell prospectus: guidance for Local System Partnerships*. (2024). Department for Work and Pensions. Department of Health and Social Care.

referrals in NASP's *Thriving Communities* social prescribing programme were from outside the healthcare link worker system[22] . Social prescribing systems have the potential to become the main, at-scale means to unlock health and economic improvements in local populations and address inequalities because of their ability to reach people with the greatest health and wellbeing needs, and to help individuals with what works best for them. This enhanced reach through social prescribing into deprived communities is illustrated in both the Thriving Communities programme and the cross Government Green Social Prescribing programme[23] (see Figure 4).

Figure 4. Green Social Prescribing



22 Parkinson A, Tanner S, Burgess A, Usher S, Knight E, Heath O. (2022). *Evaluation of the Thriving Communities Fund*. Wavehill: social and economic research.

23 Haywood A, Dayson C, Garside R, Foster A, Lovell R, Husk K, Holding E, Thompson J, Shearn K, Hunt A, Dobson J, Harris C, Jacques R, Northall P, Baumann M, Wilson I. *National Evaluation of the Preventing and Tackling Mental Ill Health through Green Social Prescribing Project: Interim Report - September 2021 to September 2022*. (2023). Department for Environment, Food and Rural Affairs.

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) the Department for Environment, Food and Rural Affairs (Defra) led a cross-Government *Green Social Prescribing* programme funded by Treasury, which targets mental health needs; (ii) the NASP, Utley Foundation and Arts Council England *Power of Music Fund*[24], providing music-related activities through social prescribing to support people living with dementia (*Figure 6*); (iii) the Arts Council England, Natural England and Historic England funding of the NASP *Thriving Communities* programme, and (iv) Department for Transport through its *Active Travel Social Prescribing* pilots[25]. Through the Department for Levelling Up, Housing and Communities (DLUHC) the Government is also planning on investing £2.6bn, through a UK Shared Prosperity Fund, in social infrastructure in our most deprived neighbourhoods to help tackle geographical inequalities[26].

Figure 5. Community Wealth Fund in England

Community Wealth Fund in England

In March 2023, the government confirmed that community wealth funds would be added to the list of beneficiaries of the dormant assets scheme. The Dormant Assets Scheme is led by the financial services industry and backed by the government. Since 2011, the Scheme has unlocked £982 million of dormant assets for social and environmental causes across the UK. The expansion of the Scheme could potentially unlock a further £738 million in England over time.

Initial funding of the Community Wealth Funds will be £87.5 million from the £350 million expected to be released by the Dormant Assets Scheme in England over 2024 to 2028. The same amount will be dedicated to each of three other causes: youth, financial inclusion and social investment.

The National Lottery Community Fund will deliver the Community Wealth Fund with support from the Department for Digital, Culture, Media & Sport and with advice from partners, including members of the Community Wealth Fund Alliance.

Technical consultation on a Community Wealth Fund in England. (2023). Department for Culture, Media and Sport. Department for Levelling Up, Housing and Communities.

24 *Power of Music Fund*. (2023). National Academy for Social Prescribing (NASP).
25 *Active travel social prescribing pilots: local authority allocations*. (2023). Active Travel England.
26 *UK Shared Prosperity Fund: prospectus*. (2022). Department for Levelling Up, Housing and Communities.

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 at the time by NLCF's excellent report *Connecting communities and healthcare: making social prescribing work for everyone*[27], which 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'.

12. **The lack of sustainable investment in social prescribing capacity now serves as the biggest brake on the potential for social prescribing to improve health and wellbeing outcomes, reduce inequalities, moderate avoidable demand on the NHS, strengthen civic society, and support economic growth**. This is particularly true in the most deprived areas, which evidence shows often suffer from a lack of basic community infrastructure as well as a weaker VCFSE sector[28]. Furthermore, voluntary sector organisations have also experienced major funding difficulties in recent years, given real-term cuts to Local Authority budgets, the COVID-19 pandemic, and the cost-of-living crisis[29][30][31]. Consequently, many social prescribing activities are now running at maximum capacity, and indeed hold waiting lists[32]. There is limited scope for further expansion (as for example envisaged under *WorkWell*) without relatively modest levels of additional sustained investment in activities, services and organisations and of course the overhead costs associated with these (including support for volunteers). As other programmes invest in infrastructure, such as the *Community Wealth Fund (Figure 5)*, separate and distinct investment in social prescribing capacity can help make best use of those assets, in a mutually reinforcing way[33].

13. **There is a strong consensus amongst those stakeholders we consulted that addressing the inadequate, fragmented, and short-term funding to build social prescribing capacity is urgently required**. Of course, there will always be a need for one-off, 'pump-prime' funding for specific activities or client groups. But stakeholders told us the critical need is for *bigger*, more *certain*, *longer-term*, *joined-up*, *repeat investment* to support the scale and breadth of social prescribing activities needed to meet the existing and rapidly growing demand and in a way that reduces health inequalities.

27 Davison E, Hall A, Anderson Z, Parnaby J. (2019). *Connecting communities and healthcare: Making social prescribing work for everyone*. The National Lottery Community Fund. Version 1: KL19-03.
28 *Left behind? Understanding communities on the edge*. (2019). Local Trust and the Oxford Consultants for Social Inclusion.
29 Gilburt H and Ross S. (2023). *Actions to support partnership. Addressing barriers to working with the VCSE sector in integrated care systems*. The King's Fund
30 Jopling K and Cole A. (2022). *Changing lives, changing places, changing systems. Making progress on social prescribing*. National Voices
31 Cole. A, Jones D, Jopling K. (2020). *Rolling Out Social Prescribing. Understanding the experience of the voluntary, community and social enterprise sector*. National Voices.
32 *Charity Resilience Index*. (2023). Charities Aid Foundation.
33 Brodie E. (2023). *Learning from social prescribing*. National Association for Voluntary and Community Action (NAVCA).

14. **The clear view of stakeholders is this challenge could be readily addressed, not least given the widespread interest of many different funders in developing innovative models of investment.** At NASP, unlocking a solution to this hitherto failure of collective action is a top priority. In December 2023, we published our *Vision for the Future of Social Prescribing in England*, setting out the five inter-linked actions needed to accelerate the scale and impact of social prescribing in England over the next five years[34]. 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[35]. In this report, 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), National Voices, and evaluations of previous NLCF programmes.

15. **Our vision of shared investment funds is not just an aspiration**. Some early progress is happening. For example, 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 and services[36].

16. Overseen by NASP, *The Power of Music Fund*, set out in detail below, and *Green Social Prescribing* are also models of effective shared investment.

17. The **process undertaken through this NLCF development grant has revealed that the appetite now exists in many 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 test the model if there is a national investment partner. As well as generate much needed investment, we have heard that the design of the model will also serve to stimulate and strengthen local partnerships.

34 *The Future of Social Prescribing in England*. (2023). National Academy for Social Prescribing (NASP).
35 Kimberlee R, Bertotti M, Dayson C, Elston J, Polley M, Burns L, Husk K. (2022). *Sustainable funding models for social prescribing*. National Academy for Social Prescribing
36 *Introducing Community Chests - a model for a thriving voluntary and community sector o support social prescribing in London*. (2022). NHS Healthy London Partnership.

What is the fund?

