A two-year evaluation of the Young People Social Prescribing (YPSP) pilot

An outcome, process and economic evaluation of social prescribing for young people in three English sites

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Institute for Connected Communities
The Institute for Connected Communities (ICC) (previously known as the Institute for Health and Human Development) is engaged in research and training into the social, economic and cultural productions of health and well-being. ICC has attracted funding from UK research councils, charitable trusts, NHS, the European Commission, UNICEF, and national government departments. We have major programmes of intervention innovation and development including the Well Communities programme, and cybercrime and child internet safety. We have also developed considerable expertise in the evaluation of social prescribing interventions and training and are founding members of the international social prescribing network.

Disclaimer
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1 Executive Summary

Background

The Institute for Connected Communities (ICC) (previously known as the Institute for Health and Human Development) based at the University of East London (UEL) conducted an outcome, process and economic evaluation of the Social Prescribing for Young People Pilot in three English sites (Sheffield, Luton and Brighton & Hove) between September 2018 and September 2020, funded by the Department of Health and Social Care (Health and Well-being Fund) and managed by StreetGames, a national charity set up to create positive change in the lives of disadvantaged young people across the UK

Methodology

The evaluation was based on a mixed methods approach which included the following:

- Health and social outcome evaluation: baseline and six months follow up survey of young social prescribing users (between Feb 2019 and Sep 2020). We collected data about personal well-being (life satisfaction, worthwhile life, and happiness from the ONS), general health, mental well-being (WEMWBS), loneliness, social capital, use of health and social care services, and physical activity. A total of 192 baseline service user questionnaires and 77 follow-up questionnaires from the same users were collected by link workers and UEL researchers.
- Process evaluation: the outcome evaluation was supported by a process evaluation consisting of 21 in-depth qualitative interviews and three focus groups with key stakeholders (including service-users and link workers) documenting their experience of the service.
- Economic evaluation: cost-benefit analysis (SROI) and analysis of healthcare service use (GP consultation, A&E attendance and hospital admission) was carried out

Key Findings

- In interpreting these findings, two main considerations are important: first, the follow up and some of the qualitative interviews were carried out during the coronavirus pandemic; second, the results of the health and social outcomes evaluation are heavily influenced by the disproportionately stronger contribution to data collection of one site (Sheffield).
- The intended group of young people was targeted for support: with a mean age of 16 years and more than half with long standing physical and/or mental illness. Gender distribution was balanced with an almost equal split (52.7% female). Many more men are attending young people social prescribing services than in the adult counterpart where the presence of men is much lower, often about 30%. Therefore, it appears that young men have fewer issues in accessing social prescribing services than adult men.

- In terms of health and social outcomes, (i) personal and mental well-being have improved, particularly for those who had the lowest levels at baseline; (ii) loneliness also experienced a decline for the group most in need, despite the coronavirus pandemic. Mental well-being followed a positive trend recording a statistically significant positive change between baseline and follow up, confirming once again that social prescribing is an effective mental health service.
- Overall, the young respondents found that the service made them feel welcome, particularly the 'buddying' service. Young people reported that link workers contributed to improving their sense of autonomy, reduced their sense of 'stigma' around mental health challenges, and filled a gap in mental health service provision by providing almost immediate access to non-clinically based emotional support. Yet, the support service was sometimes affected by complicated transport to reach distant activities, and the cost of sessions. Moreover, young people would have liked more information on what to expect from social prescribing and also from their link worker sessions.
- Interviews with stakeholders showed that the role of the young people social prescribing link worker is even more complex than the adult's role, particularly in terms of balancing primary focus on the young person with the input and needs of parents/carers, and the need to coordinate support amongst a large number of providers, for example in relation to schools and CAMHS.
- The coronavirus pandemic had an important influence on the relationship between link worker and young person with a shift from face to face interaction to text messaging and telephone calls. Although communication between link workers and young people continued, primarily through text messaging, this was seen as a 'second best' rather than the most preferred option.
- Lack of available data meant that It was only possible to conduct the economic evaluation of the Sheffield young people social prescribing service. This showed a social return on investment above average if compared to adults' services (£1:£5.04).
- GP consultations and A&E attendance showed a statistically significant decline over the period so that the decline is not likely to be due to chance but the effect of another factor which one could interpret as being the effect of the social prescribing service. In addition, non-elective hospital admissions also declined but without statistical significance. However, the combined savings from GP consultations, A&E attendance and non-elective hospital admissions was limited to a total of £4,668 over the six months period of analysis
- Stakeholders interviewed were also concerned about the sustainability of social prescribing as a range of critical issues emerged in relation to VCSE recruitment and retention of link workers across sites, with the coronavirus pandemic making the situation even worse.

Key recommendations for the development of young people social prescribing

We just offered a summary of the recommendations here. For a more detailed explanation, see section 7 (p.48) of the report which also includes some of the key principles to be considered when setting up a social prescribing for young people service (0, p. 51)

Recommendation 1: continue the process of testing young people social prescribing schemes and learning from experience to fine tune the model across England and beyond (test and learn). It is important to assess health and social outcomes further and investigate the specific role of young people social prescribing amongst other health and support services and funding mechanisms.

Recommendation 2: consider more research into the role of young people social prescribing link workers and specific training to support their role, particularly in delivering services remotely, including the creation of practical guidance based on the pilot delivery sites' experience for others to emulate.

Recommendation 3: balance the centrality of young people's needs with the role of parents/carers highlighted by data collected in this report

Recommendation 4: Consider clarifying what the young service user can expect from social prescribing including number of sessions with link worker and how and when the young service user can contact their link worker.

Recommendation 5: consider setting up a small advisory group made up entirely or almost entirely by young people who could advise (during design, implementation and evaluation) a steering group via a representative.

2 Introduction

Social prescribing is now firmly at the forefront of UK health policy with the recent commitment from the Department of Health and Social Care to refer 900,000 people to social prescribing services by 2024. Alongside this, the NHS Long Term Plan is set to recruit and train 1,000 Social Prescribing Link Workers to work within primary care services by the end of 2020/21 (DHSC, 2019). Social prescribing was recognised as an important model for the future of the NHS in its Five Year Forward View (NHS,2014) and The General Practice Forward View (NHS, 2016) has also recognised social prescribing as one of the 10 high impact interventions to release capacity in GP practices and would do so by making greater use of assets available in the community such as the third sector.

In January 2019, the NHS Long Term Plan identified social prescribing as an universal service which therefore covers all age groups (DHSC, 2019). One of the implications of this commitment is the extension of the current mainly focussed adult service to the under 18 age group.

There is a strong evidence for the need to focus on younger groups. The Five-Year Forward View (2016) reported that 850,000 young people have a diagnosable mental health condition, half of all mental health problems are established by the age of 14 and three quarters of all mental health problems are established by the age of 24 (Kessler et al., 2005). There is also an important socio-economic component to this, the so-called social determinants of health: young people in gangs face high rates of mental illness, NEET (Not in Education, Employment or Training) have more mental health problems and substance misuse than non-NEET peers. Half of people in poverty live in a working household, and families with children are the biggest group in poverty (JRF, 2014). Adolescent mental health costs the system £59,130 per person per year (Suhrcke et al 2008).

Although there is a strong interest in the development of social prescribing services for young people at local and national level (StreetGames, 2020), this policy area is still at very early stages of development. To confirm this, a review of social prescribing for children and young people (Hayes et al., 2020) which screened over 1,307 records found no evaluations of social prescribing for children and young people.

In this context, the Institute for Connected Communities (ICC) (previously known as Institute for Health and Human Development) based at the University of East London (UEL) was funded by the Department of Health and Social Care (Health and Well-being Fund) to conduct an outcome, process and economic evaluation of the young people social prescribing service in four English sites (Sheffield, Luton, Brighton & Hove and Southampton). However, it was not possible to collect any evaluation data from Southampton

beyond few baseline questionnaires as this site experienced a range of significant problems to recruit and retain link workers and experienced wider management changes at crucial times of data collection.

Thus, this final report presents the results, discussion and recommendations from the evaluation of three sites (Sheffield, Luton and Brighton & Hove) that took place between September 2018 and September 2020. A description of the three social prescribing services is available in the section below followed by the methods used for data collection which includes a quantitative study of service users (baseline and six months follow up), a qualitative study of young people experiences through in-depth interviews and focus groups as well as a cost-benefit analysis which identifies the economic return from investment in this social prescribing programme.

3 Description of the Social Prescribing Service pilot in the three sites

This section describes the main similarities and differences between the three sites, namely Luton, Sheffield, Brighton & Hove (see Table 1 below for a summary) drawing on analysis of periodical updates from sites and data collected as part of the evaluation.

All three sites focussed on supporting young people and employed link workers from three different VCSE organisations: Active Luton (Luton), Sheffield Futures (Sheffield), and YMCA DownsLink Group (Brighton & Hove). All sites support people with a wide range of needs including low mood, social isolation, physical and learning disabilities. The age range of young people supported across the three sites was between 11 and 24 years old (mean 16).

All sites had a number of referral routes including schools, CAMHS, internal referrals, adult and social care, drop-in services (self-referrals) and GP practices. As opposed to the majority of adult social prescribing services, GP practices were one rather than the main referral route in most sites, with the exception of Brighton & Hove which recorded 63% of their referrals from GP practices. Luton (35%) received a third of their referrals from within their own service.

Link workers in all sites worked flexibly with young service users and adapted the number of sessions and type of support depending on need. On average, sites provided about 4-5 sessions per young person (up to 8). The average length of each session was around one hour, shorter the first and longer after. The length of support varied substantially across sites from 12 weeks (Luton) to 12 months (Brighton & Hove).

Table 1: Details of social prescribing services in the three sites

	Luton (Active Luton)	Sheffield (Sheffield Futures)	Brighton & Hove (YMCA DownsLink Group)
Brief description	A Link worker employed by Active Luton receives referrals from a range of sources (see below),mainly supporting young people to access physical activity and emotional health support sessions. Active Luton also run a Social Prescribing programme for adults.	One link worker provides support for CYP (*) from different sites, but primarily well-being café (Door 43). The model complements and adds value to the newly developed Youth Information Advice Counselling and Support (YIACS) service.	Link worker operates from YMCA but also community centres, including home visits (outreach). Brighton and Hove well-being have one referral pathway. All referrals come through a centralised system which is found on Brighton and Hove Well-being website. Once the referral has been received the experienced triage team assesses where the referral should be placed.
Main target groups	All CYP in Luton. However, in practice focussed on CYP aged between 11 and 18 (Mean=15) with high levels of anxiety and loneliness.	CYP with emotional problems (11-24 years old) who live in Sheffield (mean age 17)	CYP who are socially isolated or at risk of social isolation (11-21, mean 15). Particularly those who do not attend school and/or do not engage with social activities
Referrals into the YPSP service from	Initially stated referral routes include GP surgeries, social services, youth offending service and schools. However, the service also received considerable referrals from CAMHS (40%) and friends/family (35%). The latter is mainly through the adult SP programme	Schools/college (27%); Self-referrals through drop-in well-being café in the city centre (Door 43) (9%) and friends/family, 14.9%, combined 23.9%); GP surgeries (21%); Adult and social care (11.9%); None from CAMHS (Sheffield Children's Hospital NHSFT) and AMHS (Sheffield Health and Social Care NHSFT)	Wide range of referral routes. Most referrals come from GP (63.6%) and friends/family (18.2%). Interviews with CYP also revealed referrals from schools and CAMHS. Other sources can also include self-referrals.
How referred?	Prescription pads, electronic referral forms, dedicated phone line and website. All referrers use a single referral form, sent by email to a central secure 'Active Luton' nhs.net address where it is triaged and sent to the correct Link Worker or alternative service.	A single 'Professional Referral Form' is in use across the City, which is completed and sent by email to the SP service. There are also existing referral routes from CAMHS and AMHS. Some young people also self-refer through the well-being café'	Well-being service referral online portal, then triage and if appropriate referral to SP Link worker
Role of Link Worker	LW provides home outreach to CYP, travels to secondary school, face to face consultations with CYP alone and/or with parent/responsible adult. Through Motivational Interviewing and behaviour change techniques, it motivates and empowers the CYP how to make some changes to lifestyle, access to support including ongoing support and funding.	One link worker is based on YIACS team but travels to well-being cafés and can provide outreach. For example, LW may accompany CYP to other organisations, at least in the initial stages of support.	The link workers role can access and work with young people in the home or school (outreach). The LW meets the parent/ carers typically at the initial meeting. The Link Worker can also spend time with young people flexibly and can provide basic help such as accompanying the young person to activities
Planned number of sessions offered	Holistic, sessions last typically 40 minutes. The CYP are entitled to 12 weeks of support and funded access to local services. LW gives people a quiz and starts conversation by looking at CYP's own interests. Contact between LW and CYP also takes place by text.	Holistic, typically 4-5 sessions take place over a period of 2-3 months with fortnightly appointments. Mean session was just under one hour (59 minutes). Second and third sessions were often longer than the first (80 minutes).	Holistic, very flexible as LW outreach, typically 4-5 sessions (up to 8 sessions) and can last up to 12 months. Referral to assessment takes approximately 2 weeks. Typically one session per week at the beginning and then more bespoke depending on need. On average, sessions are about one hour.
Referring onto the following	Physical Activity: swimming, gaming; Acting, singing, scouts; Weight Management; Stop Smoking; Drug	One to one and group work support provided by the Youth Information Advice Counselling	Young carers; Healthy lifestyle; Sussex Night Stop; Sanctuary counselling (refugees/asylum

	Luton (Active Luton)	Sheffield (Sheffield Futures)	Brighton & Hove (YMCA DownsLink Group)
types of activities	and Alcohol support; Youth Services; Mind; Homeless Charities - Noah, Mary Seacole, Penrose; Flying Start	and Support (YIACS) service in-house: Youth clubs and groups already part of existing network; Substance misuse support; Careers guidance (incl. finance); Sexual health and relationships information support; volunteering	seekers); Youth clubs; English language; Youth advice centre; Counselling; Support with tackling domestic violence
Young people supported (**) (Nov 2018 to Oct 2019)	180	144	196

(*) CYP = Children and Young People; (**) Young people spoken to at least once over the period

4 Methods

4.1 Study aims and design

We adopted a mixed method approach to investigate social prescribing for young people in three English sites including a survey of health and social outcomes, qualitative interviews, a process evaluation and an economic evaluation (Table 2). The evaluation took place in Sheffield, Luton, and Brighton & Hove over the period between September 2018 and September 2020.

