Committee: Health and Wellbeing Board

Date: 28th November 2023

Agenda item: **Social Prescribing (Children) challenges and opportunities**

Wards: Primarily in the East Merton and Morden Primary Care Network areas; Pollards Hill, Longthorton, Graveney, Figge's Marsh, Cricket Green, Ravensbury, St Helier and Merton Park

Subject:

Lead officer: Mike McHugh, Consultant in Public Health

Lead member: Councillor Peter McCabe, Cabinet Member for Health and Social Care

Contact officer: Megan Coe, Public Health Principal and Rachel Tilford, Senior Public Health Principal

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Recommendations:

A. Health and Wellbeing Board member organisations to note and discuss the challenges and opportunities of the CYP Social Prescribing pilot.

B. Health and Wellbeing Board member organisations to agree to actively seek out opportunities to promote children and young people's social prescribing and wherever appropriate, embed CYP social prescribing pathways in services that they commission and/or deliver.

C. The Health and Wellbeing Board agrees to receive an update from the Children and Young People's Social Prescribing pilot prior to the end of the pilot.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the report is to provide an update on the Children and Young People's Social Prescribing pilot, including insights into the pilot model, its outputs and outcomes to date. It also shares the opportunities and challenges faced by the pilot as well as possible next steps.

1.2. The report asks that the Health and Wellbeing Board promote and champion the pilot to their networks and encourage partners to reach out to the provider and refer service users.

2 BACKGROUND

2.1. Social prescribing for adults has been well established both nationally and in Merton for a number of years but it is only since 2021 that interest has really grown in social prescribing for children and young people. There are now a small but growing number of Social Prescribing services for children and young people (CYP) across London, some of which can be found on a recently developed London Social Prescribing map.

2.2. Merton's CYP Social Prescribing pilot started mobilising in July 2022 and seeing young people from October 2022. The pilot started in one Primary Care Network (PCN), East Merton and a second area, Morden PCN started

delivery in September 2023. The eligibility criteria for the pilot are CYP struggling with their emotional and mental health and/or CYP who are living with obesity.

2.3. The pilot is delivered by Enable Leisure and was originally funded by Public Health and in 2023-2024 funding was secured through the South West London's Inequalities Fund to continue and expand the pilot. The contract is managed by Merton's Public Health Team and is overseen by a multi-agency steering group.

2.4. The main purposes of the pilot have been to provide evidence about how CYP Social Prescribing works, what impact it has and how CYP social prescribing differs from adult social prescribing. A key aim has been to refine and adapt the model in response to continuous learning. The pilot is being independently evaluated by an external organisation.

3 RATIONALE FOR THE SERVICE

3.1. Mental health needs amongst young people have increased in complexity and prevalence during and following the COVID-19 pandemic, with both national and local data highlighting the negative impact of the pandemic[1]. Findings from Merton's Young People's survey highlighted that the pandemic had a negative impact on both the physical and mental health of young residents[2].

3.2. Childhood obesity is a significant risk factor for poor physical and mental health, impacting children in their youth and into adulthood[3]. The COVID-19 pandemic also contributed to increases in CYP living with overweight/obesity and eating disorders and disordered eating. In Merton, approximately 1 in 5 children in Reception (4-5 year olds) and 1 in 3 children in Year 6 (10-11 year olds) are overweight or living with obesity, with wards in the East of borough, such as Ravensbury, experiencing higher levels than wards in the West of borough[3].

3.3. A recent Barnardo's report suggests that when situated with wider support networks, social prescribing can work well for CYP with mild mental health problems[4]. Furthermore, social prescribing linked to arts, cultural activities, physical activity and nature have been found to be beneficial as well as support from a link worker to facilitate attendance and engagement in these activities to help with nervousness and anxiety.[4] Barnardo's also estimate a

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[1] Merton Council, 2023. Merton Story 2022/23 Start Well Mental Health, Available at: https://www.merton.gov.uk/healthy-living/publichealth/jsna/the-merton-story

[2] Merton Council, 2021, Survey: Impact of COVID-19 on young people in Merton, 2021, Available at: https://www.merton.gov.uk/council-and-local-democracy/get-involved/young-residents-survey-2021#:~:text=We%20found%20that%20over%20a,behind%20at%20school%20and%20sports.

