CYP Call for Evidence: Evidence-Based Interventions to Improve Quality and Performance in Child Health

1.6 Description of intervention

Describe the intervention, including:

- Describe the aim of the model, including specific details of intended outcomes
- A high-level overview of the intervention. This should include:
    - Details of the problem/gap addressed including clinical need addressed and population
    - Key components of the intervention
    - A theory of change or logic model if available
    - How the intervention aligns with the ambitions of the 10-Year Health Plan
    - How co-production has shaped the intervention
    - Details of the delivery model are to be included in the next question.

Aim and outcomes:

Social Prescribing for Children and Young People is a structured, personalised and non-clinical intervention which aims to improve child health outcomes through addressing wider determinants of health, many of which are linked to wider social inequalities faced by children and their families. In particular, social prescribing addresses the rising presentations of low-moderate mental health challenges, and poor physical health in young people including obesity. Without a holistic approach, children and young people often default into clinical pathways, contributing to pressure on services and often resulting in partial or short-term support which increases waiting lists, escalation of need whilst waiting for support, and inefficient use of clinical capacity. Crucially CYP social prescribing is a whole-system approach and a core mechanism for neighbourhood health. It connects multiple agencies around the young person, supports navigation across complex and sometimes fragmented systems, and provides agency for young people to actively shape their support.

Overview:

Social prescribing provides a way of connecting a young person and their family/support network to trusted, community-based support which can be both preventative or work alongside clinical support. It begins with a referral (whether from a GP, trusted adult, community worker or similar roles) which connects the individual to a trained link worker. Link workers spend time understanding the young person's circumstances, interests and motivations before supporting them to access community-based activities, resources and services that meet their needs. The link worker provides a bridge between clinical services and community infrastructure. As social prescribing is

an intervention which supports people across the life cycle, it can provide continuity of support, particularly where young people might 'fall through the gaps' during transition between services as they age.

Key Components, Co-Production and 10 Year Plan:

The core components of the approach involve:

- Triage and referrals to a social prescriber, which may involve redirection from clinical services where appropriate
- Trained social prescriber link worker (SPLW) carries out a holistic, strengths-based assessment ("what matters to you")
- SPLW co-produces a personalised support plan addressing root causes
- Navigation and structured connection into VCFSC and community provision which may include physical activity, creative and cultural offers, nature based programmes, advice services, peer support and family support.
- Ongoing relational support to sustain engagement and outcomes, which are (where relevant) recorded onto clinical systems. CYP social prescribing is directly aligned with the key shifts in the 10 year plan:
- Hospital to community – Supporting CYP into community-based support that meets their needs.
- Sickness to prevention - Utilised throughout the wellbeing journey, from prevention/early intervention to waiting list support or the step-down from specialist services, which prevents escalation of poor health.
- Analogue to digital - Emerging digital platforms support referral, asset mapping, outcomes capture as well as online support activities for young people. Co-production is also fundamental and embedded within the approach, where social prescribers actively co-produce a support plan with the young person, and where relevant, their families – with outcome frameworks taking a personalised approach to ensure they're meaningful and relevant to the young person.

1.7 Delivery model of the intervention (Optional)

Describe the delivery model of the intervention, including:

- Where is it delivered?
- What is the population footprint of delivery?
- Describe the delivery model including key partnerships, funding model, and workforce required for delivery.
- Describe the core processes and pathways involved to enable delivery.
- Details of barriers and enablers are to be included in section 4 of the form.

CYP Social Prescribing is delivered as a whole system approach, and can be embedded within a range of settings, reflecting the principle that support should 'meet young people where they are'. This includes:

- Primary care
- Specialist services (such as CAMHS)
- Community settings/youth settings
- Family support hubs
- Local authorities/SEND provision
- Education settings
- Digital support settings

The social prescribing model is already embedded within many neighbourhood health offers. SPLWs, as part of multidisciplinary neighbourhood health teams, are able to connect multiple agencies around a young person, by translating their needs across systems, advocating for the individual and aligning support to navigate the young person to.

SPLWs do not require formal, statutory registration as they are non-clinical roles. NHS-funded SPLWs must complete the NHSE training for SPLWs and SPLWs must hold, or be working towards, an occupationally relevant qualification at Level 3 or above. Their role is set out by the workforce development framework. SPLWs are an all-age service but CYP-specific LWs are present in some services.