Table 2: Research design of young people social prescribing in three English sites

Type of evaluation	Themes	Design and methods of data collection
Outcome evaluation	To capture individual changes in mental well-being, physical health and social connectedness	
	Changes in the following: - Subjective Well-being (overall, mental) - Physical activity - Loneliness - Social capital (social networks, soc. Support) - Use of services (e.g. GP consultations, A&E attendance, hospital admission)	Methods: baseline and 6 months follow up **quantitative study**. Baseline and 6 months follow up survey of young social prescribing service users Data collection: Baseline and follow up data collected by link workers at each site on printed questionnaires and submitted to UEL quarterly Data analysis and outputs: regression analysis and economic assessment to be undertaken by UEL
Process evaluation	To examine mechanisms and contextual factors across different sites including fidelity, dosage, access, and sustainability	
	- Fidelity: Did actual programme performance meet the original goals for implementation? Which elements worked and which didn't and how these have affected, altered or amended the original plan and aims of the programme? - Monitoring progress: the intended outcomes of the programme activities such as number of sessions delivered, number of link workers trained, number of young people engaging in each stage of the programme. - Access: were the intended participants able to access the programme effectively? Who did and who did not have access?; what were the barriers - Sustainability: is the programme sustainable?	Fidelity and access (Sep – Nov 2019): semi-structured **qualitative interviews** with young people undertaken by UEL: 8 in Brighton & Hove, 3 in Luton and 5 in Sheffield. Two focus groups (Sheffield and Luton) undertaken by **Young commissioners** to document what has changed and young people's level of involvement in service improvements Contextual factors and mechanisms (incl sustainability): **Stakeholders interviews** (GP, 2 VCSE sector reps, council official, NHS official) and one **focus group** with link workers;

4.2 Health and social outcomes evaluation: quantitative study

The quantitative study collected data from young social prescribing participants between Feb 2019 and Sep 2020. As per initial protocol, agreed by collaborators, both baseline and follow up data were originally intended to be collected by link workers. However, only baseline data were collected by link workers as it was realised that follow up data collection would not have taken place as initially intended. With the agreement of all sites, the UEL research team suggested an alternative strategy to collect follow up data as follows: (i) UEL would send a text message and a one week reminder (if necessary) to young people with a link to a Surveymonkey questionnaire which could be completed by young people and would be received and analysed by UEL researchers. (ii) if the questionnaire was not returned after a two-week period, link workers in each site would contact young people and collect follow up data on the phone. Unfortunately, this strategy only worked in one of the sites, Sheffield, as the other sites, even with additional support from UEL researchers, were able to return only a small amount of follow-up data (see Table 3). Thus, much of the data presented in sec. 5.1 (p.14) really refers primarily to Sheffield.

Table 3: Baseline and follow up data by site

Data collection	Sheffield		Luton		Brighton & Hove		All sites	
Baseline	123	64.1	22	11.5	24	12.5	169	100
6 months Follow up	62	80.5	7	9.1	8	10.4	77	100

4.3 Process evaluation

The process evaluation examines the experiences of service users and stakeholders from each of the three social prescribing services as well as common factors influencing the implementation and development of the services. Factors examined include: fidelity and access; context and mechanisms and the future sustainability of social prescribing for young people. Five interviews with stakeholders were conducted including one GP, one senior NHS manager, one county council official, and two representatives from the voluntary, community and social enterprise sector. These were complemented by one focus group with link workers and 16 in-depth interviews with service users conducted by our researchers and two focus groups with young service users led by young people as user experience was seen as key to understanding the effectiveness of the piloted social prescribing provisions in how they each in turn helped to improve young people's lives. The three peer researchers who took part in this evaluation were trained using the NIHR funded young commissioner framework (Sharpe et al, 2018).

The young commissioners were male, aged between 17-21, two of the young commissioners were from South Asian background and one young commissioner came from a white British background. All three of the young commissioners were considered as experts by experience, having had first-hand experience and knowledge of health and social care strategies and policies. Vitally, their background in public commissioning helped the whole team to make better sense of the participants' accounts with the goal of producing recommendations for service and policy improvements (DCMS, 2019). In practice, the engagement of the young commissioners required bespoke training in preparation to co-deliver the focus group meetings across England, which provided the young people the opportunity to use their skills and understanding of using and delivering youth support services to co-inspect social prescribing provisions and to make judgements about how well providers did indeed achieved user satisfaction.

Qualitative data from the interviews and focus groups were analysed using a Thematic analysis approach (Braun & Clarke, 2006) in order to identify recurring themes across the data.

4.4 Economic Evaluation

We conducted a cost-benefit analysis of social prescribing by calculating a Social Return on Investment (SROI) and a cost assessment of healthcare service use (GP consultations and A&E attendance). There are different forms of cost-benefit analysis and different types of SROI. We followed the well-being valuation approach which has not yet been used in evaluations of social prescribing to date (Fujiwara, 2013). Yet, the well-being valuation approach has been supported by HM Treasury Green Book which includes a range of recommended approaches to economic analysis (HM Treasury, 2018). The well-being valuation approach is based on a different economic rationale involving the use of routine large-scale data (e.g. British Household Panel Survey; Understanding Society, Crime Survey for England and Wales). As Trotter et al. (2014) explain, large-scale data is used to identify the impact that target activity (e.g. volunteering) have on self-reported life satisfaction, once adjusted for all the other factors that may impact on individuals' satisfaction levels. Using the same statistical techniques, one can calculate the amount of money needed to induce the same change in life satisfaction and that constitutes the well-being value for that activity. The advantage of this approach is that is uses data from large scale routinely collected studies in order to produce financial proxies. It thus therefore represents the opinion of a large number of people.[1]

[1] For example, large-scale data is used to identify the impact that volunteering has on self-reported life satisfaction, once adjusted for all the other factors that may impact on individuals' satisfaction levels. This may show that volunteering leads to an average increase of 3% in people's satisfaction levels. Using the same statistical techniques, one can calculate the amount of money needed to induce the same change in life satisfaction of 3%, say for example (£5,000). This is the well-being value for that activity.

It is important to note that we were able to produce a Social Return on Investment for Sheffield only it was the only one which provided sufficient baseline and follow up data for this particular exercise. On the other hand, the analysis of health care use relates to all sites.

5 Results

This section describes all the results from the quantitative and qualitative data collection, beginning with a descriptive analysis of participant characteristics, health and social outcomes,

5.1 Descriptive analyses of participant characteristics

As mentioned in other sections (4.2, p.12) the vast majority of the data collected by the quantitative study refers to Sheffield. However, in relation to the analysis of participant characteristics, we can usefully provide a picture for all sites as there is adequate data. The mean age of young respondents is 16 with a age range across the sites between 11 and 24 years old. Sheffield and Luton had a lower proportion of 11-15 years old than Brighton & Hove, so on average they supported a slightly older age group.

Interestingly, there is a very even distribution of male (42.6%) and female (52.7%) respondents, unlike adult social prescribing which typically records a 70/30 female/male split. The White British young population in the sample (73.8%) is higher than the adult White British population in the three sites (68.3%)[2]. Thus, there appears to be a slight over-representation of White British in the sample as a whole with the exception of Luton which shows a much higher proportion of Black/Black British respondents. In terms of employment status, as perhaps expected the majority of respondents are in education (school and college, 48.8%) with a substantial proportion of 'other' (10.4%) waiting to start or attending university. Some 14.3% of respondents are in full time, part-time or self-employment, and almost the same proportion unemployed (13.1%). The vast majority of respondents live with others (i.e. family or foster parents/carers) (92.7%) with only a small proportion living alone (4.7%) in Sheffield, an area with a slightly more adult population. Finally, it is noticeable that more than half of the sample (50.3%) has a long standing physical and/or mental illness that limit their day-to-day activities. This confirms that the sample of young people is in need of support and is therefore the right target group for young people social prescribing.

[2] ONS population estimates by ethnicity (2019). This estimates are for the adult rather than young population, but considering that younger populations are more diverse, the argument still stands. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationcharacteristicsresearchtables

Table 4: Participant demographic characteristics at baseline

Profile	Sheffield		Luton		Brighton & Hove		All sites		
	n	%	n	%	n	%	n	%	
Age groups (years)									(*) percentages are out of total for each row . So for example, 20.2% of respondents to the question about employment , were actually employed either in a full time , part-time or self-employed capacity; (**) mainly responded that they are waiting to start university or are at university
11-15	33	26.8	10	45.5	14	58.3	57	33.7	
16-20	70	56.9	12	54.5	9	37.5	91	**53.8**	
21-25	20	16.3	0	0.0	1	4.2	21	12.4	
Mean (min-max)	17 (11-24)		15 (11-18)		15 (11-21)		16 (11-24)		
Gender									
Male	48	39	9	40.9	15	62.5	72	42.6	
Female	68	55.3	12	54.5	9	37.5	89	**52.7**	
Prefer not to say	3	2.4	0	0	0	0	3	1.8	
Prefer to self-describe	4	3.3	1	4.5	0	0	5	3.0	
Ethnicity									
White British	99	81.1	5	22.7	20	83.3	124	**73.8**	
Black or Black British	4	3.3	7	31.8	0	0.0	11	6.5	
Asian or Asian British	9	7.4	2	9.1	0	0.0	11	6.5	
White Other	5	4.1	1	4.5	3	12.5	9	5.4	
Mixed	4	3.3	4	18.2	1	4.2	9	5.4	
Other	1	0.8	3	13.6	0	0.0	4	2.4	
Employment status (*)									
Employment (FT, PT and self)	30	25	2	9.1	0	0	32	14.3	
Unemployed and looking for work	17	14.2	2	9.1	2	11.1	21	13.1	
At school (GCSE and below)	49	40.8	9	40.9	13	72.2	71	**31.8**	
At college (above GCSE)	26	21.7	10	45.5	1	5.6	37	16.6	
Government training course	2	1.7	0	0	0	0	2	0.9	
Unable to work due to illness	9	7.5	0	0	0	0	9	4.0	
Looking after house/family	4	3.3	0	0	0	0	4	1.8	
Other (**)	14	11.7	2	9.1	2	11.1	18	8.1	
Living Arrangements									
Alone	7	5.7	0	0	0	0	7	4.7	
With spouse, partner	0	0	0	0	0	0	0	0	
With others (family, foster parents/carers)	112	91.1	22	100	23	95.8	157	**92.7**	
Secure housing	2	1.6	0	0	1	4.2	3	1.6	
Temporary accommodation	2	1.6	0	0	0	0	2	1.0	
Rough sleeping	0	0	0	0	0	0	0	0	
Long standing physical/mental illness									
No	40	39.6	12	54.5	8	50.0	60	**43.2**	
Yes, limited a little	31	30.7	6	27.3	6	37.5	43	30.9	
Yes, limited a lot	22	21.8	4	18.2	1	6.3	27	19.4	
Prefer not to say	8	7.9	0	0	1	6.3	9	6.5	

5.2 Health and social outcomes evaluation

Data collected were analysed by the Institute of Connected Communities (ICC, previously known as Institute for Health and Human Development) based at University of East London. This section analyses 169 baseline and 77 follow up responses from young service users in the period between Feb 2019 and Sep 2020. However, as mentioned in the method section (see breakdown Table 3, p.12), the data presented here draw heavily on young participants from Sheffield as other sites only collected very limited follow up data. Changes in health and social outcomes are analysed here including personal and mental well-being, loneliness, social capital and physical activity.

