

Evaluation of the Teenage Health Demonstration Site Programme

1st Annual Report 2007

Helen Austerberry
Mary Sawtell
Anne Ingold
Meg Wiggins
Lisa Arai
Vicki Strange

Social Science Research Unit
Institute of Education
University of London

May 2008

ACKNOWLEDGEMENTS

The evaluation team would like to thank all the young people and professional stakeholders who gave their time to participate in this evaluation. Additionally, we would like to give a special thank you to those who helped us organise the evaluation activities. This includes members of staff working in the four health demonstration sites – we couldn't have done this work without your help! Thank you also to our evaluation advisory committee members.

We are also very grateful to those who provided research and administrative support to the project: Catherine Aicken, Sandra Stone, Chloe Austerberry, Chris Delaney.

This work was undertaken by the Social Science Research Unit, Institute of Education, University of London, who received funding from the Department of Health. The views expressed in this publication are the authors' and not necessarily those of the Social Science Research Unit or Department of Health.

This report should be cited as:

Austerberry H, Sawtell M, Ingold A, Wiggins M, Arai L, Strange V, (2008) *Evaluation of the Teenage Health Demonstration Sites Programme: 1st Annual Report 2007*. London: Social Science Research Unit, Institute of Education, University of London.

ISBN: 978-0-9559087-0-5

TABLE OF CONTENTS

	Page
Executive summary	i
1. Background to the Teenage Health Demonstration Sites Programme	1
1.1 Aims of THDS programme	1
1.2 Background to sites	2
1.3 This evaluation report	3
2. Approaches to service delivery	4
2.1 Introduction	4
2.2 Approach 1: One-stop shops in innovative settings	5
2.3 Approach 2: Community settings	10
2.4 Approach 3: Enhancing mainstream NHS provision	13
3. Overview of progress made by each demonstration site in year one	15
3.1 Bolton	15
3.2 Hackney	17
3.3 Northumberland	21
3.4 Portsmouth	24
4. Strategic Management	28
4.1 Project structure and strategic partnerships	28
4.2 Management boards	29
4.3 Site co-ordinator role	29
4.4 Management ethos	30
4.5 Managing the start of the demonstration site programme	34
5. Local services delivered as part of THDS	35
5.1 Making services more young people friendly	35
5.2 Staff roles and workforce issues	37
6. Working with key target groups	43
6.1 Addressing the need of the most vulnerable	43
6.2 Working with young people with long-term medical conditions	45
6.3 Work on repeat conceptions in teenagers	47
6.4 Emotional and mental health support for young people	49
7. Local delivery issues: You're Welcome; health in schools; participation of young people	54
7.1 You're Welcome quality criteria	54
7.2 Health in schools	55
7.3 Young people's voice	58
8. Benefits of the programme so far	63
8.1 Perceptions of impact on health needs	63
8.2 Numbers and types of young people using services	66
8.3 Young people's satisfaction with services	67
8.4 Staff views on impact on work service issues	68
8.5 Challenges to showing benefits of the programme	69
9. Conclusion and summary of key learning points	70
10. Issues for consideration	72
Appendix – Methods and participants	73

Executive Summary

Introduction

The Teenage Health Demonstration Site (THDS) programme aims to demonstrate different approaches to enhancing services in order to promote the health and well-being of young people in the broadest, holistic sense particularly targeting the 30% most vulnerable young people in the local population. Specific objectives of the programme are to show how to ensure health improvement information, advice and guidance can be delivered to young people more effectively in non-health settings and to demonstrate how best to configure health services to target and meet the health needs of all young people, including those with long-term medical conditions. The THDS programme is funded by the Department of Health (DH) and runs for two years from November 2006.