Social prescribing can be funded through ICB-commissioned contracts, local authority public health grants, specific programme funding, personalised care budgets. Importantly, research has shown that social prescribing has a cost saving benefit. The research by Barnardo's calculated that every £1 spent on social prescribing delivers long-term benefits of about £1.80 in terms of reducing pressure on mental health services, antisocial behaviour, A&E attendance, housing problems, and children being taken into care as well as preventing truancy. Delivery is intentionally place-based, embedded within neighbourhood and community infrastructure, with evidence showing that it is particularly effective in areas of high deprivation and unmet need.

By shifting support into communities and tailoring interventions to individual context, CYP Social Prescribing reduces reliance on services that are often harder to access for disadvantaged groups. It increases uptake of support, improves engagement within and across communities, and helps prevent escalation into crisis services.

Section 2: Health Inequalities (Optional)
2.1 Describe how the intervention addresses health inequalities

Include details of:

- Which groups benefit most.

- Specific inequalities the intervention aims to reduce and specific steps taken to reduce barriers to access, including for Core20PLUS5 groups.
- How the intervention improves equity and evidence of reduced inequalities
- The impact of the intervention on vulnerable groups (e.g. children with disabilities, complex needs, safeguarding concerns, children experiencing deprivation).

Social prescribing is a person-centred approach. It can be (and has been) targeted to support particular cohorts. In adults this has included those with frailty, cancer and long-term health conditions. The community activities and services that social prescribers can connect CYP into are often targeted to address particular needs and interests. We are pleased to see the evidence that SP referrals are increasing in areas of deprivation where they can address health inequalities, although availability of LWs in those areas will always be a limiting factor.

Because social prescribing with CYP operates across systems and settings, such as within the community/education settings, it allows SPLWs to build trusted relationships with young people within their own communities, reaching those who may otherwise not access support. Engagement is often one of the biggest challenges in CYP care, and this form of community-based, relational approaches are often more accessible and less stigmatising, supporting young people who might not engage with more traditional pathways.

Link workers recruited from, and reflective of, the communities they serve and often provide flexible methods of engagement, with delivery typically within community settings rather than clinical environments. CYP link workers have the time to tailor support to cultural, developmental, and individual needs including for young carers, care-experienced young people and those in contact with the justice system. For neurodivergent CYP or those with complex needs, the personalised strengths based approach empowers their access to support in a way that works for them.

CYP social prescribing supports the Core20PLUS5 CYP framework, providing a community-based response to clinical priorities with examples and case studies to show positive impact on mental health, asthma, obesity and diabetes. For CYP experiencing deprivation, the intervention addresses practical as well as emotional needs, with link workers often brokering access to food, uniform, benefits advice, housing support and holiday activities which improve children's long-term health outcomes.

Section 3: Evidence (Mandatory) In this section, please summarise the evidence available regarding the interventions ability to deliver improvement across the 3 principles of quality (effectiveness, safety and experience).

3.1 What type of evidence is available to demonstrate the impact of this intervention?

Select all that apply

☒Peer-reviewed research
☒Independent evaluation
☒Local service evaluation
☐Routine service data/audit (not part of a formal evaluation)
☒Case study/descriptive account
☐Other
If selected other, specify:

3.2 Provide evidence that demonstrates improvement in each of the following domains of quality: safety, effectiveness and patient experience.
Include links to publications where possible.

3.2.2 Improving effectiveness, performance and efficiency
Describe how this intervention has improved effectiveness, performance or efficiency, and summarise the evidence available to show this improvement.
You may wish to include:

- Impact on performance and efficiency, such as waiting times, patient flow, reduction in avoidable admissions, activity shift from hospital to community.
- Impact on clinical outcomes and wider child outcomes (e.g. development, education, wellbeing, participation etc.).
- Cost-effectiveness, including whether the intervention demonstrated cash releasing or time-releasing benefits, and any quantified efficiencies or savings (including any economic evaluation).
- How impact was measured, including specific metrics, data sources, evaluations or reviews undertaken. Strength of the evidence.
- When the evidence is from.