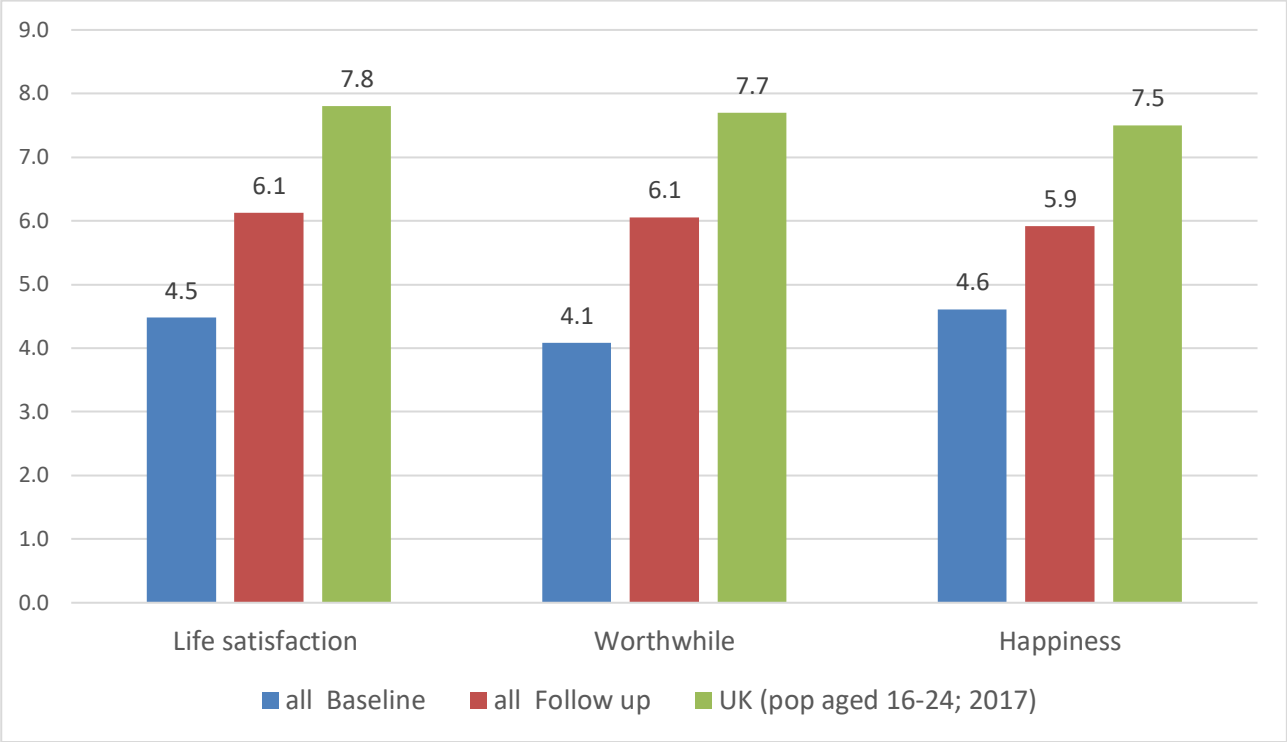
5.2.1 Personal well-being

Personal well-being is a validated and widely use of personal well-being used routinely by the Office for National Statistics (ONS). It is made up of four components including life satisfaction, a worthwhile life, happiness and anxiety. However, as these questions were asked to young people from age 11, it was decided not to ask the latter question about anxiety for ethical reasons. In terms of ONS Personal well-being questions, respondents are asked to rate these four components from '0' (not at all satisfied) to '10' (completely satisfied). The ONS provides ratings for life satisfaction, worthwhile and happiness as follows: Low (0 to 4), Medium (5 to 6), High (7 to 8), and very high (9 to 10). On this basis and looking at Figure 1, personal well-being in all areas together could be rated as 'medium', whilst the corresponding rate for the UK population aged 16-24[3] in 2017 could be rated as 'high' overall. This shows a lower rate of personal well-being for the respondents in relation to the UK average which is to be expected, given that the target group of young people are in search of support to address a need.

Moreover, all three components of personal well-being grow over the period, despite the fact that much of the follow up data collection took place during the course of the Covid-19 pandemic.

[3] ONS does not publish data on younger people below the age of 16.

Figure 1: Mean changes in personal well-being in all sites and UK



However, much of this positive change is to be attributed to Sheffield site as shown in Table 5 as Sheffield was the only site showing an improvement in the three components of personal well-being and managed to submit higher number of baseline and follow up data.

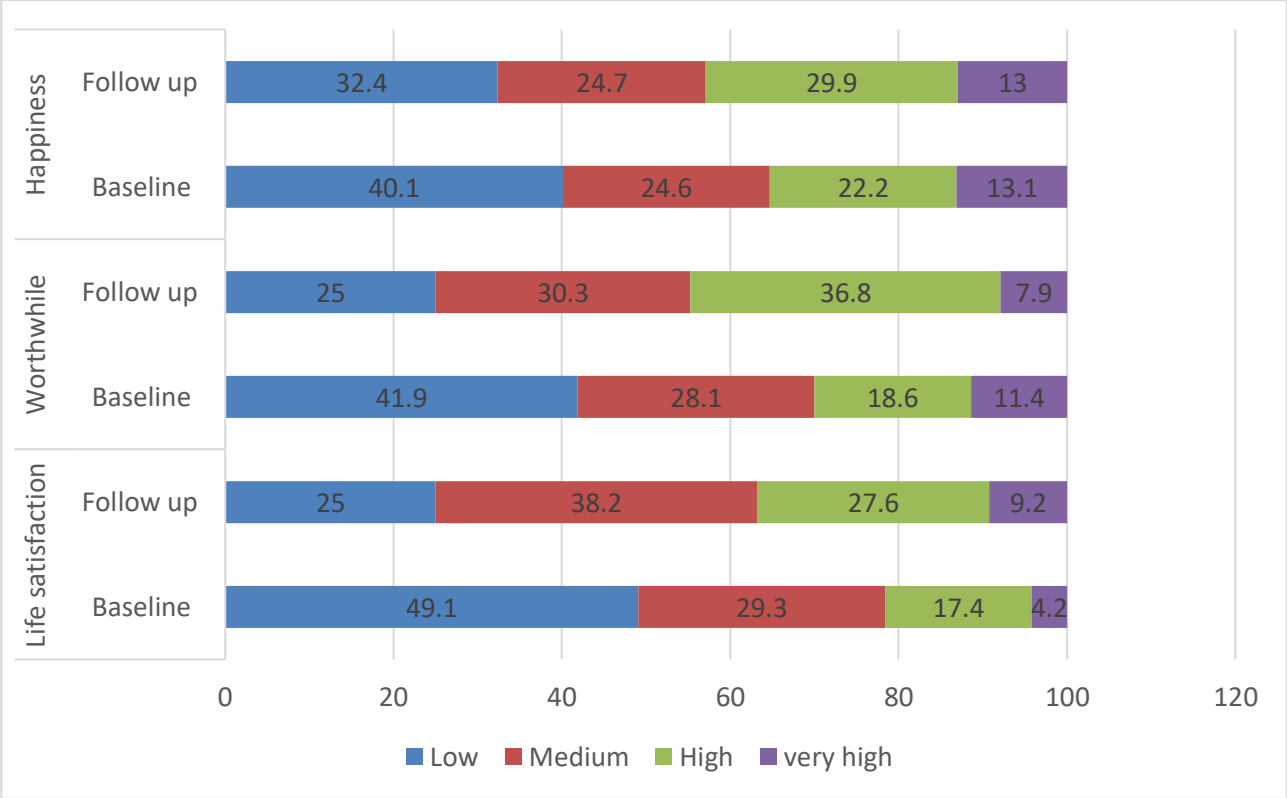
Table 5: Mean change in personal well-being by site

Profile	Sheffield		Luton		Brighton & Hove		All sites	
	Base	FU	Base	FU	Base	FU	Base	FU
Life satisfaction	4.2	5.7	8.0	7.4	5.7	5.3	4.5	6.1
Worthwhile	4.7	5.5	6.0	7.4	5.6	5.3	4.1	6.1
Happiness	4.6	5.7	7.6	6.4	6.3	5.6	4.6	5.9
Sample size (N)	*122*	*61*	*22*	*7*	*24*	*8*	*168*	*76*

Base=Baseline; FU=Follow up

Figure 2 shows rates of change in personal well-being to assess how groups of young respondents changed rates of personal well-being from baseline to follow up. It is noticeable that the proportion of respondents who reported low life satisfaction (49.1%), low worthwhile (41.9%) and low Happiness 40.1%) at baseline substantially declined at follow-up (25%, 25%, and 32.4% respectively). This means that change in personal well-being are more marked for those who had lower scores at baseline.

Figure 2: Rates of change in personal well-being (all sites)



5.2.2 Mental well-being

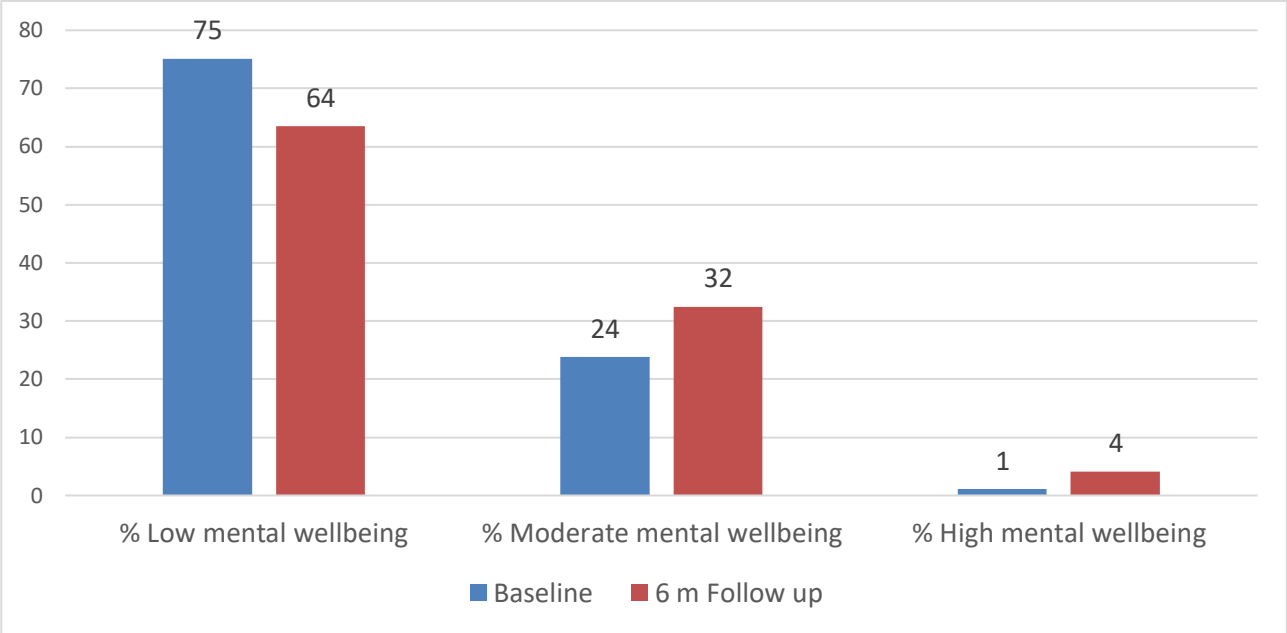
Mental well-being was measured using the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS) which is a validated scale of 7 items used for the measurement of mental well-being of any population aged 13 to 74. It comprises seven positively worded statements and participants are asked to rank on a Likert Scale (from 'None of the time' to 'All of the time') each mental well-being statement in the previous two weeks. Mental well-being refers here to positive states of being, thinking, behaving and feeling and is a good indicator of how people and populations are able to function and thrive (Putz et al 2012).

Mental well-being of the sample at baseline (19.2) was below the national average (23.6)(HSE, 2011)[4]. The mean change score is positive (from 19.2 to 21) which is not defined as 'meaningful'[5], but nevertheless indicating an overall increase in mental well-being. Looking at components of mental well-being, the greater positive change comes from respondents being more able to deal with their problems (0.42) and

[4] This is the latest data available using the short WEMWBS.
[5] Guideline on mental well-being from (Putz et al., 2012) regards as 'meaningful', a change between 3 and 8 points in SWEMWBS score between baseline and follow up in both positive and negative directions.

feeling closer to other people (0.42). it was possible to run Wilcoxon singe rand test P value which showed a statistically significant positive change between baseline and follow up (p<0.05; SD=181.90; z=3.39). Furthermore, analysis by level of mental well-being shows reductions in the proportion of respondents reporting low mental well-being from baseline to follow-up (from 75% to 64%) and an improvement of both moderate and high mental well-being.

Figure 3: Changes in mental well-being by rate (all sites)



Again, as for other quantitative analyses in this section of the report, much of the positive results in mental well-being are due to the contribution of Sheffield rather than the other three sites (Table 6). Sheffield showed a statistically significant positive change in mental well-being, alongside Luton. However, it is important to exercise some caution about the result in Luton as the sample size of respondents is very small. In addition, the mean score (Table 6) across the sites is positive for Sheffield and Luton but negative for Brighton & Hove. Again, the sample size for the latter two is very small so caution should be exercised in interpreting these results.

Table 6: Mental well-being score by site

	Sheffield		Luton		Brighton & Hove		All sites	
	Base	FU	Base	FU	Base	FU	Base	FU
Mean score	18.4	21	20.4	23	21.5	21	19.2	21
N (sample size)	*119*	*61*	*29*	*13*	*22*	*7*	*170*	*74*
Statistically significant (*)	Yes		Yes		No		Yes	

(*) Wilcoxon Signed rank test P value (p<0.05)

5.2.3 Loneliness

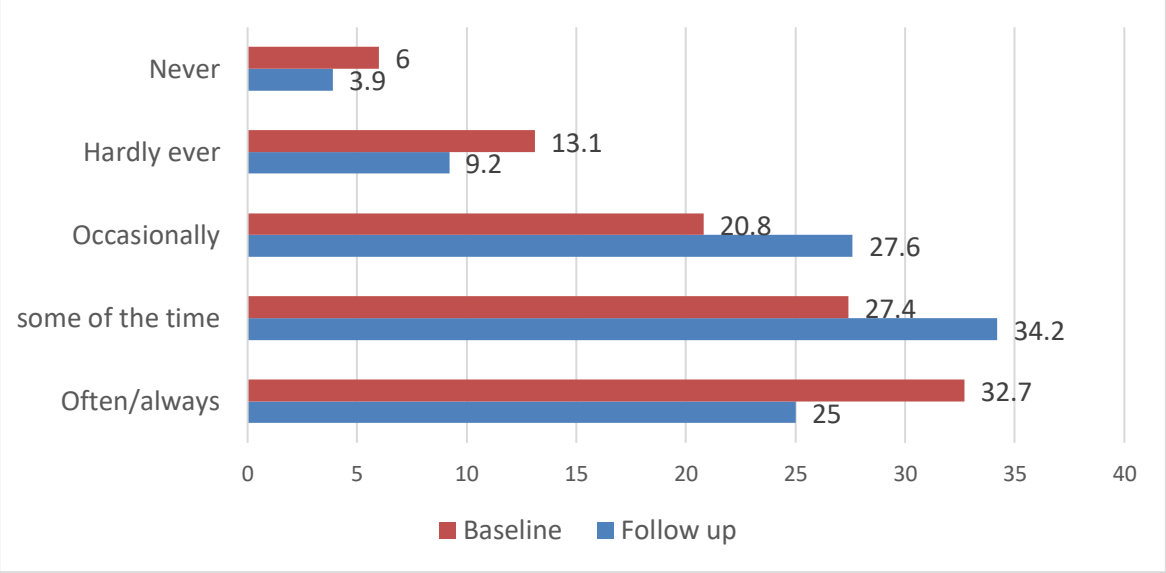
There are many measures of loneliness, different length and use in different context and age groups. However, as the space on the questionnaire was limited, we chose one single question, accepted by the Office for National Statistics. The question is "how often do you feel lonely?" and it has five possible answers including 'often/always', 'some of the time', 'occasionally', 'hardly ever', and 'never'. Thus, the higher the mean scores in Table 7, the lower the loneliness experienced by respondents. Across all sites, loneliness appears to remain essentially stable (2.32 to 2.33). However, when considering each site, loneliness in Sheffield and Luton appears to decline (2.09 to 2.26; 2.95 to 3.50), whilst it increases in Brighton & Hove. As mentioned in other parts of the report, the samples of Luton, and Brighton & Hove are very small, thus any results should be interpreted with extreme caution.