The Power of Music Fund is a collaboration lead by the National Academy for Social Prescribing (NASP) to test new models of investment in social prescribing activities-specifically music for dementia. The Fund supports grassroots music projects, including dementia choirs and music groups for carers, especially in parts of the country where the needs are the greatest. It will boost research and, through a new Centre of Excellence, create lasting change in the way the health system works with community groups.

NASP has worked with a wide range of partners and stakeholders to co-design and launch the 3-year, multi-million-pound Fund, with investments from The Utley Foundation, Arts Council England and Music for All, as well as private donations and public fundraising. This innovative shared investment fund is in high demand and remains open to other potential investors.

What will the fund achieve?

The Fund will invest in grassroots social prescribing dementia projects with improved access to music and gather evidence of the benefits to people living with dementia and the wider health and social care system.

By building bridges between the health and social care system and community groups, we can help to take pressure off health and care services and ensure that more people are able to live well with dementia.

Through strategic shared investment – drawing on both grassroots and corporate expertise – we intend to create financially stable, easily accessible music for dementia groups for years to come.

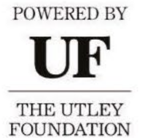
Why is the fund needed?

Music can be a lifeline for people living with dementia and their carers. While dementia is a progressive condition without a cure, music can improve mood, offer opportunities for self-expression, and creativity, strengthen personal relationships and reconnect people to those they love.

However, dementia choirs and other grassroots music groups can struggle to meet costs from one week to the next. Too often their work is not integrated with the health system, meaning that people miss out on accessing activity that are available in their communities. This is what we need to change. The first round of Small Grants offers 70 multi-year grants to providers across the UK, benefitting over 4,500 people and championing innovators and best practice in the field, as well as focusing on areas of high need.

The first Centre of Excellence, led by a charity, has secured £771,000 in matched funding from their local partners, including the local health system. Other proposed sites have demonstrated similar success with match funding including investment from partners as diverse as a premier league football charitable trust, universities and local community fundraising projects.

The Centres will test new approaches to embedding music as part of dementia care, gather evidence of cost savings for the NHS and local authority, and design new models of care which can be scaled up and spread across the UK.



Key Design Questions

18. Our design process was structured around four questions:

Q1. **Fund generation** – What is the best way of maximising investment from diverse investors?
Q2. **Fund operation** – What are the options for managing the investment budget, 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?

Table 1. Key Design Questions

Design Assumptions

19. Through our discussions with stakeholders and analysis of lessons from other programmes, we have developed 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 is to generate financial investments from multiple sources - local statutory partners, businesses, employers and philanthropists, and national funders.

(ii) **Unlock an ambitious-enough level of investment to make a difference**, 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 provide clarity and certainty; incentivising investment in social prescribing activities and ensuring accountability while also reducing transaction costs. It would be more attractive to many investors than the current fragmented approach, leveraging investment and spreading risk.

(iv) **Adopt a long-term approach to fund generation and grant-making.** The matched investment rules should 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 providers, to provide financial stability to help promote innovation, build organisational capacity, and thereby generate scale and resilience.

(v) **Centre the approach on existing local partnerships**. The 42 Integrated Care Partnerships (ICPs) in England are key, as well as for example Local Infrastructure Organisations, as a way of helping with health generation and community development, across the NHS, Local Authorities (LAs), and VCFSE partners.

(vi) **Operate the Social Prescribing Fund at ICP level or 'place footprint' rather than hold and manage the money in a 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. For example, in large ICPs such as North East and North Cumbria, West Yorkshire, there might perhaps be an even stronger focus on place than in the smallest such as Dorset. The design of the funds should allow for flexibility to promote place-based models.

(vii) **Enable and encourage comprehensive nation-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 inequality and continuing the current piecemeal approaches to funding.

(viii) **Reflect additional needs for inequalities in the design of investment arrangements**. National rules around matched funding arrangements should take account of additional needs including inequalities, by using best available per capita weighted formula.

(ix) **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 community-based social prescribing activities.

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

(xi) **Start with the community.** Enable and encourage comprehensive mechanisms at ICP level for empowering VCSFE organisations and community groups to develop community-led decision making in the fund management and deployment. Principles of co-production are essential to embed in this process offering agency and control to local communities and helping community-led organisations to thrive.

(xii) **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.

(xiii) **Allow local flexibility about how the Social Prescribing Fund is spent within broad guiding principles**. The fund would only invest in additional activity, and extra non-clinical community services, rather than substituting for what already exists. This is essential to ensure that new national investment is genuinely matched by new local contributions. The fund 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. NASP would also expect any conflicts of interest to be managed explicitly as part of effective local governance, for example in line with the extant February 2017 national guidance that applies to all ICBs[37]. Section 5 refers to the actions expected of all decision-making forums and their participants, including those making procurement and/or grant making decisions, to manage conflicts of interest.

(xiv) **Use and improve data**. We already have the potential to provide some regular, systematic and aggregable social prescribing data across England. Over time, there is a clear option to go much further, even using the fund as an exemplar on data. In the final section of this report, we set out the long-term potential for data and analysis to cover all aspects of what is being bought (the spend on activities and referrals), for whom, and with what effect (e.g., improvements in self-reported satisfaction, health and wellbeing status, reductions in loneliness, moderation of avoidable NHS utilisation across primary and secondary care, and potentially improved employment status and productivity gains).

37 *Managing Conflicts of Interest in the NHS*. (2017). NHS England.

(xv) **Commit to a nation-wide programme, with the option of making early progress through demonstrators**. A number of ICPs are enthusiastic to apply a 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 data flows working with national partners; (iv) work together as a community of peers to learn from each other, and also working with a national oversight organisation help to identify and share 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 an agreed framework.

20. The following sections of the report expand on how these design assumptions should be put into practice.

Generating a Social Prescribing Fund

21. 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, building bridges across the statutory sectors and the VCFSE.

Equal Local & National Contributions

22. **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).**

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

24. **We have designed this 'buy one get two' model 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, while also reducing the risk to individual investors. Furthermore, by building mutual interdependence in fund generation, this model should also help cement stronger partnership working across sectors and all contributors.

25. **All investors want to know that their contribution will lead to improvement, rather than be used as a reason to withdraw existing funding**. During the development of this report, some local systems asked if they could brigade together pre-existing investment in services to count towards the local funding requirement. This is entirely understandable given budgetary pressures[38]. However, they also recognised that to do so would contravene the spirit and principle of matched funding, and risk cannibalising existing investments in the VCFSE sector. **The clear consensus reached is that rebadging existing investments would not be acceptable**. The Social Prescribing Fund is about securing additional capacity and impact, which would also be demonstrated by our proposals in the Demonstrating Impact section 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 activities, it is not purporting to be the sole nor exclusive way of funding the future expansion of those activities. Additionally, the fund should never replace NHS funding of NHS clinical services, or core funding by other statutory bodies.

38 Warner M and Zaranko B. *Pressures on the NHS*. (2021). The Institute for Fiscal Studies.

26. At the same time as insisting on a set of core requirements for the Social Prescribing Fund, it may also make practical sense for local systems to operate and grow the fund as part of an even bigger local pot. Nothing in this report rules out that option.