The four demonstration sites are based in Bolton, the London Borough of Hackney, Northumberland and Portsmouth. The sites were selected because they displayed one or more of a range of features. These included: strategic commitment to prioritising young people's health; innovative services in place or in development; and particular characteristics, such as being rural (Northumberland), or having large Black and Minority Ethnic populations (Hackney). Each site drew up a two-year plan for DH detailing how they would meet programme objectives. These objectives included supporting specific pieces of work directed at young people in their locality including the implementation of the You're Welcome¹ quality criteria and the participation of schools in the Healthy Schools Programme².

The THDS evaluation annual report highlights the interim evaluation findings from the first year of the demonstration sites. It focuses on: the lessons learnt from examining the processes of planning and implementing the programme during the first year; young people's uptake of and satisfaction with services; and stakeholder perceptions of early impact. The two-year evaluation is being carried out by a team at the Social Science Research Unit, Institute of Education, University of London. The evaluation methods used include interviews and surveys with young people, programme staff and other stakeholders, and quarterly monitoring of service uptake by young people over two-week periods. The evaluation is advised by a range of stakeholders including young people and THDS staff.

Key interim evaluation findings

Design and delivery of adolescent health services

Three main approaches to service delivery are being used in the THDS:

- Enhancing or developing teenage-specific, holistic health services ('one-stop shops') in innovative health and non-health settings
- Creating or enhancing health provision for teenagers in non-health settings
- Enhancing mainstream health provision to be more youth friendly.

The sites are using combinations of all these approaches. However the ways these approaches manifest locally, and the balance between the different approaches varies widely as sites develop services that address local need. Bolton and Hackney are using a model based on a central one-stop shop (hub) with outreach sites (spokes), Portsmouth's

¹ Department of Health (2007) *You're Welcome quality criteria: making health services young people friendly*; London: Central Office of Information – www.dh.gov.uk/en/Publicationsandstatistics

² The National Healthy Schools Programme, www.healthyschools.gov.uk

focus is on developing neighbourhood-based services, and enhancing the mainstream is a particular focus of the Northumberland demonstration site.

Some themes are emerging about the benefits and challenges of the different approaches. For example, a central hub is an efficient way of bringing together a wide range of services and operating flexible opening hours, but is unsuitable in areas where young people are unwilling or unable to travel to a centralised resource. Neighbourhood-based services can be located where they are accessible to deprived populations but are unable to deliver such flexible or seamless provision. The outreach approach delivers to young people who would not access traditional healthcare and can be targeted at disadvantaged groups, but does not provide a holistic service. A mobile unit brings health facilities to young people in scattered neighbourhoods with low population density or poor transport links but may be unable to offer a comprehensive health service.

A vast array of innovative services are now being delivered or are poised to start early in the second year of the programme. Much of this delivery is in non-health settings such as schools and community centres and often involves multiple agencies from the statutory, voluntary and community sectors working together in a range of different ways. Examples of the types of partners involved include sports clubs, youth inclusion programmes and substance misuse services.

Key factors for consideration when planning services include: type and location of settings; mix between drop-in and by-appointment services; and balance of types of staff who are experienced and skilled at working with young people. At this early stage facilitators for success for planning and delivering services include:

- Having a core clinical team comprised of adolescent lead nurses, lead GPs, paediatricians and senior adolescent mental health workers; this is important both in terms of delivery to young people and to raising standards in other services
- Forging strong partnerships with other agencies including those in fields other than health and in the community and voluntary sectors
- Involving young people in service planning and development – supported by a dedicated participation worker
- Incorporating those elements that are most important to young people: drop-in services with flexible opening hours; premises that are easy to get to; a friendly, non-judgemental approach; confidentiality; a range of activities being available alongside health provision; and opportunities for young people to be with their friends
- Offering services: that go to where young people are rather than expecting young people to travel to them; and that involve workers who are specialists in delivering to vulnerable groups
- Providing flexibility in the range of places and types of settings - ideally young people can access the same member of staff in a range of different locations
- Having flexible referral systems - bypassing traditional referral pathways through the GP or social worker. Fostering self-referral, word-of-mouth and referrals from a range of agencies
- Having well-trained staff - concerning You're Welcome quality criteria, young person-friendly practice, common teenage health conditions and effective support pathways for young people
- Offering staff training that is: inclusive of all staff involved with the work; includes learning from young people; and is offered through a range of approaches, such as training sessions delivered in provider settings and work placements
- Building in scope for flexibility - staff are using learning from the first year to modify provision even at this early stage.