Table 7: Mean changes in loneliness over time (all sites)

	Sheffield		Luton		Brighton & Hove		All sites	
	Base	FU	Base	FU	Base	FU	Base	FU
Mean score	2.09	2.26	2.95	3.50	2.92	2.00	2.32	2.33
N (sample size)	122	62	22	6	24	8	168	76

Figure 4 shows the change by type of response in all sites. There has been a reduction in extreme feeling of loneliness (i.e. often/always), but this has been offset by a negative trend in all the other types of response which led to an increase of feeling of loneliness overall.

Figure 4: Change in reported loneliness (all sites)

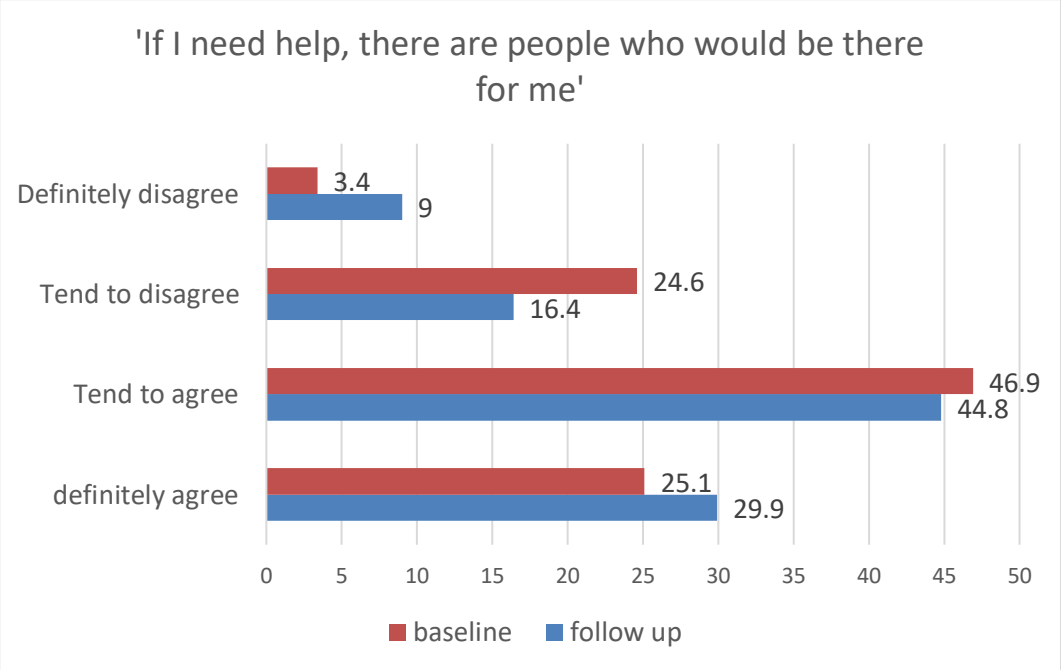


5.2.4 Social capital

A wide range of measures of social capital are available as the literature has been developing over two decades. Much literature has shown a positive association between social capital and health (Kawachi and Berkman, 2001; Poortinga, 2006). Through support and encouragement to engage offered by both link works and voluntary sector activities, social prescribing is expected to increase reported support received, trust, volunteering, and neighbour relations.

In order to assess this, we asked young people about support received by asking how much they agreed or disagreed with the following statement: 'If I need help, there are people who would be there for me'. As shown in Figure 5, most respondents tended to agree with that statement and this statement remained essentially stable between baseline and follow up (mean change -0.02).

Figure 5: Close support (all sites)



In addition to receiving support, importantly, one out of five respondents (21.9% or 33 respondents) looked after or provided special help for somebody who is sick, disable or elderly potentially including a relative, partner, sibling or friend.

In addition, young people were asked whether they agreed (or disagreed) that most people in their area/ including school or college can be trusted. On average, the response was 'neither agree nor disagree' and remained stable between baseline and follow up. On closer analysis, it becomes clear that the response is

equally split on each side so there are an almost equal number of respondents agreeing and disagreeing with the statement but not so many extreme views.

The questionnaire also asked young respondents how often they chatted to any of their neighbours, more than just to say hello. This question is asked to measure neighbour relations, a component of social capital. Figure 6 shows a marked improvement in number and frequency of contacts with neighbours over the period. This is likely to reflect the wider UK changes toward neighbours over the Covid-19 period.

Figure 6: Changes in neighbour relations (all sites, %)

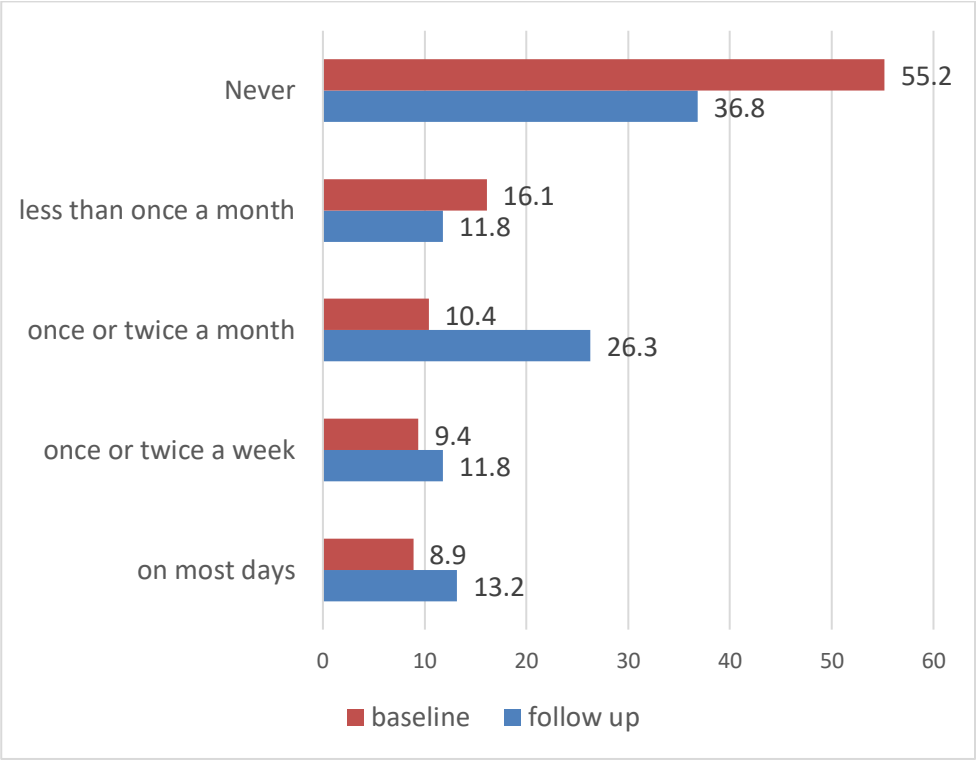
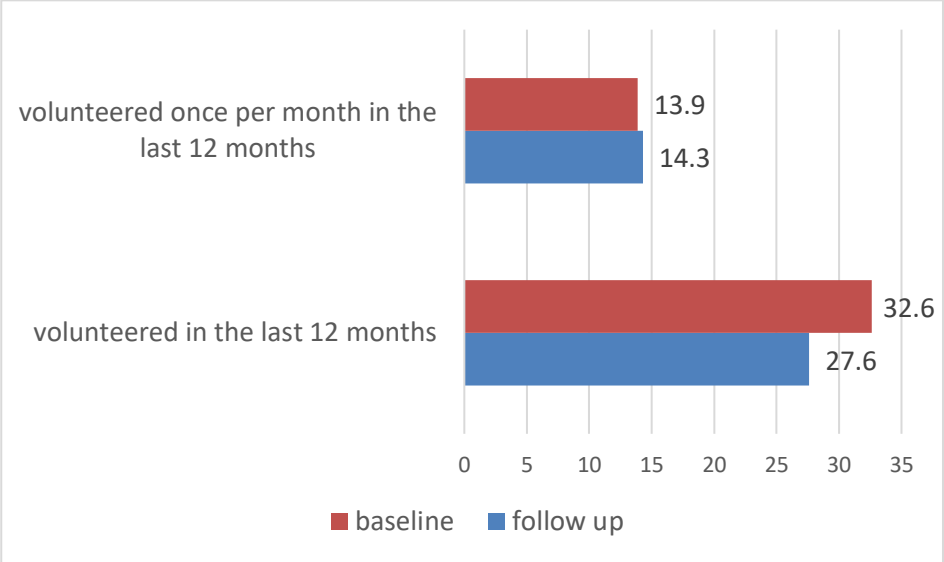


Figure 7 shows the proportion of respondents who **volunteered regularly** (once per month in the last 12 months) and **more occasionally** (i.e. in the last 12 months). As expected, more young respondents volunteer occasionally and this has declined over time. On the other hand, there are fewer more regular volunteers (broadly one out of ten) who appear to volunteer regularly over time as the difference between baseline and follow is only 1% (13.9 to 14.9%). It is also interesting that this remains so stable, given the Covid-19 pandemic at the time of follow up. This could mean that young regular volunteers have carried on volunteering given the increasing need from vulnerable elderly in the community.

Figure 7: Percentage of respondents who volunteered (all sites, %)



5.2.5 Physical activity

The evaluation also collected data across different types of physical activity including walking, cycling, sport, fitness or dance to assess whether social prescribing may have had an impact on physical activity levels. In order to assess physical activity levels, we used the definition of 'active' from the UK Chief Medical Officer (CMO, 2019) as follows:

- For respondents 19 to 25 years old, the CMO defines as 'active' all those people who achieve 'at least 150 minutes of moderate intensity physical activity per week across all types of physical activity
- For respondents 5 to 18 years old, the CMO defines 'active' all those people who achieve 'at least 420 min per week (i.e. 60 min per day) of moderate physical activity per week' across all types of physical activity

For both definitions, 'moderate intensity' physical activity requires a raised breathing rate, but the person is still able to talk.

Table **8** shows that the proportion of respondents who were active increased from 46.1% to 53.4% overall. Respondents were considered as 'active', if the sum of the minutes per week across different types of physical activity achieved the CMO recommendations.

Table 8: proportion of respondents achieving an 'active' level of physical activity

	Sheffield		Luton		Brighton & Hove		All sites	
	Base	FU	Base	FU	Base	FU	Base	FU
Active (%)	44.8	57.4	47.4	41.2	66.7	50.0	46.1	53.4
N respondents	*105*	*47*	*38*	*17*	*12*	*6*	*128*	*58*

Table 9: mean level of physical activity by type (minutes per week)

	All sites	
Mean minutes per week	Base	FU
Walking	388	606
Cycling	145	78
Fitness (e.g. gym, dance, other sports)	352	109

We also measured mean minutes per week spent by respondents walking, cycling or fitness (e.g. gym, dance, other sport) at a raised breathing rate. It was not possible to differentiate per site as the data was not sufficient for an appropriate analysis. Overall, walking and fitness seem to be the most favourite choice for respondents (388 and 352 minutes per week respectively), whilst cycling much less so (145 minutes per week). Mean walking minutes per week increased substantially over the period, whilst cycling and especially fitness declined substantially. It is difficult to explain why this may be the case. One possible explanation is that the first wave of coronavirus with gyms' closures and limits to face to face interaction affected levels of fitness and cycling with respondents engaging more in walking near the homes.

5.3 Process evaluation

The process evaluation examines the experiences of service users and stakeholders from each of the three social prescribing services as well as common factors influencing the implementation and development of the services. Factors examined include: fidelity and access; context and mechanisms and the future sustainability of social prescribing for young people. In order to provide evidence for these, 16 in-depth qualitative interviews were conducted with service users referred onto the three social prescribing services. In addition, two focus groups were held with Young Commissioners from two of the sites. Five in-depth qualitative interviews were also conducted with stakeholders as well as one focus group including link workers from each service. Stakeholders included one representative from primary care (i.e. GP), one senior NHS manager, one representative from the VCSE sector and one local authority official. The qualitative interviews and focus groups are supplemented by monitoring data on referrals collected for each of the sites.

5.3.1 Reasons for referral

Respondents were asked about the main reasons for their referral to the social prescribing service. Figure 8 (p.25) shows that across the sites, mental health/well-being was the most important reason for referral with two out of five responses (40.1%), Social isolation (18.3%) and lifestyle changes (13.1%) were far behind. Overall, it is possible to note that health reasons are more frequent in the referral than social determinants of health reasons with financial and social welfare advice, work and training only marginally important. As the interplay between social and health issues is complex with social issues initially appearing as health ones (e.g. mental or physical health problems due to work or housing issues), it is difficult to generalise from these results, although they do indicate a high prevalence of young people with mental health/wellbeing issues.