Ambition Commensurate to Need

27. **As the NHS continues to invest in link workers and referrals, so there needs to be commensurate investment in activities, services and organisations for those referrals[39]. A simple rule is that for every £1 spent annually on link workers, so we should aspire to see the Social Prescribing Fund bringing in *at least* the same for building social prescribing capacity, e.g. activities, services, and organisations**. This would only form a contribution to the total cost of capacity building. This formula would generate an England-wide fund of *at least* £100 million per annum at today's prices.

28. **We have tested this principle extensively with stakeholders. The fund needs to be big enough to make a material difference, whilst also being affordable.** Although a number of local systems argued that the amount needed to be bigger, they also agreed that this was a realistic and useful minimum. We heard a consensus view that £100 million a year should be the starting point for the Social Prescribing Fund: the 'critical mass' required to make it work well. It is worth noting that many local pilot programmes focusing on just one type of activity are investing more than this per head of population.

29. **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 programme, which gave 150 communities approximately £1 million to improve health and wellbeing over 10 years[40]. The recent evaluation report of Big Local was able to show statistically significant improvements in health and wellbeing compared to comparator areas by using national Census data[41]. Recent research published in February 2024, by the Institute for Voluntary Action Research (IVAR) sets out a compelling rationale for the benefits of longer-term funding, as well as it being cited as a top priority by 92% of 1,241 survey respondents. See Figure 7 for further details.

30. **£100 million per annum would generate a £1 billion Social Prescribing Fund over 10 years at today's prices.**

31. We also propose that a principle underpinning the design of the Social Prescribing Fund is the **investment requirements, both locally and nationally, would logically be uprated in line with the Consumer Price Index (CPI), to avoid erosion of purchasing power**. The absence of automatic uprating has been a significant long-term issue for the VCFSE sector[42]. Our proposed mechanism is intended to address the rise in organisations' operating costs, as opposed to the separate issue of funding to address rising demand.

39 *Workforce development framework: social prescribing link workers*. (2023). NHS England.
40 *The Halfway Point. Reflections on Big Local*. (2019). Local Trust
41 *Left behind? Understanding communities on the edge*. (2019). Local Trust and the Oxford Consultants for Social Inclusion.
42 *Charity Resilience Index*. (2023). Charities Aid Foundation.

The Benefits of Multi-Year Funding

'The difference for charities between single year and multi-year is so vast – in the administrative burdens, the level of planning and strategic thinking that is possible, and the relationships with funders.'

Single-year grants continue to be the dominant practice among UK grant makers. In 2021-2022, just 13% of grants were for three or more years, and 77% were for a year or less.

Multi-Year Funding Benefits Include:

1. **DELIVERING EFFICIENCIES FOR FUNDERS AND CHARITIES**
Small and medium-sized charities are estimated to spend more than a third of the income raised through grants on making grant applications.

2. **PROVIDING CHARITIES WITH CERTAINTY AND STABILITY WHICH ENHANCES THEIR ABILITY TO PLAN**
Having access to multi-year funding can reduce the risk of a shortfall in income, allowing charities to budget confidently and operate with lower reserves. When charities can plan confidently, they become more strategic, which benefits the overall delivery of their mission.

3. **SETTING REALISTIC TIMEFRAMES FOR THE DELIVERY OF ACTIVITIES AND CHANGE**
Multi-year grants align with the timeframes during which meaningful change can occur. This increases the chances that long-term initiatives will be successful. Multi-year funding is especially important when tackling enduring and complex problems and where funders desire social and 'systems change'.

4. **ENHANCING ORGANISATIONAL CAPACITY**
A significant benefit of multi-year grants is the way it allows charities to build organisational capacity. As well as providing long-term stability, multi-year grants help charities to invest with confidence in their organisation, with particular benefits around the management of human and financial resources.

5. **BUILDING TRUST AND ENABLING MORE OPEN RELATIONSHIPS**
Working together over a long period helps to deepen relationships and build trust. This can lead to a more collaborative and mutually beneficial relationship between the funder and grant recipient, which is more likely to result in the achievement of shared goals.

6. **SUPPORTING BETTER LEARNING TO IMPROVE PRACTICE**
Multi-year funding can improve programme quality by allowing time to develop operational learning, and for this to be recycled into making programme improvements over the course of a grant.

Mills, C., Firth, L. and Cairns, B. (2024). Time to end the dominance of short-term grants: The evidence for multi-year funding. London: Institute for Voluntary Action Research.

Local Investment Share

32. **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, nor do they have a role in wider local fundraising or represent the VCFSE sector. But they do have a critical role in promoting action and investment to improve health, reduce inequality and strengthen partnership working across private and public sectors including the VCFSE sector and community groups. So, they are ideally placed to lead the conversation and broker contributions from the local statutory sector, most likely as the bulk of the local investment share. The Social Prescribing Fund would be a specific, clear, and actionable opportunity for them to generate added value.

33. **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 between different parties is for local determination.

34. **We propose that the local investment level would be set at a mean of 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. The actual amount per ICP would be adjusted to take account of health needs including inequalities, as discussed further below.

35. Given the scale and duration of the funding, we propose to **establish a fixed investment requirement across all 42 Integrated Care Partnerships, with the specific amount for each ICP adjusted for relative need including inequalities**. In designing the scheme, we recognise that Local Authority and NHS partners are all under unprecedented financial pressure, and many will find it challenging to contribute their share of the local investment, *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. Without it, there is no nationwide equity. It takes away what would otherwise be a difficult and time-consuming local debate about how much to invest. It also removes the affordability risk for national investors of having to match higher-than-expected local contributions. We received strong stakeholder support for this approach.

36. **Furthermore, we propose that the commitment by local systems and the national investor(s) to the Social Prescribing Fund would be for the entire duration of the fund, i.e. over a 10-year period** with a binding contractual commitment from local and national investors alike. A ten-year contractual commitment provides the certainty and clarity of investment protection from what could become ever more intense day-to-day financial pressures. We have heard that the amounts involved are not so large as to render that impracticable. After all, many investments in physical capital commit public payers to vastly bigger revenue flows over decades.

The 10-year duration is for the existence of the fund itself. It would be entirely a matter for local systems to decide how to invest its fund, on what activities, over what duration including potential break points.

37. **The Social Prescribing Fund is intended to provide an attractive investment vehicle for local communities including businesses, philanthropic organisations, foundations and individuals.** From philanthropic investors we have heard clear enthusiasm subject to certain assumptions. Any arrangements need to (i) remove uncertainty about there being a 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. From the VCFSE sector and community groups there was a strong call to ensure mechanisms at ICP level for empowering VCSFE organisations and community groups to develop community-led decision making in the fund management and deployment. Principles of co-production are essential to embed in this process offering agency and control to local communities. The ICP geography would need to demonstrate that the local investment share includes some contribution from non-statutory organisations. The ICP itself might well not be the vehicle for organising these, but it would need to be sure that an effective and appropriate arrangement is in place. For example, the Community Foundation might be able to play a role. 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 (for example, the local VCFSE alliance).

38. **Some philanthropic organisations and the social finance sector more widely have told us that they—and potentially large employers—may be interested in investing on a multi-geography or even national basis.** NASP could help by offering a ‘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 ICPs who are participating according to weighted population;

    (ii) *targeted*: the opportunity to focus on particular geographies of greatest interest to them (e.g. either regionally; or say 10-20% of ICP areas with highest levels of deprivation); or

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

39. Our thinking is that such investments would best count, for the purpose of matched funding, towards meeting the local investment share. Timing is probably too constrained for this arrangement to work well for any potential local demonstrator programme, as opposed to wider national roll-out.