Work around promoting the implementation of the You're Welcome quality criteria and the Healthy Schools Programme is at an early stage. Findings in relation to You're Welcome include the value of having young people and champions from relevant professional groups at the heart of the process. Multiple examples of innovative collaborative work in education settings are being tested in all the sites.

Different models of support for increasing young people's participation in health service development and delivery are being used in the different sites. Facilitators for success at this stage include:

- Putting young people's sustained participation at the centre of the development and delivery of adolescent health provision from the start
- Involving a wide range of different young people, including service users from vulnerable groups, working on different projects/issues
- Employing a dedicated participation worker.

Managing the programme

High levels of commitment from managers across multiple agencies at senior strategic and operational management levels had been achieved prior to beginning as a demonstration site. This was considered key to success in year one. Sites have adopted different models for the site co-ordinator role – no clear overriding advantage for one model over the other has been identified at this stage in the programme. However important factors to emerge are: having sufficient dedicated time, seniority and a strategic component to the role; previous knowledge of local services. Change-management skills are seen to be an important aspect of the role holder's skill set. An inclusive, bottom-up management ethos emerged as a consistent facilitator to progress and staff satisfaction.

Uptake of services, perceived benefits and progress in year one

Some positive trends emerged in terms of uptake of services and perceived benefits of the programme at the level of individual young people. Key findings include:

- A general trend, in the services being monitored between June and September, of increased numbers of young people accessing services as well as a wider range of types of services being offered
- Staff and young people are positive about the impact of services – perception of impact on sexual and reproductive health emerges most strongly
- Young people's satisfaction with services in the sites is very high: 94% said they would recommend the service to a friend and 91% found staff easy to talk to
- Target numbers of the 30% most vulnerable young people appear to be being met
- Innovative approaches are improving access by harder to reach groups – for example enhanced sports programmes are reaching young men.

Despite reaching many vulnerable young people, accessing certain specific groups of young people remains a major challenge in the demonstration sites. These include, for example, Asian young people in areas of high Asian population; young people with long-term medical conditions or a disability; and young people who have offended or are looked after by the local authority. These are particularly vulnerable and marginalised young people whose specific needs have historically been neglected by service providers. Hence there is no existing local baseline for some of these groups from which to work. The main progress in year one has been in scoping the work to be undertaken with certain groups in order to target delivery effectively in year two.

All the sites reported challenges to early progress. Specific difficulties included:

- Finding appropriate, affordable accommodation for delivery of services
- Recruitment of experienced and qualified staff
- Managing the effects of change on workforce
- Coping with the impact of organisational change in key agencies
- Communication across the multiple partner agencies
- Changing young people's perceptions and behaviour with respect to service use.

Consequently, in some cases services were slow to start and small numbers of young people were accessing many of the new services that had come into operation in the past year. However, passionate and committed managers and front-line staff had worked hard to overcome challenges and were now in a position to build on foundations that they had established in the first year to take their plans forward over the coming months. Facilitators for success with start-up included: realistic lead-in times in acknowledgment of the fact that setting up and running services that achieve sustained use by young people is highly skilled, specialist work; basing decisions on local scoping exercises; young people's participation in the design and development of services; prioritising effective engagement with partners, for example, through the use of service level agreements; building on service foundations that are already there rather than starting from scratch; and ensuring budgets include adequate resources for support staff such as administrators and caretakers.