Figure 8: Reasons for referral (% responses, all sites)

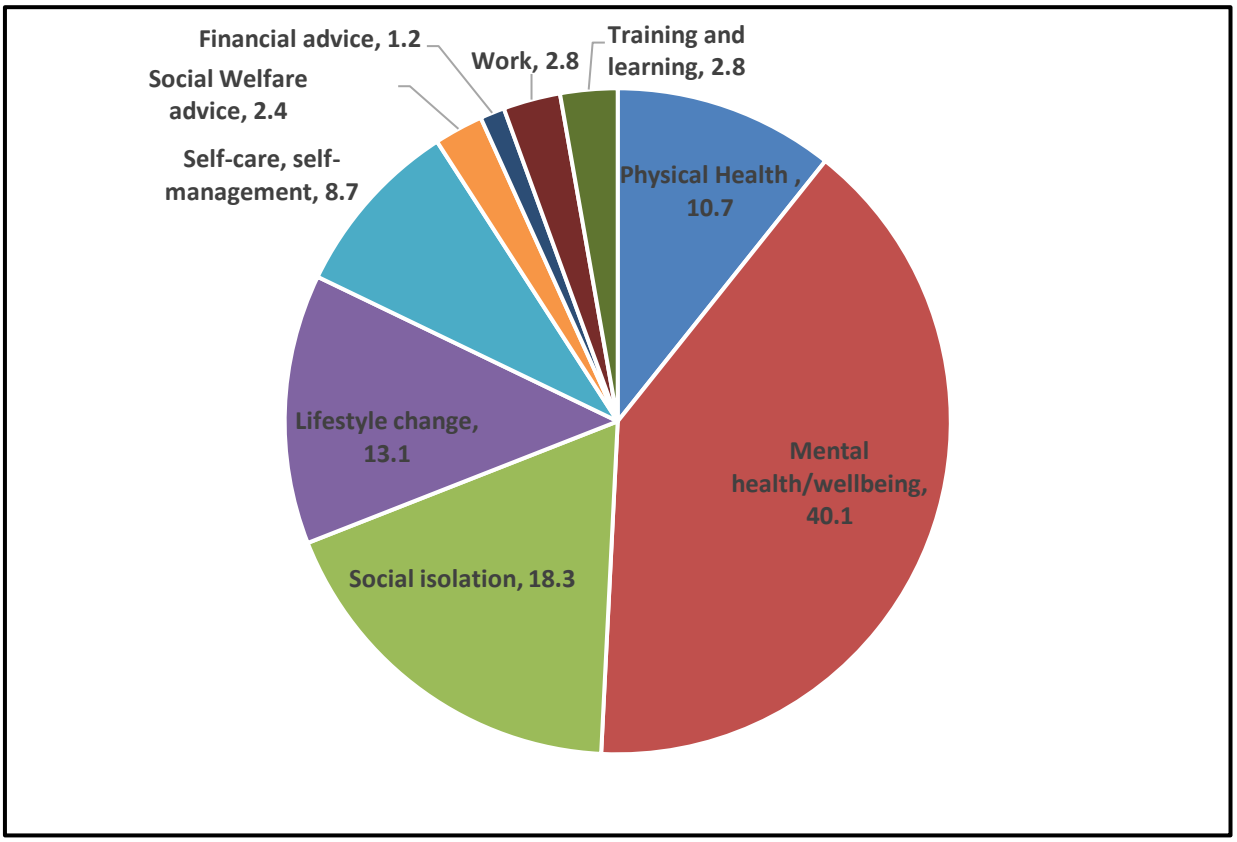


Table 10 shows the breakdown of referral reasons by site. There is no great difference between reasons for referral between different sites. Mental health/well-being features prominently across sites, particularly in Sheffield (45.6%). 'Physical health' stands out in Luton (24.2%) which is not surprising given the emphasis of this social prescribing service on physical activity for young people and adults led by Active Luton. Social isolation is particularly relevant in Brighton & Hove (22.9%), again reflecting the YMCA emphasis on the most vulnerable groups.

Table 10: Reasons for referral by site

	Sheffield		Luton		Brighton & Hove		All sites	
	N	%	N	%	N	%	N	%
Physical Health	13	*7.6*	8	*24.2*	6	*12.5*	27	*10.7*
Mental health/well-being	78	*45.6*	9	*27.3*	14	*29.2*	101	*40.1*
Social isolation	29	*17.0*	6	*18.2*	11	*22.9*	46	*18.3*
Lifestyle change	16	*9.4*	9	*27.3*	8	*16.7*	33	*13.1*
Self-care, self-management	16	*9.4*	1	*3.0*	5	*10.4*	22	*8.7*
Social Welfare advice	5	*2.9*	0	*0.0*	1	*2.1*	6	*2.4*
Financial advice	3	*1.8*	0	*0.0*	0	*0.0*	3	*1.2*
Work	6	*3.5*	0	*0.0*	1	*2.1*	7	*2.8*
Training and learning	5	*2.9*	0	*0.0*	2	*4.2*	7	*2.8*

Notes: multiple responses were possible, so the total number of responses is greater than number of respondents.

5.3.2 Sources of referral

Respondents were asked how they found about the social prescribing service (Table 11). The main source of referral across all sites was varied including 'friend or family' (18.9%), followed by General Practitioners (18%), schools/colleges (17.2%), mental health services (10.7%) and adult social care (10.7%). Sheffield received most of their referrals from 'school or colleges' (22.8%), whilst Luton from mental health services (42.1%) and Brighton & Hove from GPs (63.3%). However, it is important to note that Luton and Brighton & Hove had a very small number of responses which may not represent the source of referral of the overall number of young people they have supported over the period.

Table 11: Sources of referral (all sites)

	Sheffield		Luton		Brighton & Hove		All sites	
	N	%	N	%	N	%	N	%
Friend or family	14	*15.2*	6	*31.6*	3	*27.3*	23	*18.9*
General Practitioners	15	*16.3*	0	*0*	7	*63.3*	22	*18*
School or college	21	*22.8*	0	*0*	0	*0*	21	*17.2*
Mental health service (e.g. IAPT, CAMHS)	4	*4.3*	8	*42.1*	1	*9.1*	13	*10.7*
Adult social care or social services	10	*10.9*	3	*15.8*	0	*0*	13	*10.7*
Within the same organisation	10	*10.9*	0	*0*	0	*0*	10	*8.2*
Project staff/volunteer	6	*6.5*	0	*0*	0	*0*	6	*4.9*
Website	3	*3.3*	0	*0*	0	*0*	3	*2.5*
Leaflet or poster	1	*1.1*	2	*10.5*	0	*0*	3	*2.5*
Community hospital	1	*1.1*	0	*0*	0	*0*	1	*0.8*
Other	7	*7.6*	0	*0*	0	*0*	7	*5.7*
Total	92	*100*	19	*100*	11	*100*	122	*100*

5.3.3 Fidelity and access

Stakeholders across all three sites were asked about their experiences of the implementation of the social prescribing services. These included one GP, one senior NHS manager, one county council official, two representatives from the voluntary, community and social enterprise sector (VCSE), link workers Specifically, whether they felt their service had remained true to the original intentions of the model and proved to be accessible to the intended groups of young people. Broadly speaking, stakeholders felt that each social prescribing service had met its initial aims and was working well.

"We're able to work with the social prescribers who can support the people to attend our activities and also recommend activities that that young person would most benefit from. So, I just think really, I think it's been a real benefit for us and within the whole team we've all gone, 'Oh what an amazing service. We've needed this for years and years and years." (VCSE sector stakeholder)

"It engages them in diversionary activity which is kind of good for managing their emotional well-being and erm, challenging some of their behaviours and the fact that there's a sort of mentoring type approach, gives them like a, hopefully, a positive attachment to a good role model which might be something that they're lacking." (County council official)

"I think where it works, I think it's trying to connect young people to very, very local resources." (General Practitioner)

Factors facilitating accessibility

Several factors were identified as facilitating the accessibility of social prescribing for their young service users. The social prescribing services do their best to make the service feel accessible and welcoming. The services do this by providing several meeting point options so young people can be directed to their nearest. All the services also operate some form of outreach service enabling their link worker to meet the young person on familiar territory, at school or in their own home.

"The area that is used as well within our building was designed by the young people themselves, so it's a very young person friendly, they feel very comfortable in that environment." (Link worker)

"The major plus for us is the fact that it's an outreach model so we can erm…have a wider reach in the community which is a huge plus for us as a service." (Link worker)

For those young people who lacked the confidence to access further support and activities within the community alone, the buddying aspect of the link worker role has been a big success.

"The biggest barrier has been, they don't want to go on their own. That's been a huge barrier…we can take them to their first session and we can sit and wait for them and then go back with them." (Link worker)

Another effective way of easing young people into a new activity is to collect as much information about the activity beforehand for them, so they know what to expect. Sometimes this can be facilitated by offering the young person a taster session with no commitment until they've decided it is right for them.

"I'll always offer the option to, just go along to whatever group it is or whatever activity it is, just to check it out, become familiar with the environment, with the staff, with you know the other people and see the other people who actually access. Sometimes we might even go when a group isn't running but you just go to see the venue and speak to the staff themselves who deliver the groups to find out more information." (Link worker)

5.3.4 Context and mechanisms

The stakeholders were also asked in more detail about the mechanisms and processes at work within the social prescribing pathways, as well as the wider context within which the services were operating (for example, how social prescribing fits into and makes uses of other services). The results are presented below.

Filling a gap in mental health service provision

A common theme among the social prescribing services was the sense of 'filling a gap' in available support, particularly for young people with mental health challenges. With long waits for services like CAMHS which also require a high threshold need before they can be accessed, social prescribing provided much-needed support for local young people.

"I mean well I think the first thing which is glaringly obvious is that the system is not working because if you get to a point where you need specialist interview as a child and then you may have to wait for a year, then the system is not working…if they're kind of told that they need a service which they cannot access? It's pointless isn't it, it's not only unacceptable its utterly pointless." (Council official)

Social prescribing was also found to support young people who did not go to school and presented with mental health problems as another gap in the support service available.

"A lot of those (statutory mental health) services tend to be accessed through schools and a lot of the kids with serious mental health issues aren't going to school…CAMHS is just very, very inaccessible for the vast majority of people." (VCSE sector rep)

Social prescribing was also seen as a vehicle to improve the effectiveness of a young person's mental health support pathway, to provide an accessible and timely mental health support for people waiting to receive further support from statutory mental health providers (e.g. CAMHS). place.

"This is not about saying that we don't need CAMHS or whoever anymore, but it's about saying that we need to make sure that the people that are accessing those services are the ones that really need it, that can access it swiftly and effectively in a timely manner. And that actually for some people, a social prescription approach would be the absolute best and that's enough." (NHS official)

What makes social prescribing for young people different?

Even for those services who had established adult social prescribing pathways to build on, working with young people in this way has presented a new set of challenges. Most obviously there were extra factors around gaining consent from parents and carers for the under 16s and often the need for link workers to coordinate their work with that of a number of other agencies involved in the care of the young person. Working with families often became part of the service and the tension between developing a trust relationship with the young person and at the same time managing confidentiality and the expectations of parents and carers can need careful negotiating.

"We've had families where the mother and daughter have gone off to do sort of gym classes and stuff like that together which helps obviously with family relationships and things like that. But erm, yeah sometimes parents can sort of take over. Or they might not think it's the right support…I've got some families where parents want their child to be doing loads of activities and the children just aren't interested which can obviously be a bit of a barrier and a bit of family relationship work going on to try and help families understand what each other wants." (Link worker)

Link workers on the whole, found ways to manage their communication skills in order to relate successfully to both parents and their young people and saw the opportunity to work with the whole family as a positive opportunity for change.

"I've found it really helpful to be able to talk to the parent, talk to the young person and open up a dialogue between them both, to move the young person forward. And the family sometimes, cos the family can be quite stuck." (Link worker)

Encouraging the young person to have a voice and express their needs is an important part of the collaborative trust relationship built with their link workers and leads to a sense of empowerment. This can be of particular importance to young people who tend not to have much say in their own care and are used to decisions being made for them.

"I do think we've got a bit of a job to do strategically in terms of, people often think that the service is the solution. They don't often think that they have the solution within them, because they've not always been given the permission to have that voice, or take that control." (NHS official)

"Adults have more autonomy than children generally, and our services have reflected that. There's been a much more kind of, you know these are the adults, they're the experts they know what you need. And actually, very poor kind of listening to children and accepting their perspective on their needs and recognising their expertise to kind of manage their own lives and working alongside them which is what's going to empower them to kind of manage themselves as they go forward in life." (Link worker

Another positive aspect of the social prescribing services is the potential to avoid the stigmatisation that might come with being referred to more traditional mental health services.

"They don't want to be labelled or diagnosed with a mental health condition, they just, you know it's more of an environmental factor that's causing their distress." (Link worker)

Challenges

Challenges to delivering the social prescribing services going forward included, dealing with inappropriate referrals and a greater number of mental health related referrals than initially expected.

"We've definitely had successes, and I think for us going forward the biggest, the biggest thing to really focus on is going to be looking at how we get a much m- the right referral coming in and where we access referrals from." (Link worker)

Link workers also spoke about the complexity of their role, which involves far more than just managing their caseload of service users. Identifying appropriate activities and support in the local area and keeping up to date with projects that come and go is a constant challenge. As is building relationships with project managers and external organisations. Another challenge for services and their link workers has been to maintain their visibility to health professionals and other referrers.

"It's just really hard to work with young people and manage the referrals coming in and then also be your own marketeer." (Link worker)

Impact of Coronavirus

The onset of the Coronavirus pandemic has seen a significant shift in the way the social prescribing services are delivered for young people, with link worker sessions moving to remote forms of communication like texting, and support services and activities closing down altogether. With young people confined to their homes, finding a safe and confidential space to communicate can become a challenge.