Adjusting for Local Needs Including Inequalities

40. **A local flat rate contribution of 90p per head of ICB population—whether Manchester or Surrey—is clearly wrong and not what we propose**. The question of how best in practice to target an England-wide social prescribing fund, both its differential generation across ICP geographies, and subsequent distribution within neighbourhoods, is complex with no obvious, perfect answer. A core design principle is that a fund should be comprehensive across England, with no places left behind. **Consistent with this, we have heard unanimous support for an objective, formula-based model that equitably reflects health and wellbeing needs including health inequalities**. In an ideal world, a weighted-capitation model would be used *based on differential population needs specifically for social prescribing activities*.

41. **Although the perfect formula does not currently exist, we can nonetheless use best available proxies**, drawing on the available evidence, including for example the 2023 analysis of different public sector funding models by the Institute for Fiscal Studies (IFS). **On balance, our proposal is to use the existing subset of the NHS ICB allocation formula for general practice** (ideally stripped of the dispensing doctors' additional costs adjustment)[43]. **It reflects population health needs and has the benefit of including a specific 15% population adjustment for inequalities for unmet needs using Index of Multiple Deprivation scores. As set out by the IFS, the NHS formulae better reflects the latest population estimates than other comparable public sector allocation formulae** – which is essential, given major ongoing changes in population distribution across the country[44]. Pragmatically, it is also well understood by ICPs. We are seeking to get the balance right between making tangible progress towards addressing inequalities whilst also avoiding the real risk of excluding some ICPs from the programme on affordability grounds solely arising from any excessive distributional impact of the weighting.

42. **The 90p per head of ICP population is just the mean figure across all ICPs; the actual amount for each ICP level contribution would be weighted using the NHS ICB allocation formula for general practice**. We would test this weighting method further through a dedicated workshop, and work with the NHS England analyst team who lead on financial allocations to make the final calculations. In this way we can, in the short term, accommodate variations in social prescribing needs across the country at ICP level. For the longer-term, we would like to be able to sponsor the development of a bespoke formula for social prescribing activities, drawing on cross-sectoral expertise, including but not limited to ACRA (the highly regarded independent expert Advisory Committee for Resource Allocation, for the Department of Health and Social Care and NHS England, first established in 1976).

43 *Technical guide to allocation formulae and convergence for 2023/24 to 2024/25 revenue allocations*. (2024). NHS England.
44 Ogden K, Phillips D, Sibieta L, Warner M, Zaranko B. (2022). *Does funding follow need? Analysis of the geographic distribution of public spending in England*. Institute for Fiscal Studies. IFS Report R224.

43. It is also important to note that the Social Prescribing Fund is not allocating the totality of resources available for all social prescribing activities, services and organisations. Instead, it is a supplementary fund, adding to the existing base of infrastructure and services. **So, there is also an argument that the distribution of the fund should also consider relative gaps in the local supply of social prescribing activities and services, relative to actual social prescribing need, in order to help fill holes and level-up**.

44. **We have heard that it is important for this challenge to be directly addressed through the ways that local systems distribute those resources. The internal distribution of resources within each of the ICP geographies will be even more important in tackling inequalities and unmet need than the relative distribution between the 42 health systems**. Systems will be mindful of the risk of 'spreading the butter too thinly'. Instead, learning from the experiences of the *Big Local* and the EU predecessor arrangements to the UK Shared Prosperity Fund[45], the greatest benefits are likely to be yielded from targeted investment. We highlight two sources of data as likely to be of particular use as local systems make their own decisions: (i) the demand for activities as revealed by link workers and their referrals; and (ii) the Community Needs Index 2023, developed by Oxford Consultants on Social Inclusion on behalf of the Local Trust, which assembles a wide variety of measures of community needs and assets, helpfully now at Lower Layer Super Output Area (LSOA) level rather than ward level[46].

45 *UK Shared Prosperity Fund: prospectus*. (2022). Department for Levelling Up, Housing and Communities
46 *Community Needs Index - measuring social and cultural factors*. (2023). Oxford Consultants for Social Inclusion.

The Matched National Contribution from Statutory Bodies

45. **Following confirmation of the local investment share of a mean of 90p per head of population, in line with the rules of the fund, it is then automatically matched with exactly the same amount - an additional national mean of 90p, as adjusted for needs including inequalities.**

46. **We have designed the proposals for the first tranche of 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 Community Fund, or Government, or both working together.

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

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

    (ii) although the Social Prescribing Fund is only buying supply-side activities 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; and

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

48. The Social Prescribing Fund has the potential to be a much better value proposition than the many opportunities for standalone investment in community activities, for example through traditional grant-making processes where a single party applies to a single investor.

49. **Under the rules of the fund, the national contribution would only be activated when the local investment threshold has been met**. Whilst local participation is voluntary, we would strongly 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.

50. **Learning from the experience of the Local Trust's *Big Local* endowment from the NLCF, one approach to simplify operations for the national investor and maximise value is to secure an expert national delivery partner**. NASP could oversee the operation of these rules including transfer of funds and regular reporting arrangements, as well as support local improvement activities and identification and spread of best practice. 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 the *Setting Up and Operating This Fund* section of this report.

In-built Flexibility for the Future

51. If the approach in this report comes to fruition, it is likely to stimulate additional investor appetite. For this reason, the Social Prescribing Fund has been designed from the start with future expansion in mind.

52. **We have heard that once established the Social Prescribing Fund is likely to generate rapid further momentum. It has the clear potential to serve as a more powerful, new overarching vehicle for future national investments in health and wellbeing and community development**. The *Introduction & Design Principles* section of this report outlined some of the investments that the National Lottery Community Fund and different Government departments have previously made in health and wellbeing, and social prescribing activities specifically, largely without matched funding, and not explicitly connected to the NHS social prescribing system.

53. **This report mainly illustrates 'tranche one' of the Social Prescribing Fund, but we are not limiting the fund to a single investment over a 10-year period**. If in future years additional national investors sought to participate, NASP would co-design further matched investment tranches.

54. **Individual Government departments may seek to use the fund as an investment vehicle or even more powerfully, different Government programmes could choose to work together; for example, if there were to be an ambitious and co-ordinated cross-Government approach to investment in health improvement activities**. One of the purposes of Government funded pilots is to prove the value of Government investment, through an approach that is then replicable and affordable across the country. Nationwide investment is then the logical next step. NASP can confirm that the operational framework for deploying the Social Prescribing Fund on building social prescribing capacity, and the data flows, would maintain focus onto the priority areas of national investors. For individual Government departments, this would of course include their own respective interests. If the investment scale is large enough, it may even be feasible to develop bespoke approaches to the weighted capitation formula, to reflect different needs, where that is relevant.

Setting Up and Operating the Social Prescribing Fund

Local by Default

55. **The previous section (*Generating a Social Prescribing Fund*) set out how specifying simple national rules is the most effective way of generating local funds.** These would give all 42 ICP geographies across England the freedom and right to participate, with total flexibility about the balance of differing contributions between constituent local partners.