Future challenges

All the sites have overcome a number of barriers to the development and implementation of their programmes. Ongoing challenges that need to be addressed in year two are:

- Some proposed services were not operational by the end of year one. Ensuring they become so early in year two is critical if acceptability and satisfaction are to be assessed before the end of the programme
- Some areas of work – such as transition to adult services and promoting the implementation of the You're Welcome quality criteria - were at an early stage and require considerable progress to be made on them in year two
- Young people's perceptions and use of services remains predominantly focused on sexual and reproductive health. Widening this so that both young women and young men increasingly use services for holistic health needs is important
- Specific vulnerable groups are not being reached by services in the different sites. Broadening the reach of services to ensure that all groups of young people are able to use them is a key challenge for all sites to address
- Participation by young people in the planning, management and review of services was less than ideal in some sites. Increasing the scale and effectiveness of sustained participation by young people is therefore a priority
- Effective systems that allowed all levels of staff to be involved in decisions around the work of the programme were not always in place. Action to address this needs to be taken as soon as possible
- Working to ensure sustainability, of aspects of the work demonstrated to be valuable, after funding ends in October 2008 is an absolute priority.

1. BACKGROUND TO THE TEENAGE HEALTH DEMONSTRATION SITES PROGRAMME

1.1 Aims of the Teenage Health Demonstration Sites programme

The Teenage Health Demonstration Site programme (THDS), funded by the Department of Health (DH), provides an opportunity to explore how best to deliver health services to young people. The two-year programme aims to demonstrate different approaches to enhancing services in order to promote the health and well-being of young people in the broadest sense, particularly targeting the 30% most vulnerable young people in the local population, including those with long-term medical conditions. Using the Every Child Matters³ framework, it is intended that this holistic provision should cover the areas of: smoking, alcohol and substance misuse; emotional well-being and mental health; suicide and self-harm; sexual and reproductive health; and obesity.

The programme which is being carried out in four sites around the country has two key objectives:

- To demonstrate how to ensure health improvement information, advice and guidance can be delivered to young people more effectively in non-health settings, particularly targeting the 30% most vulnerable young people in each site
- To demonstrate how best to configure health services to target and meet the health needs of all young people.

The THDS initiative forms one component of an increased attention to young people's health within the UK policy context since 2004. Launching the Children's Plan in December 2007 Ed Balls, Secretary of State for Children, Schools and Families said, "*Our aim is to make this country the best place in the world for our children and young people to grow up*"⁴. The Demonstration Sites were introduced through the Youth Matters green paper⁵ as a way to explore how best to improve the take-up of health services by young people and to improve emotional and physical health outcomes for young people. *Our Care, Our Health, Our Say*⁶ explains that the Demonstration Sites were intended to investigate the potential of delivering accessible services in youth-centred, non-formal settings. *Choosing Health*⁷ sets out a public health strategy that includes integrating services for children and young people across health, education and social care in order to promote healthy lifestyles amongst young people.

Within this broad remit, the THDS are expected to facilitate the development of You're Welcome quality criteria⁸ within local health services as set out in the *National Service Framework for Children, Young People and Maternity Services*⁹, which set standards for children and young people's health and social services and the interface of these services with education. The You're Welcome quality criteria lay out principles to make health services friendly to young people, in the community and in hospitals. Young people are to be

³ *Every Child Matters*, www.everychildmatters.gov.uk

⁴ Press release concerning Children and Young People's Plan, Department for Children, Schools and Families, 2007

⁵ Department for Education and Skills (2005) *Youth Matters*, London: TSO

⁶ Department of Health (2006) *Our Health, Our Care, Our Say: a new direction for community services*, London: TSO

⁷ Department of Health (2004) *Choosing Health: making healthy choices easier*, London: TSO

⁸ Department of Health (2007) *You're Welcome quality criteria: making health services young people friendly*, London: Central Office of Information - www.dh.gov.uk/en/Publicationsandstatistics.