"Some feedback we've been getting is a lot of young people don't really like talking over the phone. And also, I think there's the issue of, the young people are obviously at their homes now and there's other people there and they're having to talk and it's not as confidential." (Link worker)

"I think one of the big challenges has been that young people haven't had places to go while, COVID, especially during lockdown." (General Practitioner)

"Before we used to communicate a lot through school and then we'd target individually the people at home. And sort of them ring them or go round. Cos we're not going round so much, again, vulnerability and the isolation is quite scary." (General Practitioner)

One respondent was also worried about an increase in online grooming and that already scant resources will be diverted towards the older population when for some young people, being out of school has impacted on their basic needs as their families struggle to make ends meet.

"We've tried to centre our efforts is around the foodbank. The foodbank obviously is you know, triple usage…(we're) knocking on the door and checking people have got enough." (General Practitioner)

However, it is not all bad news as many young people are comfortable with the technology and happy to interact with the service remotely. The individual services have also responded in kind by making support and activities available digitally, as well as frequently checking in with their young service users.

"We've had an online chat set up, so we can talk to young people all the time, we've done weekly phone calls to those that we felt were most vulnerable. And we've run lots and lots of activities. We for example we did like a cooking activity, where I went round and delivered a parcel to everybody and everybody cooked and took photos and we did a bit of a competition." (VCSE representative)

5.3.5 Sustainability and future of social prescribing services

The most obvious limiting factor to the sustainability of the social prescribing services is felt to be financial and, in particular, the need for more focussed targeting of funding into VCSE organisations service delivery.

"When organisations can't continue to sustain themselves through their own funding bids and voluntary contributions as a charity, then that provision just disappears. And that's something that we're facing now of course, because it's been much harder for charities to keep going…in an ideal world I think the bulk of the investment should be in early intervention and prevention and most of the delivery should be in community-based organisations so, voluntary and safe sector organisations." (Council official)

Another significant challenge in sustainability was to adapt to new ways of working in the face of the Coronavirus pandemic, with more online services being made available for young people to access at home. There was also a suggestion to expand the number of physical locations where young people can attend social prescribing (for example, schools) and extend the service to support other age groups. There was

acknowledgement of identifying what is going well and building on that, whilst also acknowledging that different areas of the country have different local needs.

"We have to build on those strengths because we don't have the time, human resources, or financial resources to recreate something that means we're going to throw all that out. And actually that's really disrespectful to do that because there's a lot of really fabulous stuff out in the community that's already working really, really well." (NHS official)

"Guidance that says, 'there might be things that you need to do in your local area that are different, but actually if you want to get it right these are the…I don't know 10-12 however many things that are the non-negotiables of how we do it for children and young people.' And I think that's what I want to see, is something very simple." (NHS official)

5.3.6 Service users experience

In-depth interviews were carried out with 16 service users across the three sites in order to find out more about their experiences of their particular social prescribing service. For Sheffield this included five interviews with young people and one focus group. In Luton the data analysed came from two interviews with young people, one interview with a parent and one focus group; and for Brighton & Hove there were seven interviews with young people and one with a parent.

Findings specific to the Sheffield site

***Referral data**:* Mental health is by far the most important reason for referral in Sheffield (45.6%), followed by social isolation (17.0%) and lifestyle change (9.4%). More social reasons for referrals such as social welfare advice, financial advice, work or training/learning are not so important (between 2-3.5% of reasons for referral). Most referrals in Sheffield came from schools/colleges (22.8%), followed by GPs (16.3%) and Friend/family (15.2%).

Accessibility

Young people were referred by either their school, doctor or other parts of the NHS onto the service for support, mostly with mental health challenges. Sometimes, they also self-referred through Door 43, a drop-in service run by Sheffield Futures. Within Door 43, young people then went on to take part in physical activities like yoga and football or volunteering in their local community. A young people spoke about being made to feel welcome at their first visit which encouraged them to return:

"When you come for the first time they need to make it obvious that you're in the right place and that they're not trying to send you back out the door. No, you've come to the right place, this is what you want yes, here you are. And then the next time around they're like happy to see you again and not like, 'Oh it's you again.'" (Young person)

"I feel like, if you've come to this place in the first place you've probably got something that you want to talk through that might take time it resolve so it's not just, fix it, it's a good kind of place where you can keep coming back." (Young person)

What worked well

Participants felt that Door 43 filled a much-needed gap in mental health support for young people. They spoke about the welcoming atmosphere and found it easily accessible unlike the long waiting times encountered when trying to access more traditional services. Young people appreciated the informality of the service and that there was no pressure to attend. They also found it less stigmatising than being referred onto counselling or other more specific mental health services as well as an important immediate support, whilst waiting to be seen by CAMHS.

"I think Door 43 does actually fill a massive gap in that sense of things. Because they're, I think the recovery team it takes a long time to get to them, they're not erm, if you go to your GP you won't get straight put through to them. So I think in that sense Door 43 is definitely more erm, available…I think sometimes mental health can be, I know I shouldn't use the word embarrassing but it can sometimes feel like that and that's very much, not a stigma there because they have the well-being café and that kind of thing. So, I would say that's been brilliant, and actually I'd put that above the NHS in my own experience, I have preferred them." (Young person)

"I've only really been under the NHS in the past and I've had really bad experiences with them in terms of help with mental health and well-being and sort of a lot of waiting lists and er, not really anything being done in the meanwhile so I mean quite recently I was er….I was diagnosed with borderline personality disorder, and I'd have to wait a year just to get on therapy. So yeah so meanwhile it's definitely been a big help." (Young person)

All the young people interviewed spoke highly person-centred approach and in particular the relationship they had developed with their link worker.

"He's really friendly, he's up for anything and yeah he's not judgemental or anything like that. Yeah he's good." (Young person)

"He was very welcoming, very understandable, he really understood the situation I was in." (Young person)

"I find it difficult to trust people so it takes me longer than I guess most to like trust someone. So like just coming in on a Tuesday and seeing him every week and getting to chat every week, and then like by now in our sessions I feel there's a level of trust there." (Young person)

For some of the young people, attending activities within their community felt too difficult to manage on their own and they found the buddying aspect of the social prescribing service gave them the much-needed confidence to attend first sessions.

"I tried my best to be independent so I was going on my own and that morning I text him and I was like, 'I can't do it.' So he rang me and then he was like, 'Oh I'm free this afternoon I'll come with you.' So I met him here and he walked all the way down and that was really good, because it just put me in a more positive mind set when I got in there. And I did do it on my own, but the fact that he was just there, and I knew he was waiting outside for me, just made a massive difference." (Young person)

"Yeah he was just in the like reception, so just cos I knew he was there. And I knew he'd be there at the end just to talk so, it was good." (Young person)

With the advent of Coronavirus, the young people found themselves stuck at home and unable to access the service in person, or the activities they had begun to attend. They all appreciated their link worker checking in with texts from time to time, as well as reading the Instagram posts and blogs produced by the service. and were looking forward to the return of normal life. However, for the most part they reported they were coping well with the situation and some had even discovered new past times to keep them going.

"I've been going on a lot of bike rides which I never usually used to do." (Young person)

"It's a bit different, at times it can be difficult being on my own not seeing people face to face. But I'm still in contact with friends and family over zoom and over the phone so, I suppose it works quite well in that sense but yeah, I think given that it's been about two or three months now, it's something I've learnt to cope with I suppose." (Young person)

"I feel like I've spent more time, you know walking in the woods, erm, I've started running a bit, I think there's more time to be outside in nature rather than you know in town, in streets with people, so that's been quite nice. I've read a lot more books so that's been good. So yeah there is certain good things." (Young person)

What did not work so well

However, the cost of sessions in the community proved to be a barrier for some, and several young people were also put off attending the activities they were referred to by complicated public transport journeys.

"Yeah it all comes down to public transport. Its help if it is, or help if it's not because it's just, everything goes in to Sheffield centre and out the other side. So it's actually quite hard to do stuff that's on the edges." (Young person)

"So that's sort of like the main problem with my situation which was like, trying to turn up and play a football session, which, Christophe took me to see how it was and it was the sort of thing that I'd like to do but it was just too far away and that was like the main reason why I chose not to do it." (Young person)

Findings specific to the Luton site.

***Referral data**:* Main reasons for referral were mental health/well-being (27.3%) and lifestyle change (27.3%), followed by physical activity (24.2%). Mos referrals came from mental health services (e.g. CAMHS, IAPT) and friends/family via the adult service (31.6%). However, data here are only indicative as the overall sample size was small (N=23).

Accessibility

All the participants found it easy enough to access the service in terms of distance, and didn't mind walking if necessary. One of the locations of the meeting space was perceived as unwelcoming by some participants because they had experienced trouble from others there in the past. Referrals were generally mental health related and came through CAMHS or GPs and the young people did not have to wait more than a couple of weeks for their first link worker appointment. After filling in a form detailing their interests and hobbies, most were offered a variety of support and activities in their local community including gym memberships and group activities to increase social connections.

What worked well

"*They were kind and generous and nice people in general – a nice service really."* (Young person)

Almost all the participants were very happy with their experience of the service. They described positive effects on their well-being such as feeling calmer, fitter and sleeping better as a result of the social prescribing. All participants had nothing but positive reports for their link worker, even if in some cases they hadn't wanted to or felt able to access subsequent referral activities:

"I'm comfortable with her, like it's like another friend in a way but it's not if you know what I mean." (Young person)

"(She) was really good, she understood, she could see that (he) wasn't the same as everybody else in the group erm, by the way he just presented himself. How he would cry. That he couldn't handle this situation. How he wouldn't interact with any of the other children…(she) spent the time to talk to him, and that, so

which he's okay if he builds up the trust with somebody, you know. Which she did over the weeks so she done really amazing with (him)." (Parent)

"*It's like, I feel like I can talk to (her) about like, anything kind of thing cos she's nice."* (Young person)

The social prescribing service was seen as more pro-active than more traditional services like CAMHS in that it was less focused on what was wrong and more on supporting the young people to get out and try new things and meet new people.

"…it's just like, like take action on things whereas like if you compare it to CAMHS it's just like talking and not really coming up with anything new." (Young person)

"I like that sometimes like we'll go, not off topic but we'll talk about like home life and stuff like that, we're not just always talking about what's wrong, if that makes sense." (Young person)

Participants also liked the fact that their link worker was closer to their age than the health professionals they had encountered at CAMHS and this helped them develop trust relationships quickly. They also liked the informality of the service and being able to text their link worker when they needed to and encountering understanding when they missed a session.

What didn't work so well

One area where the participants felt the service could improve was in providing more information at the point of referral. The young people didn't know what to expect from social prescribing and felt there should be leaflets available at CAMHS and GP offices. They also suggested implementing more user-friendly ways of promoting the service by posting information through Instagram and Snap-chat.

Another area where there was lack of clarity was around the number of sessions they could expect with their link worker. This uncertainty caused anxiety for some, particularly if they weren't confident about being able to make contact with their link worker themselves.

"When you're like really anxious, you don't really want to go and ask because you don't want to see rude, so it's just like you sit there, and wait." (Young person)

During COVID-19 lockdown, access to activities stopped as did face to face meetings with their link worker. However, participants were for the most part philosophical about this and appreciated receiving texts from their link worker to check how they were doing. For one young person who found interacting socially very stressful, lockdown was a source of relief:

"I mean lockdown for (him) he says this is his heaven. (He) likes to be on his own, (he) likes to introvert in to his own world, so yeah where everybody else struggles (he) doesn't." (Parent)

Findings specific to the Brighton & Hove site

***Referral data**:* The most important reasons for referral was mental health/well-being (29.2%), followed by social isolation (22.9%), and lifestyle change (16.7%). The vast majority of referrals came from GP practices (63.3%), followed by family/friend (27.3%). However, this data need to be interpreted with caution as the number of responses was only very small and thus may not represent the most important reasons or sources of referral.

Accessibility

Participants found out about the service through a variety of means including their GP, Young Carers and the YMCA. They were generally referred initially for support with their mental well-being and the link worker helped some to access physical activities and advice services. One thing that the young people really appreciated about this service was that their link worker would meet them at home or at school. For some young people this avoided the anxiety of having to go to an unknown place for sessions.

"Well she came to my house, and yeah we just sat in my kitchen for a bit…then she kind of introduced herself and then she started coming around more often and it was really nice." (Young person)

"So the issue was, if he'd had to go (there) I don't think he'd have seen anybody." (Parent)

What worked well

All the young people and parents interviewed described very positive experiences of their relationship with their link worker.

"I listen to her and talk to her, erm….it just makes me happy when I'm liking talking to someone who I can trust, it helps a lot." (Young person)

"She like reassured me that she wouldn't tell anything to my parents unless it was properly serious. And erm, I don't know she always kind of looked at both sides of the argument and she just kind of listened, it was really lovely." (Young person)

"She was really encouraging, engaged really well with him, wasn't patronising at all. Really easy to talk to. You know understood that you know…she just got him, and the first time she came, and Jo said, 'She gets me mum.'" (Parent)

The buddying service provided by the link worker was another part of the social prescribing which was appreciated by the young people who struggled with their confidence when trying new things:

"Well she just, she helped me through a lot. She like helped me get on a bus which I was struggling to and then she helped me to go to Young Carers, she just helped me through a lot." (Young person)

The young people and their families liked the informality of social prescribing as compared to other services like CAMHS and counselling, describing how there was less emphasis on why they felt bad and more on how they could pro-actively feel better:

"With the CAMHS help they were trying to work out, why (he) felt like that. Like he did with anxiety. But (link worker) almost went, yes you've got anxiety let's see what we can do to help you with that. Rather than, let's work out why you've got it. This is how you feel so let's work out what we can do to make you feel better. Which is what (he) wanted really." (Parent)

"*She was very much down to earth, so not really, not so formal and not so stuffy."* (Young person)

The young people were taught coping skills to deal with their anxiety and other members of the family were supported too:

"She got him lots and lots of help at the school for me, she sorted out a lot of counselling, she's helped me out with a restricted timetable, she's come to meetings at the school, she's been in contact with the school all the time and about the CAMHS referral." (Parent)

5.4 Economic evaluation

5.4.1 Social Return on Investment

There are many different approaches to calculate Social Return on Investment (Fujiwara, 2013). One of these is the well-being valuation method which enables to place a financial value to each point change in the Warwick Edinburgh Mental Well-being Scale (Trotter, Adams and M-K, 2017) and also to other changes in service users' including employment, volunteering, financial manageability, attendance to organized activities, fear of crime, and overall health.