56. **When it comes to setting up and then operating the Social Prescribing Fund, the evidence is unambiguous: the optimal approach is local by default, with relatively few national boundaries. We therefore propose that local systems work to empower VCFSE organisations and community groups through a co-design process, to ensure community-led decision making in the management and deployment of the Fund**. In particular, they need freedom: (i) to grow and nurture their own partnerships; (ii) arrive at the optimal footprint, legal vehicle, and governance of their Social Prescribing Fund(s), that marries efficient use of existing infrastructure with sensitivity to place; and (iii) determine their own approach(es) to capacity building to target the unmet needs of different neighbourhoods.

57. **Local authority and NHS partners also told us that when it comes to supporting their social prescribing ecosystems, trying to hold too much to themselves does not work**. They said they were more successful once they had learnt to embrace their communities and VCFSE partners fully to maximise their input and leadership. This is a critical lesson for the local establishment and operation of the fund. And at the same time, with a modicum of care, it is also possible through a community-led, co-design process to (i) empower local communities to develop greater community-led decision making and agency in the fund management and deployment (ii) avoid giving excess influence to the few larger partners only; and (iii) manage conflicts of interest in decision-making processes, as set out earlier in the *Design Assumptions* section.

58. **Insofar as there are national stipulations, these flow from the design principles** in the *Introduction & Design Principles* section, backed by national and local stakeholders. For example: (i) the fund cannot be held by the NHS or the LA; (ii) it cannot substitute for NHS funding for link workers or be spent on clinical services; (iii) it must generate additional capacity for services, not divert or rebadge existing funding; and (iv) it must supply consistent national data and reporting.

Setting up Local Social Prescribing Funds

59. **The process for ICP geographies to establish their new Social Prescribing Fund(s) ought to be developmental**. Operational arrangements, commitments, and status have to be worked-up and confirmed. From experience we know that the prospect of investment will stimulate significant interest and conversations. The question for local systems is how they harness that initial energy into relationships and partnerships that blossom and endure.

60. **A number of ICPs have been working with NASP to share their emerging thinking on likely set-up arrangements**, including through joint workshops and bilateral meetings. They include Bath, North Somerset and South Gloucestershire; Greater Manchester; Leicester, Leicestershire and Rutland; and South East London. Our thinking draws heavily on their shared learning and insights.

61. **Once a decision is made by a national investor to support an England-wide Social Prescribing Fund, a national oversight body (such as NASP) would communicate that outcome to all local systems.** When the England-wide process begins, the oversight body would provide all the essential information that people need, including national guidance. This would be based on the framework and principles set out in this report, co-produced with partners and formally agreed with the national investor. This would include the local contribution shares for each ICP geography. If some ICPs go first to demonstrate set-up arrangements (an option NASP recommend later in this section), the oversight body would incorporate learning from their experiences.

62. **NASP would strongly encourage all ICPs to take part**. Our record of generating interest, for example from all 42 ICPs for the Green Social Prescribing programme, gives strong grounds for optimism. Partner organisations such as the NHS Confederation, Local Government Association and the National Association of Voluntary and Community Action (NAVCA) have confirmed that they would use their own networks to encourage participation. National partners across the arts and heritage, nature, physical activity, and financial advice sectors should also engage and support their own local networks. This would further boost local interest, engagement, and momentum across all sectors. NAVCA's messaging would help ensure small VCFSE organisations get to hear about the fund at the earliest possible moment.

63. **NASP would recommend a series of virtual open days are delivered to community groups and the VCSFE organisations within an ICP area, to explain the vision and intended benefits of the Social Prescribing Fund, the model and its simple rules, the timetable, and the co-process.** NASP would encourage all ICP geographies to identify a named Senior Responsible Officer for the purpose of fund establishment (e.g. board-level director), and an operational lead. Being the senior reporting officer for convening partners to enable Social Prescribing Fund establishment (and/or subsequent ICP sponsorship of the fund) is a different function from being the SRO for running the fund itself.

64. **All ICP boards would want to consider what is likely to be needed, particularly partnership, leadership, and support arrangements**. At least one further ICP board discussion is likely to be helpful to sign off their '**Declaration of Local Readiness**' (see below).

65. **Our working assumption is to set a national timetable of up to six months—from the point of initial communication—for ICPs to establish their Social Prescribing Fund(s), and then to 'go live'**. Nearly all of this time would be for the local development process, with a relatively short final stage to complete and confirm arrangements and commitments required for the establishment and subsequent operation of the fund.

66. **To support the local development process, the national oversight body should provide a simple national format and timetable for completing a Social Prescribing Fund 'Declaration of Local Readiness'**. This voluntary tool would be made available as part of the initial national guidance. Our intention is the 'Declaration of Local Readiness' document provides a useful, future focal point. It should help local systems to crystallise the local decisions, relationships, and partnership arrangements that are necessary to allow the local Social Prescribing Fund(s) to be established.

67. **It also becomes the product to evidence that the local work is on track to establish the Social Prescribing Fund(s)**. On completion of the declaration, local systems would be required to lodge it formally with the national oversight body, by a specified deadline, to help with programme planning and trigger the formal agreement process. We envisage that the 'Declaration of Local Readiness' would confirm the eleven requirements set out below in *Table 2. Declaration of Local Readiness*.

68. **Midway through this process, NASP would recommend a major national learning event be held to share ideas and learning, open to all 42 ICPs and national partners**. This would serve to accelerate peer-to-peer learning and help forge a national network. It could have a dedicated focus on working with social and philanthropic investors. If there have been demonstrator systems (as recommended later in this section), these would share their experiences for the rest of the country's benefit. NASP's aim would be to help all parts of England progress.

Declaration of Local Readiness

1. The existence of **a documented local social prescribing plan, agreed through a community-led co-design process**, which helps build collective, local understanding of the current position, and future local priorities for action.

2. **Collective commitment that the ICP geography as a whole** (rather than constituent places) **will meet the local investment share over a 10-year period.**

3. **The expected financial breakdown of how the ICP geography will initially meet the required level of local investment at ICP level.**

4. **A description of engagement with potential social investors including businesses and the philanthropic sector.**

5. **The anticipated geographical footprint of the Fund(s), if disaggregated below the whole ICP**, e.g. to place level.

6. **The existing or new entity or entities expected to hold the fund(s)** (which cannot be an NHS organisation or the LA). This will need to be described clearly.

7. **The named lead responsible officer(s)** and operational managers for the management of the Fund(s).

8. **Collective commitment to meet the national requirements of the Fund** as set out in the national guidance, including the additionality rule.

9. **A description of how local community groups and VCFSE organisations are fully embedded as an equal partner in the Fund.**

10. **The signatures of key leaders** including VCFSE partners, community organisations, the ICP chair, the ICB CEO, and relevant LA CEOs.

11. **Where and how the signed Declaration of Local Readiness has been made locally available**, to ensure full transparency.

Table 2. Declaration of Local Readiness

Honouring a 10-year Funding Guarantee

69. **After the Declaration of Local Readiness, the next stage is formal agreement with the national oversight body.** We intend this to take the form of a signed contract, as the basis of accessing matched funding. Our working assumption is this stage will take no more than two months.