⁹ Department of Health (2004), *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health

provided with opportunities to have an active say in the development, management and review of health and youth support services, as set within Hear By Right¹⁰ participation standards.

The Demonstration sites are also required to help drive forward their local *Healthy Schools Programme*¹¹. This programme is a joint initiative between DH and the Department for Children, Schools and Families (DCSF) to help health services and schools to work in partnership to promote the health and well-being of pupils. Demonstration Sites are also required to work on preventing second conceptions, which is a target area within the Government's refreshed Teenage Pregnancy Strategy.

It is hoped that the learning gained through the course of the programme can be transferred to other areas in order to advise national policy and support local planning, service configuration and sustainability.

In addition to transforming existing health settings, all sites are targeting young people in non-health settings, such as in schools and community based services, in order to: reach young people who are reluctant to access traditional health services; address the health and well-being of young people in a broad and innovative sense; and promote healthy practice in non-health settings.

1.2 Background to sites

There are four demonstration sites based in Bolton, the London Borough of Hackney, Northumberland and Portsmouth. The four sites were selected because they displayed one or more of the following features:

- Strategic commitment to prioritising young people's health
- Innovative services in place or in development
- Record of good partnership working
- Young people at the heart of service development
- Particular characteristics, such as being rural (Northumberland), or having large Black and Minority Ethnic populations (Hackney).

Each site drew up a plan for the two years as to how they would meet programme objectives, which was agreed with the DH. More detailed information about each site's starting point and projected plan are found in Section 3. The four sites were launched formally on 31st August 2006. It was intended that they would start operating from 1st November 2006 and that the programme would run for two years until 31st October 2008 with an overall budget of £4 million. The Sites received an average of approximately £800,000 over two years from DH to implement the programme, including additional funds to carry out work in connection with the National Healthy Schools Programme and reducing second conceptions. DH continues to oversee and support the programme, for example through a requirement for six-monthly reporting, regular joint network meetings for staff representatives and site visits.

¹⁰ Hear by Right participation standards were developed by the National Youth Agency - www.nya.org.uk/hearbyright/

¹¹ *The National Healthy Schools Programme*, www.healthyschools.gov.uk

1.3 This evaluation report

This annual report highlights early findings from the national evaluation of the THDS programme undertaken by the Social Science Research Unit, Institute of Education, University of London. During the first year of this independent evaluation we have gathered data using a range of methods which include: questionnaire surveys with a) young people (n=622) and b) front-line staff (n=48); interviews with service providers, other stakeholders (n=33) and young people using services (n=42); two rounds of monitoring data (n=827 one-to-one contacts and 921 within group sessions); and observation during site visits (see Appendix A). This report will cover key emerging themes relating to: how sites have chosen to organise services; strategic level operations; and ground level operations. It concludes by exploring the benefits that the demonstration site programme has brought so far.

It is important to note that this report is based on data collected between January and November 2007 (with reference to the initial scoping study carried out by another research team¹²). In the second year of the evaluation we will focus on: extending the range of perspectives beyond that currently captured in the qualitative data (some additional members of staff and young people with particular experiences have yet to be interviewed); gather more detailed information on the many services and other initiatives that currently are still at a very early stage in their development; and capture views on issues that staff have particularly prioritised for the second year of the programme, such as sustainability.

¹² Evaluation of the Teenage Health Demonstration Sites: Scoping and baseline study report July – September 2006 Policy Research Bureau October 2006.

2. APPROACHES TO SERVICE DELIVERY

In this section we shall highlight the three main approaches that the demonstration sites have taken to address the challenge of enhancing health and related services for young people. Examples will be given of how these approaches have been translated on the ground. We shall evaluate the benefits and challenges of the models chosen in order to assess what approach appears, at this early stage, to work best.

2.1 Introduction

From the outset, the four demonstration sites have differed widely from each other in a number of ways: local policy context; existing service provision for young people; and social and demographic characteristics (see Section 3 on overview of progress in year one for a detailed description of the four sites). This deliberate variation in selection has allowed there to be a broad representation of the different complexities that exist in local provision across England.