[3] Merton Council, 2023. Merton Story 2022/23 Start Well Healthy Weight, Available at: https://www.merton.gov.uk/healthy-living/publichealth/jsna/the-merton-story

[4] Barnardos, 2023, The Missing Link Social Prescribing for Children and Young people, Available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.barnardos.org.uk/sites/default/files/2023-10/report-missing-link-social-prescribing-children-young-people.pdf

Return on Investment (ROI) of £1.80 for every £1 invested for young people needing support with low-level mental health issues[4].

3.4. Merton's CYP Social Prescribing offer is well placed to support objectives in the South West London (SWL) Joint Forward Plan (JFP) & SWL Mental Health Strategy to deliver prevention activities for CYP at higher risk of developing mental health issues (by 2024) and JPF/Child Healthy Weight Action Plan (2022-2025) objectives on obesity and the South West London Integrated Care Partnership Strategy 2023-2028.

This pilot also aligns with:

- Merton Story (2022/23) health priorities
- CAMHS Transformation Plan
- Health and Wellbeing Strategy (2019-2024)

4 MERTON'S CYP SOCIAL PRESCRIBING MODEL

4.1. After initial funding from Merton Council Public Health's Contain Outbreak Management Fund (COMF), the pilot is funded in 2023-2024 by the SWL Integrated Care System (ICS) Inequalities Fund. An Expression of Interest (EOI) request to continue the funding, extending and expanding the pilot until December 2024 was submitted in September 2023 for the next stage of the SWL ICS Inequalities Fund and the outcome is awaited.

4.2. The two Primary Care Networks (PCN), East Merton and Morden which are the focus for the pilot are areas with the highest levels of deprivation and CORE20 populations in the borough. As part of the submission to extend the pilot's funding from the SWL inequalities fund it was proposed to include a third PCN.

4.3. Pilot Eligibility:

- Young people aged 13-18 years and up to the age of 25 years with additional needs.
- Registered with a GP, living, working or attending an education setting in the East Merton and Morden Primary Care Network (PCN) areas.
- Experiencing low-level mental health or emotional wellbeing and/or living with a high level of obesity (BMI >98th centile).

4.4. Eligible CYP are offered up to 6 appointments with a Link Worker who works with the CYP on a one-to-one basis and who makes referrals to non-clinical interventions such as community and voluntary community sector (VCS) activities/services. Appointments can take place at a GP Surgery or a location in the community or over the phone. Wherever possible, appointments are offered around educational or workplace hours.

4.5. Referrals to the service can be made by school nurses, school staff, Family Start (weight management), mental health services, early help teams, in addition to GPs. This is because children and young people require different referral routes to social prescribing services as many CYP don't reach out to GPs for health and wellbeing support until issues have escalated. This local

offer therefore differs from many CYP and adults social prescribing models which predominantly use GP inward referral pathways.

4.6. Enable's Link Workers refer young people onwards to a range of VCS organisations which have included: mental health support, webinars and grief support, food providers, housing advice and organisations specialising in autism and learning disabilities. Depending on individual circumstances, Link Workers have also supported young people when dealing with statutory organisations, such as local authority housing and social care teams. Further advice around healthy eating, approaches to changing diet and importance of physical activity are also promoted with clients.

4.7. The pilot's model incorporates a Personalised Care Grant fund for service users. This fund is in place to support CYP to access activities, such as paying for gym sessions, which they wouldn't otherwise be able to afford. An additional aim of the personalised care grants – which requires some further testing - is to support the financial impact of increased referrals to voluntary sector partners via the scheme.

4.8. CYP Social Prescribing Link Workers do liaise on the ground with Adults Social Prescribing when it is established that a parent needs support and vice versa. To better understand these pathways, we have asked for data collection in this area to be strengthened.

5 PILOT GOVERNANCE

5.1. The pilot is overseen by a steering group made up of colleagues from Public Health, Education, SWL ICS, primary and community healthcare and voluntary sector partners including mental health organisations, Merton Connected and more. Many of these partners are inward or onward referral partners. The steering group meets every six weeks to share learning, develop the pilot and embed it in the community.