70. In the meantime, **in parallel with the initiation of national roll-out, NASP recommends the establishment of a joint national technical advisory group with systems and stakeholders**. The primary function of this group will be to work up the national guidance into a jointly agreed simple legal contract between the national oversight body and local systems.

71. **There are pros and cons of going down a contractual route rather than a softer memorandum of understanding**. Is it really necessary and worth the marginal extra national set-up cost? The risk for which we are mitigating is that at some stage over the course of a 10-year time horizon, most if not all NHS and LA partners will likely face budget challenges and be required to make significant savings. In such exercises, anything that is not a legally binding requirement, either through statute or contract law, is more vulnerable. And funding for social prescribing capacity building provided by local statutory partners in a memorandum of understanding would be seen as discretionary, and therefore not secure. **We conclude that only through a legally binding contract can local, long-term funding commitments—a central tenet of Social Prescribing Fund for stakeholders—be fully safeguarded. In discussion with ICPs, they have also agreed that contractual agreement would serve as a helpful and welcome instrument.**

72. **It is critical to note that we are only advocating a contractual route for the establishment of the Social Prescribing Fund itself. We are not proposing that a formal contracting route is the right approach for local Social Prescribing Funds to choose to take for investments, as opposed to running a low bureaucracy grant process for small VCFSE organisations.**

73. **To reduce transaction costs, the contract itself would be nationally fixed, not open to local amendments or addendums.** It would include commitments to specific requirements on both parties, where these are indicated in the national guidance. For example:

    (i) financial commitment to the local and national investment shares;

    (ii) confirmation of the new local funds being deposited, to enable transfer of national matched funding;

    (iii) any operational data requirements (including those that are subject to any associated national tools being put in place to ease the burden and enable national aggregation);

    (iv) annual financial reporting arrangements to the national oversight body;

(v) any audit requirements; and

(vi) a requirement to present a report at least annually to the ICP, and the national oversight body, with certain minimum content requirements.

74. **Following contract closure and the relevant terms being met, matched funding would flow.** From a national perspective, the Social Prescribing Fund would have gone live and 'be open for business' in that area.

The Option of Local Demonstrator Systems Going First

75. This report sets out a case for an England-wide scheme. **On equity grounds, stakeholders unanimously oppose the establishment of a Social Prescribing Fund that only commits to a limited number of 'pilot' areas**.

76. At the same time, there is merit in **augmenting the commitment to a national approach, with a small number of geographies that demonstrate the Social Prescribing Fund set-up arrangements**, ideally one in each of the seven NHS regions.

77. **The purpose would be to test and confirm the viability of the matched funding model and offer learning and examples of how the fund(s) would be established in those seven geographies**. It is also an opportunity to create a strong basis for a national learning community, to support the co-design of national advice and guidance, and to confirm the viability of the initial data requirements and processes in time for national roll-out.

78. **The demonstrators would test and complete the Social Prescribing Fund set-up process described above in advance of the rest of the country**. No novelty is involved either in investing in community development, nor enriching this with social prescribing approaches. It follows that these demonstrator geographies would not be illustrating a complete lengthy cycle of grant making, audit and reporting before the national roll-out process starts that would be (i) unnecessary both conceptually and operationally, and (ii) needlessly set back the rest of the country by a significant time period, deferring the investment and ensuing benefits.

79. **To ensure fairness, the national oversight body would run a very simple, rapid, and open Expression of Interest (EOI) process for potential demonstrators**. It would convene a broad-based group to decide on applications, just as NASP has for various of its existing programmes such as the *Green Social Prescribing* programme and the *Power of Music Fund*. There would be additional costs incurred by the seven demonstrators in going first, and for the national oversight body in developing and finalising all the associated products for national roll-out. We propose that the demonstrator programme would require funding of about £500,000 for both local and national elements taken together, for example a contribution set at £50,000 for each of the seven participating ICPs rather than by population size given fixed costs and a further £150,000 for the national oversight body.

80. **At the end of the demonstrator process, which would last no more than about six months in total, the national oversight body would produce a single 'state of readiness' report for the national funder's consideration and approval.** This would draw together: (i) local learning from the demonstrators, (ii) updated guidance, (iii) the finalised formula adjustment for ICP fixed shares and the amounts, (iv) confirmation of the initial data requirements of all systems, and (v) the draft contract to be held with local systems.

National Arrangements & Support

81. **We are struck by the innovative approach that the NLCF took in developing the *Big Local* programme. It awarded an endowment to a new, bespoke national partner—the Local Trust—to oversee the entire funding programme.**

82. **Unlike that programme, a national funding partner would not be obliged to start from scratch**. NASP already exists. Adding capacity to its emerging expertise and experience might prove a fast, efficient, and effective option. NASP could oversee all of the operational arrangements for the fund, including sharing available data flows and providing formal reporting arrangements back to the national funding partner. Each local Social Prescribing Fund would be required to provide a formal annual report to NASP including on spend, which NASP would use to provide a single aggregated report to the national funding partner.

83. **An endowment-based approach** enabled the Local Trust to provide national support and help with improvement activities. We see huge potential in this, which **could also unlock the establishment a new social prescribing improvement programme**. This could include:

    (i) the **creation of learning networks** across referrers, link workers and also providers of social prescribing services and activities;

    (ii) the **curation and codification of best practice**, optimal operational models, and social prescribing 'best buys' through a centre of excellence within NASP;

    (iii) **understanding unwarranted variation in performance and addressing these**; including through

    (iv) **establishing a national data and analysis hub** which NASP would most likely commission from an external expert consortium. This is explored further in the next section of the report (*Demonstrating Impact*).

84. Our working assumption (based on the size of the total Social Prescribing Fund set out in the *Introduction & Design Principles* section of this report), is that the total costs of administering the Social Prescribing Fund would be in the order of 5% locally, partly because local systems would be building on existing infrastructure wherever possible, and a further 2-4% nationally, depending on the inclusion of improvement activities listed above. **Clarity of local and national administrative spend would form an integral part of annual reporting arrangements to the national funder.**

Demonstrating Impact

Augmenting the Case for Social Investment

85. Never is investment in community development more needed, as our post-industrial, digital-first society becomes more atomised in real life[47][48]. We see rising levels of self-reported isolation and loneliness[49][50][51][52], including amongst children and young adults as well as older people[53]. Whole trades, professions, and communities face the prospect of ever-faster disruption in patterns of employment and income generation. Millions of working age adults have dropped out of employment despite strong demand for workers, citing mental health issues[54]. Social development forms an essential part of the bigger national response, and positive impacts of social investment are set out in many reports and evaluations, including those published by the National Lottery Community Fund (NLCF) directly or funded through its programmes[55].

86. Building on that existing evidence base set out in *Box 1: Using Wellbeing to Measure Economic Impacts of Social Prescribing*, **the power and novelty of this report lies in creating an augmented, England-wide approach to investment in community development by systematically adding the 'yeast' of social prescribing**.

87. The primary objective in conceiving the fund is to expand the capacity for social prescribing activities and services. At the same time, **a national investor could seek to optimise the full potential of the Social Prescribing Fund to serve a wider long-term strategic purpose. It could be designed in such a way as to offer the prospect of significantly improving the future case for social investment**, whether by statutory organisations, social finance, or philanthropy.