This local variation, as well as differences in ethos between sites, has influenced the development of the approaches that the four demonstration sites have chosen to adopt to help them reach their goal of improving services for young people. For instance, the considerable diversity in the mix of the type of services already operating within their areas had an impact in their planning. Decisions about the plan for each area were based on a range of factors including: previous local needs assessment; mapping of services; and a pragmatic assessment of (future and current) mainstream funding available.

Despite these differences, there were also commonalities between the four sites. For instance, sexual and reproductive health (including teenage pregnancy) was regarded as an important health issue across all sites, as was substance misuse. The desire to intervene earlier to provide more support for the growing number of young people presenting with low-level emotional health support issues was also mentioned by all projects.¹³

Additionally, staff who drew up action plans in all sites made similar decisions to primarily build on existing foundations for service enhancement, rather than to develop entirely new service structures.

"We knew there was already quite a lot of work happening so we didn't feel we were starting from scratch. So some of it was just about enhancing what was there and building on it...around the children's and young people's plan, looking at the gaps that had been identified there so that it was joined up and we weren't just parachuting in with a new project that wasn't based on any need or that wasn't going to do what young people wanted." (Health service manager)

Ultimately the sites have utilised a combination of up to three main approaches to improving holistic health provision for young people through the THDS programmes. These approaches are:

1. Enhancing or developing teenage specific, holistic health services ('one-stop shops') in innovative health and non-health settings
2. Creating or enhancing health provision for teenagers in non-health settings (peripatetic / outreach work; channelling money to non-health providers to promote young people's health and well-being)

¹³ Evaluation of the Teenage Health Demonstration Sites: Scoping and baseline study report July – September 2006 Policy Research Bureau October 2006.

3. Enhancing mainstream health provision to be more teenage friendly.

We will now provide examples of how each of these different approaches have been made operational in the demonstration sites.

2.2 Approach 1: Teenage-specific, holistic health services ('one-stop shops') in innovative settings

There are three types of one-stop shops operational in the demonstration sites: those in innovative health settings; those in other community settings; and those in mobile facilities.

One-stop shops are services that provide advice and support concerning health and well-being in a broad sense, through a multi-agency team. Innovative health settings are ones which are delivered by the PCT but in a novel way in a community site. These community settings in the demonstration sites include: the youth offending team premises; Connexions advice centres; community facilities on housing estates; a healthy living centre; further education colleges; and sports centres.

a) Multi-agency one-stop shops – innovative health settings

Two of the sites (Bolton and Hackney) provide services to young people on a 'central hub with spokes model'. The hub is a young person's holistic health and well-being centre with: flexible opening hours; drop-in and by-appointment clinic sessions; support and activity-based groups; and a range of specialist staff. The hub acts as a centre of excellence that brings together multiple agencies, where previously services were provided by single agencies working in parallel and often in isolation. The spokes are a range of neighbourhood-based services for young people who are unlikely to access the central hub (see Section 2.3 for more detail).

The Bolton model was well established prior to becoming a demonstration site but used THDS funding to make considerable improvements to the building, including upgrading of the reception area (see example box about the Parallel overleaf). The Hackney hub was created by enhancing an existing young people's sexual and reproductive health service (CHYPS) to become a new young people's holistic health service (CHYPS+). The CHYPS building was reconfigured in order to create the extra space and facilities required for the new service. The adolescent health team is based at the hub (known as the House) and includes a core clinical team. This core team is comprised of newly recruited staff who are funded from the THDS budget as well as CHYPS staff who are not funded by THDS money but whose roles have been refocused to reflect the holistic nature of THDS work. The specifically recruited staff include a GP with special interest in adolescent health, an advanced nurse practitioner, and an assertive outreach nurse (see Section 6.3 of this report). The former CHYPS staff include three development workers and a lead development nurse for sexual and reproductive health. Other workers are available at the House on a sessional basis once or twice a week during general health clinic sessions. These include: a substance misuse worker; counsellor; dietician; Connexions personal adviser (see overview of progress in year one in Hackney in Section 3).