A recent peer reviewed paper from UCL estimates a £9 RoI (for a £1 investment) based on increased wellbeing scores (that are consistent with HM Treasury's Green Book approach). Evidence and case studies that outline how SP can reduce the pressure other parts of the NHS including GP appointments and unplanned hospital admissions can be found on our website. Previous research by Barnardo's calculated that every £1 spent on social prescribing delivers long term benefits of about £1.80 in terms of reducing pressure on mental health services, antisocial behaviour, A&E attendance, housing problems, and children being taken into care as well as preventing truancy.

3.2.3 Improving experience

Describe how this intervention has improved patient experience, and summarise the evidence available to show this improvement. You may wish to include:

- Details of which part of experience improved (e.g. person-centred, compassion,
- dignity, respect, involvement, responsive to individual need).
- Improvements in navigation of care or care coordination.
- How CYP are involved in decisions and feel listened to.

- How impact was measured, including specific metrics, data sources, evaluations or
- reviews undertaken.
- Strength of the evidence.
- When the evidence is from.

Social prescribing can both replace conventional medical care that cannot address the wider social determinants of health that are causing ill health, or support CYP receiving medical care (especially for long term conditions including mental health. A recent review of evidence for the impact of SP for CYP can be found here. It reports that studies reported mostly positive effects of social prescribing. Quantitative investigations predominantly reported improvements in service user health and well-being, including personal well-being, mental well-being, loneliness, physical activity, and perceived level of required support.

This study explored the benefits of SP for CYP not in education, employment or training (NEETs).

These publications also draw on studies from outside of the UK. Please see the detailed example of the clinical trial on the use of SP to support CYP waiting on CAHMs waiting list provided by Dan Hayes from UCL which provides an example of improvements in aspects like mental resilience in CYP receiving SP. This paper sets out the protocol in more detail.

We are also aware of an academic evaluation of the CYP SP service provided by Barnardo's that will be published shortly and will provide valuable evidence and insights.

Section 4: Risks, barriers and enablers (Optional)
The following questions are not compulsory.

4.1 If this intervention were to be scaled, what would be required for each of the following categories?
4.1.1 Workforce

You may wish to consider:
• What additional workforce capacity, skills and training would be required?
• What clinical governance is required?
• Is a professional registration is required?
• What are the workforce risks and constraints?
• Is a culture shift required to deliver this?
• What is the impact on workforce experience (e.g. workload, satisfaction)?

Social prescribing Link workers (SPLWs) do not require formal, statutory registration as they are non-clinical roles. NHS-funded SPLWs must complete the NHSE training for SPLWs and SPLWs must hold, or be working towards, an occupationally relevant qualification at Level 3 or above. Their role is set out by the

workforce development framework. SPLWs are an all-age service but CYP specific LWs are present in some services. Charities such as Barnardo's also fund a CYP SP service that was co-developed with young people. The SP ecosystem, including SPLWs, is supported with resources, training and webinars the National Academy of Social Prescribing with funding from DHSC and philanthropic sources. Social Prescribing for CYP is also supported by the Social Prescribing Youth Network led by UCL who we regularly work in partnership with.

Within the NHS, most SPLWs are based in primary care but there is significant potential to expand this and embed them in secondary care and community mental health trusts where they can support CYP with long term conditions.
In addition to ensuring a large enough workforce of SPLWs for CYP, there is the potential to upskill other trusted adults (specialist staff in education, youth justice, youth and sports clubs etc. to take a social prescribing approach with children and their families. This is not about a sign posting approach but and requires trusted adults to understand what matters to a child (rather than what is the matter with them); to know the assets in the community; to co-develop a plan to connect them into activities; and to support them to deliver their plan. Training in a 'social prescribing approach' is being developed by NASP.

Key constraints are:

- The number of LWs. Our response to the recent NHS workforce consultation shows that average annual caseloads are 341 people per year, while NHS guidance for safe caseloads is a maximum of 200-250 people per year for each Social Prescribing Link Worker;
- Sustainably funded community assets CYP to be referred into and supported by (see below);
- Lack of awareness of the evidence for the benefits of SP and the availability of SP services prevent the CYP most in need of support being referred to this service by clinicians and other professionals that support CYP. This may also require a culture shift so that clinical staff and others to recognise the value of taking a holistic approach to the needs of CYP. Many of our work programmes seek to address this including a Social Prescribing Champions scheme and an extensive dissemination programme.

4.1.2 Capital and financial