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Using Wellbeing to Measure Economic Impacts of Social Prescribing

There is clear demand from funders, policy makers, and social prescribing activity providers across the VCSE sector to quantify the economic impact of social prescribing using a nationally consistent approach.

The recent evaluation of the Green Social Prescribing programme (GSP), used a bespoke methodology to calculate value for money, including a 'Wellbeing-adjusted Life Year' (WELLBY) approach to measure the economic value of the benefits of the GSP Programme:

- WELLBYs place an economic value on increased individual wellbeing and refer to the total amount of well-being experienced by an individual over one year.
- WELLBYs are measured using the 'life satisfaction' component of the ONS4 measures, where one WELLBY is an increase in self-reported life satisfaction of one point per person per year.
- The GSP evaluation found a social return on investment of £2.42 for every £1 invested, and a total value of £14.0 million, using the ONS4 measure of life satisfaction and a HM Treasury-approved valuation.

This is an important step forward in terms of finding a robust, validated measure of economic value from HM Treasury, potentially reducing a major source of inconsistency. The measure of change - ONS4 life satisfaction - is a well-used metric that is already included in the new NHSE information standard for social prescribing. NASP is currently engaging with stakeholders including experts to explore the potential for its widespread use across the country.

MacLennan S, Stead I, Little A. (2021). Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance. HM Treasury.

Box 1. Using Wellbeing to Measure Economic Impacts of Social Prescribing

88. The Social Prescribing Fund could help make that case in a number of different ways:

    (i) by **establishing a stronger linkage between the scale of additional need for social investment with the scale of social prescribing referrals**;

    (ii) by deploying the proven and separately funded method of **engaging those individuals with greatest unmet needs, including those experiencing health inequalities, to use that expanded community capacity.** The Social

Prescribing Fund dovetails with the separate large and stable investment of over £100m per annum that the NHS is now making in over 3,600 full-time equivalent (FTE) link workers in general practice and their associated costs;

(iii) **by increasing the use of community assets** and thereby helping increase the return for investing in community infrastructure;

(iv) by **supporting the maintenance of existing funding for social prescribing activities/services and the Voluntary, Community, Faith, and Social Enterprise (VCFSE) organisations and community groups** through the additionality rule stipulated in the fund;

(v) by drawing on **evidence of improvement in health and wellbeing outcomes, and its financial return on investment as specified by existing HM Treasury guidance** (*see Box 1: Using Wellbeing to Measure Economic Impacts of Social Prescribing*). The fund then needs to become an integral part of any wider drive for improving the nation's health, either in aggregate, or for specific groups;

(vi) by drawing on **evidence of reduction in loneliness**. The Social Prescribing Fund similarly needs to become a leading part of any wider future drive for tackling social isolation;

(vii) by drawing on a growing body of evidence showing **moderation of avoidable NHS demand**. It does not follow that this evidence generates an obligation for the NHS to take on responsibility for funding wider social activities. But it certainly means that the Fund becomes a noticeable part of the recipe for making the NHS sustainable. Investors in social capital can then harness this motive as a compelling bonus;

(viii) by **creating and strengthening partnerships across multiple sectors**, which have the potential **to become the wellspring of future innovations**. For example, the fund could become a powerful way of engaging employers as they focus on wellbeing of their staff, as well as an attractive option to express corporate social responsibility. It could also become one element of a bigger package of help and incentives to get people back into work.

89. **The data and evidence options for the Social Prescribing Fund have been conceived with this potential in mind**. Below we describe our 'core proposition' on data and quantitative analysis, which is an essential part of the fund, not an optional extra.

90. We also look beyond that core proposition. **The award of the NCLF development grant inspired NASP and partners to consider what approach to developing data analysis and insight, could maximally enrich the future case for investing in community development**. In taking a long-term approach to expanding community capacity, we are also adopting a long-term approach to generating better evidence and data to drive and shape the required investment. At low cost, this also could prove transformative. **In the final section of this report, *Demonstrating Impact*, we envisage a long-term vision for data and analysis**. It is important to stress that

this is not required for establishing or making a success of the Social Prescribing Fund, but it offers a potentially important extra enduring legacy for an interested national investor.

91. **We start from a good and improving position. Every year, the data for social prescribing are improving and the evidence expanding (*see Box 2: Evidence on Social Prescribing*). Furthermore, the rate at which this has been happening has accelerated since the major NHS investment in link workers started in 2019.** This includes work on improving access to—and linking up—existing metrics as well as exploring how best to create additional simple and consistent metrics that would best demonstrate impact.

92. **With data and evaluation at its core**, a Social Prescribing Fund has the potential to:

    (i) demonstrate social impacts such as reduction in loneliness or increased ability to work;

    (ii) measure the wider economic impact and value for money of community investment;

    (iii) improve understanding of 'what works for whom' and how best to design and deliver services to achieve greatest benefit;

    (iv) demonstrate the moderation of avoidable NHS demand; and

    (v) establish simple, usable evaluation metrics that allow for greater consistency and utility—with minimal burden—for VCFSE organisations.

93. **It is clear that the Social Prescribing Fund as envisaged in this report would be able to generate an increasingly rich set of data and evidence about its impact for national and local investors**. NASP and stakeholders are very confident about this, given the progress already made and existing momentum.

Box 2.

Evidence on Social Prescribing

The evidence base for social prescribing, including system data, has grown rapidly in the past five years. This includes:

- Better sharing and awareness of evidence, for example NASP has produced 15 evidence reviews and plain English summaries on a range of topics including measuring outcomes, funding models, economic valuation of impacts, Children and Young People, older people, arts and culture, physical activity, financial and legal social prescribing, and nature.

- Networks such as NASP's International Evidence Collaborative (approximately 300 members) and the Social Prescribing Network, which bring together academics and practitioners to share social prescribing research and data.

- Funded research studies, including:
  - National Institute of Health Research evaluation of the roll-out of social prescribing link workers in primary care
  - Studies focusing on different patient groups or conditions such as those with diabetes or dementia

- An increasing body of research that is focused directly on community-enhanced social prescribing, or which includes strong connections and/or elements of social prescribing, such as UK Research and Innovation's mobilising community assets to tackle health inequalities programme, including a £2.1m project on creative health and community assets in which NASP is a partner.

- Major programme evaluations such as the recent independent evaluation of Defra's (Department for Environment, Food & Rural Affairs) Green Social Prescribing programme have been completed (see Figure 4). This found a social return on investment of £2.42 for every £1 invested, and a total value of £14.0m, using the ONS4 measure of life satisfaction and a HM Treasury-approved valuation.

- NHS England has developed a Social Prescribing Information Standard to enhance coding and collection of standardised data on link worker referrals. Several software providers offer solutions for local data linkage and analysis.

- The Royal College of General Practitioners (RCGP) and the University of Oxford funded a national Social Prescribing Observatory which provides comparative data on link worker referrals by demographics, region, and type of activity.

- Some Integrated Care Systems have funded research on the impact of social prescribing on their local NHS systems, with published findings from Sheffield, Rotherham and Tower Hamlets, and emerging evidence from other ICSs. The voluntary sector organisation Involve Kent worked with NHS Kent to analyse a sample of over 6,000 people that showed a 24% reduction in A&E attendance for over 55s with frailty or poor health, and a 5% reduction in inpatient stays both for over 55s with frailty or poor health.