The combination of these value offers a social return on investment ratio. The social return on investment ratio is calculated by the difference between the financial value of outcomes and the financial value of inputs (cost).

Mapping Inputs: the cost for the delivery of social prescribing for the period between Feb 2019 and Aug 2020 was estimated at £68,472. During the same period, the number of young people assisted was estimated as 153 which gives a cost per service user of £447. This cost is at the higher end of the spectrum of cost per user in audited adult services, which ranged from £109 to £560 (Bertotti et al, 2015; Bertotti and Temirov, 2020). It is important to note here that although the cost per user may be higher, the quality of the support offered may also be higher. Social prescribing models can be very different from one another

and even changing over time. For example, some social prescribing services may focus on light touch advice which will enable link workers to support more users at any given time, making cost per user lower than in other schemes. Furthermore, as it is discussed further below, this young people social prescribing service is only a pilot and the work of link workers has additional challenges which require spending more time with each young service user and therefore increasing the cost per user and the cost above is likely to be higher at the initial stages but decline over time as the service becomes embedded locally.

Mapping outcomes: the outcomes calculated in this SROI include mental well-being, employment, volunteering, financial manageability, attendance to organized activities, fear of crime, and overall health. We included only information available from respondents who completed baseline and six months follow up for each outcome (on average 50 people).

Establishing impact: in order to establish impact, we followed guidelines provided by Trotter (2014) which could be interpreted as strict but provide a conservative value of SROI rather than potentially falling into the trap of providing an overestimation. Following these guidelines, we applied suggested deadweight values and restricted the effect of all outcomes to one year, although it is likely that many of these outcomes will last much longer than that. In extending the principle of providing a conservative value, we also recorded positive as well as negative changes in outcomes, while many other economic evaluations only record positive changes. For instance, if respondents did not volunteer at baseline but did volunteer at follow up, the response was recorded as positive. On the other hand, if they did volunteer at baseline but did not volunteer at follow up, the response was recorded as negative, alongside the corresponding negative financial value.

In order to provide an as accurate as possible SROI, calculations include deadweight and drop-off. Deadweight accounts for attribution. How much of the changes that have recorded would have happened without social prescribing? The valuation approach methodology provides deadweight values for both changes in health and social circumstances[6].

'Drop-off' estimates the loss in the value of the outcomes in future years. In order to calculate drop-off, we followed drop off calculated in other studies which used multiple follow up points (Bertotti et al. 2020)[7]. This is to account for the fact that most outcomes will have a value during or just after the evaluation, but such outcomes are likely to lose value over time.

[6] Deadweight is based on the HACT valuation methodology: mental well-being (27%), volunteering (19%), employment (15%), managing financially (19%), and skills training (15%)

[7] For each year passing, drop off for mental well-being (39%), whilst drop-off for all the other outcomes is 15%.

The final SROI is calculated over a 12 months period and on the population of respondents between baseline and six months follow up (60 people). We adjusted the cost of delivering social prescribing to this population of respondents (£26,851).

Table 12 (p. 40) shows a summary of the net positive and negative changes in key outcomes, value of financial proxies used as part of the well-being valuation approach and HACT (Trotter 2014; HACT, 2018). The final 'conservative' Social Return on Investment ratio is £1: £5.04. It means that for £1 investment in social prescribing, the annual return for the first year alone is £5.04. As mentioned, this is a conservative estimate: if we assumed that outcomes last for four years, the SROI ratio would increase to £1:£10.84. Thus, the SROI return could range between £5.04 and £10.84. This is higher than the average for many other SROI in social prescribing (Polley et al., 2017; Bertotti et al., 2020; Bertotti and Temirov, 2020). It is also an underestimation if we consider that the cost of running this young people social prescribing service included not just the cost of recruiting and employing link workers - as for many other social prescribing services - but also the cost of delivering the activities and/or providing support services the service user is referred to.

Table 12: Outcomes and financial proxies for young people social prescribing

Outcome	Data source	Net change	Proxy and source	Value (£) (*)
Mental well-being	Quantitative study: SWEMWBS	60 (net positive change 33)	Warwick-Edinburgh Mental Well-being Scale (Trotter et al 2014)	£133,164.20
Full time employment	Quantitative Study	36 (net positive change is 3)	Full time employment (£13,702)(**)	£17,470
Part time employment	Quantitative Study	35 (net negative change is 3)	Part-time employment (£737) (**)	£-939.75
Self-employment	Quantitative Study	34 (net positive change is 1)	Part-time employment (£12,848) (**)	£5,460.40
Attending organised activities (e.g. youth club)	Quantitative Study	60(net negative change is 19)	Attending organised activities (£2,464)(**)	-£9,979.20
Fear of crime	Quantitative study	59 (net negative change is 2)	Fear of crime (£18,813)(**)	-£15,238.52
Volunteering	Quantitative study	50 (net negative change 1)	Volunteering (2,562)(**)	-£1,037.50

(*) this values are over 6 months and include deadweight; (**) HACT 4.0 http://www.hact.org.uk/social-value-publications

It is important to notice here that the number of people assisted by social prescribing over the period of assessment (n= 149 people) is more than double the number of respondents for the SROI calculation at six months (n=60). Thus, the SROI for the overall population is likely to be much higher, double if we assume that the results from our SROI calculation apply to the population of service users as a whole.

However, there are some limitations to the creation of this SROI and the well-being valuation approach:

- we were only able to estimate the cost of delivering the service. We did so from examining grant costs and extrapolated from that the costs to run the service.
- The financial proxies were derived from large scale surveys of the UK population, rather than from the sample of social prescribing service users that completed the baseline and follow up questionnaires.
- The last scenario above is only a rough estimate of the potential SROI value for the overall population, not a true account measured through data collection from all 149 individuals. No statistical analysis has been undertaken to assess whether the profile of our sample matches the larger sample of service users and therefore if the results can be extrapolated.
- Again, as for the other aspects of the evaluation, Covid-19 is very likely to have had an impact on some of the outcomes experienced by respondents. For example, the decline in attendance to organised activities such as youth clubs and lower volunteering rates over the period are likely to be due to fact that youth clubs had been closed so respondents could not attend these and could not volunteer.

5.4.2 Health service use changes and cost analysis

We also analysed changes in A&E attendance, GP consultations, hospital admission, mental health services and social care services between baseline and follow up. We analysed these separately from the SROI above as the methodologies used are different and so cannot be used alongside each other. Baseline and follow up data about health service use was collected by asking respondents to recollect their attendance in the previous six months. This is not the best possible way to collect this data as it is open to recall bias, respondents may not accurately remember how many times they have used health services in the previous six months. However, given the resources available for this evaluation, this was the best possible option to provide an economic analysis of health service use.

This section examines the use of health and social services in the last three months including A&E attendance, GP attendance, and hospital admission and the use of mental health and social services. Analysis of all three sites combined shows that the use of all these health services declined between baseline and follow up. We also carried out a statistical analysis (paired sample T-test) which showed that

both GP consultation rates and A&E attendance were significantly lower at follow up than baseline (Table 13, p.42).

In terms of GP consultations in the previous three months, the mean for the group of respondents (n=165) declined from 1.67 visits at baseline to 0.82 at follow up, about half the number of visits. About 14% of the total sample (N=162) at baseline could be considered as 'frequent attenders to GP practices', whilst only 2.8% at follow up (n= 72) [8]. Hospital admission declined on average from 0.10 to 0.08 in the previous three months.

Table 13: Statistical test of changes in health care service use

Measure	Effect of SP		
	N	**Net change[9]**	**Significance**
		Coef. (95%CI)	*P value(*)*
GP consultations	66	-0.712	**0.007**
A&E attendance	71	-0.0352	**0.006**
Hospital admission	68	-0.059	0.375

(*) Significant p values in bold (p<=0.05);

In relation to the use of Child and Adolescent Mental Health Services (CAMHS) and social services, Table 14 shows an increase in the use of CAMHS increase between baseline and follow up from 17.8% (n=152) to 23.5% (n=68). On the other hand, use of social services declined from 18% to 11.1%.

Table 14: Use of CAMHS and social services

	Sheffield		Luton		Brighton & Hove		All sites	
	Base	FU (*)	Base	FU (*)	Base	FU (*)	Base	FU (*)
CAMHS (%)	18.2	21.4	26.3	20.0	8.7	42.8	17.8	23.5
Sample size	*110*	*56*	*19*	*5*	*23*	*7*	*152*	*68*
Social services	20.6	13.6	9.1	0	13.3	0	18.0	11.1
Sample size	*102*	*59*	*22*	*6*	*15*	*7*	*139*	*72*

(*) 6 months follow up

Analysis of GP consultation rates

[8] Definition of frequent attendance is twice the mean consultation rate for the year prior to intervention (Bellon et al). We extrapolated the yearly rate from our three months results.

[9] Net change refers to the difference in the average score between baseline and follow-up

As shown in Table 15, all health service use costs (GP consultations, A&E attendance, Hospital admission) lead to some savings as health service use is smaller at follow up than baseline. In order to be able to attribute the savings to social prescribing, we applied a deadweight of 27% (Trotter et al. 2014) to the initial savings (net change). Although these figures in the Table 15 may seem low, it needs to be remembered that it only applies to a small number of respondents (between 61 and 71) rather than the overall population of young people supported by social prescribing and also applies to a period of 6 months rather than a longer period of time. It is also important to note that the calculation of these savings is only based on the direct costs of services offered (e.g. cost of GP's time rather than the GP practice as a whole (e.g. receptionist) or other costs (e.g. prescriptions), thus this is probably a gross underestimate of real financial savings realised.

Table 15: Health service costs for the sample of respondents over 6 months

	Baseline	**Follow-up**	**Net change**	**Financial proxy and source**	**Value (*)**
GP consultations (£) (n=66)	£3.069	£1,612	£1,457	£31 per consultation (Curtis et al., 2018)	£1,064
A&E attendance (£) (n=71)	£5,600	£1,600	£4,000	£160 per attendance (NHS improvement 2018)	£2,920
Hospital admissions (n=68)	£2,220	1,332	£888	£222 per non-elective admission (NICE, 2015)	£684.24

(*) this is the value in the six month period including deadweight (27%)

6 Discussion

This section of the report summarises the key points emerging from the results section and its policy implications for the further development of social prescribing for young people. Much of the quantitative and qualitative data collected has been collected during the first wave of the pandemic so data need to be interpreted with that in mind. Furthermore, much of the quantitative data collection relates to Sheffield as this site has collected the vast majority of both baseline and follow up data. However, qualitative interviews and focus groups with young as well as stakeholder interviews were completed in all three sites providing an interesting picture of social prescribing for young people in all three areas. Each of the sections below refers back to the result section detailed above.

6.1 Demographic profile

The demographic profile of the sample is broadly in line with the target group for young people social prescribing which was young people 11 to 24 experiencing a range of health and social issues. The higher proportion of young respondents are under 20 (mean age 16) and primarily between 16-20 years old (53.8%), slightly more female than male (52.7%), White British (73.8%), at school/college (48.4%), living with family or foster parents/carers (92.7%), and with no long standing physical/mental illness (43.2%). However, some 31% are unemployed and looking for work and 4% are unable to work due to illness. The latter is also partly reflected is the high proportion of young respondents (50.3%) who have reported a long standing physical/mental illness which has limited their activities for a period of 12 month or are expected to last for a period of 12 months. This high proportion of young people experiencing physical/mental illness is to be expected and confirms that this is the right target group for support. It is also worth noting that the gender balance for this service is markedly different than adult social prescribing services in which there is much higher representation of females, normally about 70%. Thus, young men engage more with social prescribing services than older men.

6.2 Health and social outcomes

It is difficult to disentangle the impact of social prescribing from the impact of the pandemic. The most important finding here is that social prescribing appears to be particularly effective in supporting the most disadvantaged groups of young people, those who experienced low levels of personal and mental well-being as well as high levels of loneliness at baseline. In particular, key findings are as follows:

(i) Personal well-being has improved, particularly for those scoring the lowest at baseline. The proportion of respondents who scored low personal wellbeing (happiness, worthwhile, life satisfaction) at baseline moved up to the medium and high categories at follow up (Figure 2, p.18). However, such improvements was mainly due to the contribution of Sheffield, whilst the other sites experienced a decline in all components of personal well-being. Furthermore, although the analysis registered a positive change, this is still substantially lower than the UK average for 16-24 years old (Figure 1,p.17). This means that although social prescribing may have improved personal well-being, there is still need for further support if young people supported by the service want to be brought up to the average well-being of young people of similar age.

(ii) Mental well-being followed a similar trend with a decline in the proportion of respondents in the low mental well-being category and an increase in the moderate and high categories (Figure 3, p.19). Mental well-being also followed a positive trend recording a statistically significant positive change between baseline and follow up confirming, once again, that social prescribing is primarily a mental health service, as it is for the adult service (Woodall et al. 2018; Bickerdike et al. 2018).

(iii) The proportion registering high level of loneliness at baseline (often/always lonely) declined by follow up (Figure 4, p.20) although the mean score for loneliness remained the same across the three sites. In particular, Sheffield and Luton experience a decline in loneliness over the period, but this was offset by a marked increase in loneliness in Brighton & Hove. It is important here to remember that the number of respondents in Brighton & Hove and Luton are quite low and is therefore difficult to provide a firm conclusion on the level of loneliness.