5.2. There are monthly contract monitoring meetings between Enable and Public Health and updates from these are reported back to senior Public Health colleagues. When requested, updates are also reported to SWL ICS and the Adult Social Prescribing Steering Group.

5.3. The voice of young people has been represented from the outset of the pilot for example, Public Health Young Inspectors have input into the service specification, procurement and evaluation of bids and choosing the successful provider. The Public Health Young Inspectors and the Public Health Apprentice are integral to the contract monitoring meetings and have contributed to the development of the pilot such as reviewing and amending communications materials.

6 CONSULTATION UNDERTAKEN OR PROPOSED

6.1. Since October 2022, 162 CYP have been referred into the pilot. 75% of these referrals have been for mental health issues; 65% were 11-18 year olds; 56% were female and over 70% have been from a CR4 postcode, and approximately 60% were from minority ethnic groups.

6.2. At the start of the pilot, a comprehensive monitoring template was implemented to record pilot outputs and outcomes. These are tracked through monthly monitoring meetings and through Enable's social prescribing data-system, Joy. A full list of pilot activities, outputs and outcomes can be found in Appendix 1.

6.3. **Table 1 A Summary of Pilot Outputs**

<table>
<tr><th>Demographics & Outputs</th><th>Data</th></tr>
<tr><td>Age</td><td>11-18 years old: 65%
19-26+ years old: 35%

*A small number of service users below/above our target ages of 13-25 were accepted onto the pilot where capacity allowed.</td></tr>
<tr><td>Gender</td><td>Where gender has been recorded/disclosed:
56% Female,
28% Male.</td></tr>
<tr><td>Ethnicity</td><td><table><tr><td>Ethnic Group</td><td>%</td></tr><tr><td>White</td><td>30%</td></tr><tr><td>Black, Black British, Caribbean or African</td><td>29%</td></tr><tr><td>Asian or Asian British</td><td>16%</td></tr><tr><td>Mixed or multiple ethnic groups</td><td>16%</td></tr><tr><td>Other ethnic group</td><td><5%</td></tr><tr><td>Prefer not to say/Unknown</td><td>11%</td></tr><tr><td></td><td>100%</td></tr></table></td></tr>
<tr><td>Postcode</td><td>Over 70% of referrals have been from the CR4 postcode.</td></tr>
<tr><td>Number / reason of referrals,</td><td>162 referrals

75% of referrals have been for mental health issues,
16% for CYP living with obesity and
9% of service users with both.

Additional client needs have included loneliness/isolation, housing and victim of abuse.</td></tr>
<tr><td>Number of appointments</td><td>325 appointments have been delivered.

Note this doesn't include additional work undertaken by the link worker, e.g., with parents to talk them through the pilot/offer and time taken to refer service users onto other VCSO services.</td></tr>
</table>

6.4. Wellbeing measures to ascertain service user outcomes are collected at baseline (first appointment) and follow-up (latter appointment) by the link worker. These are the Short-Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (a series of positive mental health statements/questions where responses are ranked) and the Sport England's physical activity questions. In the pilot so far, service users have had an average improvement of 14.3% in their SWEMWBS score from baseline to follow-up measurements.

6.5. Table 2 - A Summary of Pilot Outcomes

Outcomes	Data **From Oct 22 to end of July 2023*
SWEMWBS Average Baseline	46.4%
SWEMWBS Average Follow Up	60.7%
SWEMWBS Average change	14.3% (improvement)
Physical activity attitudes: Enjoyment baseline	54%
Physical activity attitudes: Enjoyment follow-up	100%
Physical activity attitudes: Confidence baseline	16%
Physical activity attitudes: Confidence follow-up	75%

7 EVALUATION AND LEARNING

7.1. Merton Public Health have commissioned an independent evaluation to help interpret the outputs, outcomes and ascertain the impact of the pilot on young people. Evaluation lines of enquiry include better understanding the characteristics of CYP accessing the service, CYP service experiences, reflections on the pilot model, an examination of the relative cost of the pilot (e.g., cost per participant) and return on investment. The findings and recommendations from this evaluation will be reflected on and learning embedded within current and future phases of the pilot. The evaluation report is expected by the 30th November 2023.