Our Core Proposition on Evaluation & Data

94. **We envisage that the demonstrator programme would work with NASP to agree the core evaluation and data requirements for all local Social Prescribing Funds.** These would be overseen by the Technical Advisory Group described above in the section *Honouring a 10-year funding guarantee*, and informed by data scientists, academics and digital providers. The evaluation and data requirements would be reflected in the contract, including annual reports to the national oversight body, and national investor. Over time, these requirements would likely be updated to reflect emerging research and practice.

95. **The core requirements would include both process and impact evaluation.** We anticipate they would include at least the following:

    (i) budget reporting including **annual income, grants made, spend on fund administration**, and any reasonable additional requirements for annual accounting and financial audit;

    (ii) the **number of link worker referrals** to services supported by the Social Prescribing Fund, in line with NHS England's data collection and **units of additional activity within services supported by the fund** where it is practicable for local systems to capture this data;

    (iii) use of a simple, **validated questionnaire on self-reported improvement in health and wellbeing**, based on the ONS4 measures and consistent with the new NHS England Social Prescribing Information Standard;

    (iv) use of a simple, validated **questionnaire on self-reported user satisfaction with services; and**

    (v) locally determined analysis of the **correlation of services supported by the Fund with facets of NHS utilisation**, particularly GP time, A&E attendances and unplanned hospital stays.

96. The core metrics described above (or similar) would deliver a comprehensive evaluation of the Social Prescribing Fund and generate useful insights for investors, as well as recipients of funding.

97. **The national oversight body would collate locally produced data and reporting and produce a richer England-wide picture** by analysing collated data and considering trends.

A Long-term Vision for Evaluation and Data

98. With stakeholders, we have been developing an emerging end-state vision for data and analysis, to which we could progress over the ten-year time horizon of the Social Prescribing Fund. **We believe that the opportunity to develop standardised national impact metrics and nationally aggregated data could lead to a step-change in demonstrating return on social investment**. More consensus and consistency in evaluation metrics would also help to reduce the burden of data collection and reporting on small community organisations.

99. **A small but powerful national social prescribing data and analysis hub would be able to navigate complex data sharing agreements, aggregate data sets, and provide analysis of local variation according to different stakeholder needs**. Such a hub could be funded by the national oversight body and would have the potential to benefit all stakeholders in the social prescribing system by providing better evidence of impact. It would also significantly enhance understanding of how to design and deliver effective services for a range of communities and populations. A data hub could be established in parallel to the proposed demonstrator programme. This idea of a national data hub is already articulated as part of NASP's vision for *The Future of Social Prescribing in England*, published in December 2023, and the concept has been enthusiastically received by stakeholders[56].

100. The hub could also become the engine that drives a transformational approach to data and analysis over the long-term and support the kind of improvement programme outlined earlier in paragraph 80.

101. **From an investor perspective greater investment in data and analysis would allow for additional reporting, such as regular analytical reports from the national oversight body**. Analysis could be provided at various scales from national to the individual Social Prescribing Fund, with possible metrics outlined below. **The vision would be for a national hub to support local Social Prescribing Funds by providing reports with analysis and insight of the data for them, flipping the reporting burden**.

102. For an annual report linked to the verified financial data on spend, **we could also aim to provide a single aggregate measure of the net financial return on investment, taking account of all the different relevant metrics (see Table 3)**.

56 *The Future of Social Prescribing in England*. (2023). National Academy for Social Prescribing (NASP).

103. The long-term aims would be for:

(i) **real-time or near real-time data** (this also increases user salience and data completion and accuracy);

(ii) **raw data captured at point-of-use through intuitive, digital data tools** to minimise the data collection burden (and facilitate compliance with data protection rules). These would be made widely available and free to use for community providers of social prescribing services as well as link workers;

(iii) **users to be able to conduct queries across data categories to understand variations and spot patterns** (but never to access any individually identifiable data). This would also be invaluable for any improvement programme as well as future research studies. We can also see the fruitful application of Artificial Intelligence tools;

(iv) **data and analysis scalable across multiple geographical footprints** (national, regional, by Integrated Care Board and/or Partnership, by place, by local Social Prescribing Fund footprint, by district authority, by ward, by Lower layer Super Output Areas);

(v) **data readily available to anyone interested in community development or social prescribing** and the progress of Social Prescribing Funds locally or nationally (i.e. not just the current Social Prescribing Observatory users, but also service providers and investors, and researchers);

(vi) **accessed via an easy-to-use digital interface (a 'dashboard')**;

(vii) **with high footfall from a thriving and growing user community**.

104. NASP has several active work streams to make a start on aspects of data transformation, including:

(i) **identifying and working with ICSs** who are leading practice in terms of data collection and local evaluations across England and capturing learning on the barriers and possible solutions to issues of different local data definitions, data capture and analytical methods

(ii) **engaging with leading academics, NHSE, and policy stakeholders** to explore the potential use of ONS4 life satisfaction measures as a consistent, HM Treasury validated method to calculate the economic return on investment.

(iii) taking forward recommendations from our 2023 evidence review *Supporting the voluntary, community, faith and social enterprise sector to evaluate social prescribing* to explore how **to minimise the burden and maximise the utility of evaluation for VCFSE delivery partners**[57].

57 *Supporting the voluntary, community, faith and social enterprise sector to evaluate social prescribing*. (2023). National Academy for Social Prescribing.

Possible Metrics for Regular Analytical Reporting

A. Effective targeting of inequalities

Metric 1	User composition in relation to deprivation
Metric 2	User composition in relation to ethnicity

B. Increase in community activity

Metric 3	Volume of referrals to activities and by referral source
Metric 4	Volume of users supported
Metric 5	Units of activity in services commissioned
Metric 6	Number of additional volunteers generated

C. Increase in community connection and economic activity

Metric 7	Self-reported loneliness of users
Metric 8	Ability to work (for working age users)

D. User satisfaction with services

Metric 9	Self-reported user satisfaction

E. Improvement in user health and well-being

Metric 10	Self-reported health
Metric 11	Self-reported wellbeing

F. Moderating avoidable demand on the NHS

Metric 12	Reduction in avoidable general practitioner appointments
Metric 13	Reduction in avoidable use of A&E attendances
Metric 14	Reduction in avoidable hospital bed-days
Metric 15	Reduction in NHS over-prescribing costs

Box 3. Possible Metrics for Regular Analytical Reporting

105. We envisage that a national investor would be interested in exploring the priority sequencing of metric development, taking account of the practical challenges. Some seemingly complex metrics, such as on moderation of avoidable NHS demand, will probably not require additional national data collection, as opposed to linkage and statistically sound extrapolation from those datasets.

106. We would want to know the **extra units of user activity of services supported by the Social Prescribing Fund**, probably through a simple count of the number of contacts. The array and heterogeneity of community activities and services makes a simple 'turn-style' count far less straightforward than it sounds. We could work with systems to discover the most practicable solution that can be applied nationwide and over what time horizon.

107. **We believe that a long-term approach to generating evidence and data is feasible and could be of immense value for investors, service providers, communities and individuals**, leading to a change in demonstrating return on social investment. If embraced as part of a Social Prescribing Fund, it might even serve as an exemplar for other strategic investment priorities.

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