These results are even more surprising as much of the follow up data collection took place during the course of Covid-19, a period where happiness, life satisfaction, mental well-being and loneliness may have conceivably been affected by the pandemic. In terms of physical activity, the proportion of 'physically active' respondents increased over time (46.1% to 53.4%) and most of physical activity time was spent walking and fitness (e.g. gym, dance and other sports), much less cycling. However, the mean number of minutes spent in fitness and cycling declined by a third and by half respectively, possibly indicating a restriction to circulation and use of sport facilities resulting from Covid-19.

In relation to social outcomes, we examined aspects of social capital in the expectation that social prescribing would improve social capital (Tierney et al., 2020). Some evidence from the literature (Woodall et al., 2018) also show that social prescribing may increase the level of social interaction and social support between individuals in the community. Wider research also shows that people with a good range and frequency of social contacts report higher levels of life satisfaction and happiness and mental health (Lelkes, 2010; Helliwell, 2008) and there is also substantial evidence of a strong positive association between social capital and health (e.g. Kawachi and Berkman, 2001; Poortinga, 2006). In terms of this evaluation, evidence from the analysis of social capital show that much of the data on 'social support' and 'trust in own neighbourhood' remained the same over the period. On the other hand, neighbour relations and volunteering changed markedly probably due to the impact of Covid-19. Neighbour relations increased and, although occasional volunteering declined, regular volunteering remained stable, showing perhaps that there is a strong core group of volunteers.

6.3 Process evaluation: factors affecting the delivery of young people social prescribing

The stakeholders interviewed across the three social prescribing services were all generally happy with the way their service was working and felt that it had achieved its initial aims. All three services had put a lot of thought into making the service feel as welcoming and accessible as possible to their young service users, with the link worker buddying aspect being a particular success. Increasing the young person's sense of autonomy was seen by all three services as key to improving mental well-being with the lack of a 'mental health' stigma attached to social prescribing also felt to be important. There was a sense amongst stakeholders from all three services that social prescribing was filling a much-needed gap in mental health

provision for this age group, who often struggle to access the 'step up' CAMHS services and are made to wait for a long time to access this service. For these respondents, social prescribing was filling an important void in mental health support provision. More generally, there is also anecdotal evidence gathered in conversations with young people and other stakeholders that social prescribing plays a role in supporting young people in 'stepping down' from mental health support, when CAMHS has provided the first level of support but young people feel they need further support. Both examples of 'stepping up' and 'stepping down' are a demonstration that social prescribing does not operate in a vacuum and is instead extremely connected with other support services and appears to feel a vacuum in such services.

In relation to other aspects of service implementation, the biggest challenge to fidelity of the running of services has been the Coronavirus pandemic. Yet, all the services seem to be adapting well to remote working. An important factor emerging from interviews is that the role of the social prescribing link worker is complex and appears to be even more complex than in adult social prescribing. For young people social prescribing link workers, this complexity can be compounded by additional factors such as the need to work in a more systemic way with families, whilst still maintaining primary focus on the young person themselves.

The young people interviewed across the three services all trusted and valued the relationship they had developed with their link worker. They particularly appreciated the buddying part of the service which helped them feel confident in accessing new activities in the local community, although complicated public transport and cost of sessions could sometimes still be a barrier. Young people felt that their needs were heard and liked the informality of social prescribing and the 'no pressure' approach. They compared the positive, pro-active focus of the social prescribing services favourably to other services such as CAMHS which they felt were more concerned with identifying the causes of what was wrong.

On the other hand, young service users would have liked more information on what to expect from social prescribing and also from their link worker sessions, and particularly information about the length of the service as a whole (number of expected sessions). Several young people were unsure of when/if they would see their link workers again and this was the cause of some apprehension. Yet, some other young people seemed to be adapting well to lockdown and the Coronavirus pandemic and all the restrictions on communication and activity this caused, some even finding positive aspects to the situation.

It is also important to note that in relation to the sustainability of social prescribing, there are some critical issues about funding for the VSCE sector and the recruitment and retention of link workers. Two social prescribing services have changed link worker during the duration of data collection and the third one is planning to do so in the near future. Ensuring continuity of service and that knowledge accumulated by managers and link workers through this pilot carries on and is transferred to other people is critical to the long-term success of social prescribing services, and most of all, to guarantee an ever-improving care to

young people. Unfortunately, this does not appear to happen. It is difficult to improve a service where there is a continuous flux of staff. This is primarily due to funding priorities which shift rapidly according to changing policy priorities. However, more recently, NHS England has decided to invest further resources in social prescribing through the Primary Care Networks which are likely to counterbalance this trend and provide additional capacity in the system of support.

Furthermore, if we consider the sustainability of support services more widely (whole system working), the delivery of social prescribing is likely to have an important positive impact on other services such as CAMHS and their levels of success in supporting young people experiencing mental distress, influencing the sustainability of the system as a whole.

6.4 Economic evaluation

We analysed the Social Return on Investment (SROI) and costs from healthcare use. We could only provide a Social Return on Investment (SROI) for Sheffield as they were the only site with sufficient data. The SROI for Sheffield young people social prescribing was £1:£5.04 which means that for £1 investment, young people social prescribing returns £5 in the first year. This is higher than many other SROI in social prescribing (Bertotti et al., 2020; Bertotti and Temirov, 2020) which stand on average at £1:£2.30 (Polley et al., 2017). This is significant considering that we were consciously conservative in our estimate. Yet, there are also a number of assumptions and limitations which we discuss in 5.4.1 (p.38). The cost of delivering the service per user was £447 which is higher than other adult social prescribing services but is likely to reflect the more intensive type of support needed in the case of young people.

In relation to the health service use cost analysis, GP consultations and A&E attendance showed a statistically significant decline over the period, whilst non-elective hospital admissions also declined but without statistically significance. The savings associated to these three components of health care cost have been modest. This is likely to be due to a range of reasons: (i) the results only apply to a small number of respondents (between 61 and 71) rather than the overall population of young people supported by social prescribing and also applies to a period of 6 months rather than a longer period of time; (ii) the calculation of these savings is only based on the direct costs of services offered (e.g. cost of GP's time rather than the GP practice as a whole (e.g. receptionist) or other costs (e.g. prescriptions)), thus this is probably a gross underestimate of real financial savings realised.

7 Key Recommendations for the development of young people social prescribing

In formulating recommendations for the development of young people social prescribing, we have focussed on the evidence gathered through the evaluation as well as the recent changes to social prescribing due to Covid-19.

7.1 Continue a 'test and learn' approach to young people social prescribing models

Recommendation 1: continue to 'test and learn' young people social prescribing in other sites across England and beyond to assess health and social outcomes further and investigate the specific role of young people social prescribing amongst other health and support services and funding mechanisms

Overall, this evaluation showed positive changes in mental health and personal well-being, particularly for those young people most in need. Social return on investment was also above average (£1:£5.04) even considering some of the limitations of this particular type of analysis (5.4.1, p.38). On the other hand, health care service use savings were modest, even considering some of shortcomings in data availability (for more details, see 5.4.2, p.41) . Qualitative interviews with young service users were also positive overall, particularly in relation to tackling mental health emergencies and filling the gap between need and current statutory sector provision.

Thus, we recommend that the service is continued. This is even more important during the current pandemic period when social prescribing has been playing a significant role of coordination between primary care and the VCSE sector, providing direct support to vulnerable people in isolation, and facilitating the process of migration of VCSE sector provision from face to face to online activities and support (Cole, Jones and Jopling, 2020). Furthermore, Covid-19 has created a higher demand for services including mental health services. Social prescribing can alleviate the strain on such services.

However, of the four sites initially included in the evaluation, this report was not able to collect substantial follow up data from two (Brighton & Hove and Luton) and none from Southampton. There needs to be more clarity about the role of the young people link worker, sources of referral, the level of involvement of the VCSE sector in the delivery of services and activities, the role of parent/carers in supporting young people, and the role of social prescribing amidst other health and social support services and roles (e.g. CAMHS, schools).

In addition, this evaluation found that unlike most adult social prescribing services, young people social prescribing relies on a range of referral sources including GP practices, schools/colleges, and mental health services, alongside self-referral through drop-in café' (e.g. Sheffield). Although a young people social prescribing model with only one referral source could be considered, this would not reflect the way young people access the service. In addition, these multiple sources of referral represent a significant potential opportunity to pull resources from different referral sources and create a more sustainable funding and risk share mechanism for the future of young people social prescribing services. There are already some examples of this for adults, particularly co-commissioning between local authorities and clinical commissioning groups (BbBC Insights, 2019). Yet, at the moment there is very limited knowledge as to whether the results from this evaluation apply more widely. Thus, as suggested in the introductory recommendation and also by a recent consultation of 647 stakeholders funded by the NHS (Street Games, 2020) the continuous testing of the approach in different sites and ensuing learning are key to the development of effective young people social prescribing models which could then be effectively integrated within existing Primary Care Network (PCN) work on adult to create a truly all-age service envisaged by NHSE and the Long Term Plan.

7.2 Recognition of the complexity and need for training of young people social prescribing link workers

Recommendation 2: consider more research into the role of young people social prescribing link workers and specific training to support their role, particularly in delivering services remotely, including the creation of practical guidance based on the pilot delivery sites' experience for others to emulate.

Recommendation 3: balance the centrality of young people's needs with the role of parents/carers highlighted by data collected in this report

Recommendation 4: Consider clarifying what the young service user can expect from social prescribing including number of sessions with link worker and how and when the young service user can contact their link worker.

In line with the growing social prescribing evidence base, data collected in this evaluation highlighted the importance of the social prescribing young people link worker role. This role is similar to that of adults in relation to the need for close one-to-one flexible support, motivating and empowering service users, create a level playing field between link worker and service user, and avoid stigmatisation. Yet, the young people

social prescribing role was in other respects more complex than the adult one: (i) the need for younger service users to involve the parents/carers in the support process, so often deliver a whole family service; (ii) as young people are at the centre of a wide range of care services, the link worker can become a coordinator of care for the young person often to counterbalance deficits of other services elsewhere in the system of care. In addition, young people social prescribing link workers had to adjust to the restrictions to mobility caused by the pandemic. The service had to be transferred from face to face to online in a very short space of time with parallel adjustments of VCSE delivery which also had to adjust to Covid-19. An implication of this is a service that is much more led on the phone and/or online. Specific training on how to support link workers to make the best possible deliver of social prescribing on the phone is therefore important.

7.3 Involvement of young people in the design and development of social prescribing

Recommendation 5: consider setting up a small advisory group made up entirely or almost entirely by young people who could advise (during design, implementation and evaluation) a steering group via a representative.

Our qualitative study highlighted that it is important for young people to have a 'voice' and exercise their autonomy through the session with their link workers. Additional research has shown (e.g. Frostick et al 2019) that this is the case with the adults social prescribing too. In order to extend this power to the service as a whole, it appears important to consider a much stronger involvement of young people in the design, implementation and evaluation of each young people social prescribing service. Thus, not just as a consultative mechanism as it is conventionally done, but throughout the service. There is now strong evidence that policy interventions are more successful when service users are involved in their design, implementation and evaluation.

As a result, it would be very particularly useful to create a small advisory group that could advise at all stages of development, implementation and evaluation of social prescribing and report to the service steering group via a representative. This would need to be adequately resourced, but it is likely to lead to major improvements in the effectiveness of each social prescribing service.

7.4 Key principles to be considered in the development of a social prescribing service for young people

This last section summarises some of the key lessons learnt, drawing on analysis from this evaluation, alongside learning from other conversations taking place in steering group meetings and wider knowledge from the literature on other evaluations of social prescribing. In planning the development of social prescribing for young people, it is important to consider the following principles:

1. As mentioned in the previous recommendation (7.3, p.50), it is important to start with co-design and co-production of the service with young people and maintain their engagement through steering group meetings and even in the design and interpretation of results from evaluation.
2. Partnership with all stakeholders: it is particularly important to ensure that all stakeholders are involved in steering group meetings and in the initial stages of development. In social prescribing for young people models, these may include the main referring organisations such as schools, CAMHS, and GP practices, and then other stakeholders involved in the implementation of social prescribing such as link workers, commissioners, and the VCSE sector. This evaluation showed that the young people social prescribing service does not only receive referrals from GP practices but also schools and other organisations so it is important to include these groups in the decision making process.
3. In promoting a coherent development of social prescribing, it is important to develop a theory of change that is shared across all stakeholders. One of the Key questions to clarify is: What is it that we are expecting social prescribing to change? As social prescribing for young people unifies different parts of the health economy, i.e. primary care, VCSE sector, schools etc. which have quite different objectives and operating mechanisms, so it is paramount to have shared idea of what social prescribing is expected to change. A theory of change also benefits the development of an appropriate evaluation framework.
4. It is important to map the assets available in the locality. These may be individual, community and/or organisational assets. One crucial question here is: Do we have enough and/or the right VCSE sector support provision for the change that we want to see in young people?
5. As mentioned in recommendation 7.2 (p.49), the role of the young people social prescribing link worker needs to be recognised as central to effective service delivery, appropriately supported with training and clinical supervision and further researched in the case of young people to assess how it sits within the wider delivery of support provision.
6. The VCSE sector - delivering support services to young people - needs to be included and supported appropriately. This was not the case for this pilot as the VCSE sector was funded to deliver activities and services to young people. However, the vast majority of adult social prescribing services do not fund the VCSE delivery of services and activities which is widely recognised as a potential threat to the sustainability of social prescribing.

7. Finally, as mentioned in recommendation 7.1 (p.48) monitoring and evaluation need to be built into the design and implementation of social prescribing and a continuous test and learn approach considered.

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