7.2. The pilot has encountered a number of challenges which have informed: engagement and communications approaches; contacts with new stakeholders and referral partners; mobilisation of the second PCN and the service model. The mobilisation of the first pilot took time, as has building referral pathways with schools and other professionals, and acquiring space in non-GP settings. Other challenges have included referral numbers and uptake of the personalised care grants.

7.3. Key benefits of the pilot include: early intervention for young people to prevent further escalation of health issues and supporting young people with complex issues and situations when there wouldn't have otherwise been another professional to support them. Two example case studies are:

- 14-year-old was heavily bullied in school for 2 years and having panic attacks regularly. Supported to write letter to school regarding reasons they want to move school, signposted to Talk Off The Record online workshops, worked on various goals. Young person (YP) is happily settled into new school with knowledge of local support services and safety net. In total we had 9 face to face sessions – this

YP is now discharged. Both mum and YP were very grateful for the support and have said they are now able to continue living happy – mum has gone back to work and they are all sleeping in their own beds again.

- A young mum referred by CLCH who was bereaved and in a complex situation which included a housing issue. She has no GCSEs and had a lack of confidence in progressing with education. She has initially declined counselling support. By working with Enable, she agreed to a referral to Jigsaw4u, an organisation that delivers bereavement counselling. Enable also supported her to apply for colleges and with applications for funding and childcare applications. She reported 'I really didn't think I would be able to do any of this before I spoke to you'.

7.4. As a result of learning from the pilot two new approaches will be trialled from December 2023:

- allowing Link Workers to attend activities alongside young people to support attendance and build their confidence.
- allowing self-referral into the service by CYP. The risks and mitigations of moving to self-referral have been identified and were discussed with the Project Steering group in October 2023.

7.5. These two changes reflect the need to adapt the model for CYP and have been informed by learning from the project to date.

8 ALTERNATIVE OPTIONS

8.1. NA

9 CONSULTATION UNDERTAKEN OR PROPOSED

9.1. To inform the service specification of Merton's pilot, specifications and learning from other London CYP Social Prescribing pilots were incorporated into the development of our specification.

9.2. A competitive tender process was run via London Tenders Portal in the spring/summer of 2022. Enable Leisure and Culture (Enable), were successful in their bid to supply the CYP Social Prescribing pilot.

9.3. Throughout the design and implementation of the pilot, Public Health Young Inspectors help shape and ensure that the voice of young people is represented.

9.4.

10 TIMETABLE

10.1. Pilot Timelines

STAGE	DATE
Phase 1: Pilot Mobilisation Start Date (East Merton PCN)	July 2022

Phase 1: Pilot Implementation Start Date (East Merton PCN)	October 2022
Phase 2: Pilot Mobilisation Start Date (Morden PCN)	April 2023
Phase 2: Pilot Implementation Start Date (Morden PCN)	September 2023
Current Pilot End Date (Both PCN Areas)	March 2024

11 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

11.1. Public Health team using COMF monies, commissioned a CYP Social Prescribing service in East Merton from July 2022 to July 2023.

11.2. Following successful funding from SWL ICB, the pilot is now sustained from external funding sources until March 2024. If the Public Health team are successful in securing additional funding from the 2023/24 SWL ICB Inequalities fund, the pilot will be extended until December 2024.

12 LEGAL AND STATUTORY IMPLICATIONS

12.1. NA

13 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

13.1. A higher burden of poor mental health and obesity is found in areas of higher deprivation. Interventions targeting people in earlier life can help reduce the burden of disease and health inequalities across the life course.

14 CRIME AND DISORDER IMPLICATIONS

14.1. NA

15 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATION

15.1. NA

16 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1 – Full list of Pilot Outputs and Outcomes

Outputs (including service user demographics)

- Age
- Gender
- Ethnicity
- Postcode

- Source of referrals (list)
- Reason for referral (mental health, obesity, both)
- Onward signposting and referral (list)
- Number of appointments
- Onward referrals per client

Outcomes

- SWEMWBS baseline/follow-up/average
- Physical activity levels/confidence/enjoyment
- Case studies around service user experience and journey with the pilot service.

17 BACKGROUND PAPERS

NA

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