The Parallel - Young persons' Town Centre Health Centre

Funded by Bolton PCT, the Parallel is a young persons' health centre designed by young people providing specialist holistic health provision for 11 to 19 year olds in a central location. Partner agencies include: CAMHS, 360⁰ Under 19s substance misuse service, Connexions, social services and the youth offending team. The nature of the collaboration with partner agencies varies but includes: joint funding of posts; location at the Parallel of a member of staff funded by an organisation other than the PCT; and joint training.

Staff working at the Parallel include:

- An emotional health practitioner
- A consultant in sexual and reproductive health
- Nurses who specialise in adolescent health
- A nurse specialist in attention deficit hyperactivity disorder (ADHD)
- A youth worker who specialises in counselling and supporting young people on lesbian, gay, bisexual and transgender issues
- GPs with special interest in adolescent health
- A nurse specialist in teenage pregnancy
- A midwife
- A youth worker
- An Advanced Practitioner – Lead Nurse
- An under-19s substance misuse worker.
- An administrator, receptionist and caretaker.

Some of the above are based at the Parallel and offer a personalised intensive support service there as well as on an outreach basis elsewhere (in both health settings and non-health settings); others are based elsewhere but come in on a sessional basis to offer a service.

General health and well-being clinics are held at the Parallel on five days a week, including Saturday, and cover emotional, social, sexual/reproductive and physical health. In general most clinics are accessible on a drop-in and self-referral basis.

Specialist services that are run routinely from the Parallel include:

- Consultant-led sexual and reproductive health session
- Under-19s '*bumps and babies*' service
- Transitional epilepsy service
- Physiotherapy for under-19 years.

The Parallel aims to have an active young people's steering group (YPSG) at its core. The role of this group includes regular monitoring and evaluation of services by using service satisfaction questionnaires. Resulting findings are disseminated at staff team meetings.

The evaluation found that the Parallel's holistic approach to health provision in tandem with a purpose-built, welcoming environment has proved very popular with young people. Asked to comment on what they liked about the Parallel young people responded:

"It is a good service and I believe that if it wasn't here today young people would be lost"

"I feel that it is more confidential"

"Get results the same day"

"I feel supported, not alone"

"They don't judge you"

"It's friendly so it's not scary"

"It's confidential and I can talk about problems"

When young people were asked what they would like to see improved, the most common responses were to have shorter waiting times and longer opening hours.

Benefits of 'hub' services

The evaluation has found that an advantage of having a central service is that it is possible to bring together the best innovative practices for young people. Economies of scale operate; this is an efficient way of providing a holistic service, where young people can access a wide range of services under one roof, sometimes in a single visit. Opening hours can be longer and more flexible, suiting school students as well as young people at work. Furthermore, agencies involved can collaborate easily thereby providing a relatively seamless service. The size and scope of such a service allows for new components to be added in response to ongoing need assessments – for example a decision to bring a dietician into the CHYPS+ service, to offer both clinic based and outreach provision, has recently been made. The hub can also function as a training centre. For example the Parallel provides placements for student nurses and doctors and plans are in place for all new youth service staff to do a one day a week placement at the Parallel during the first few months of their post. This will serve the dual purpose of providing a youth work service to Parallel users and training for these new members of staff in best adolescent health care practice.

Challenges of 'hub' services

Having a large hub as the focus of the service is not a suitable model in areas where transport links are poor or in outlying rural areas. Even in cities where transport links are adequate, the reluctance of young people to travel far in order to access services was widely commented on by staff (referred to by some staff in Hackney as *'the postcode factor'*). This means that the spoke components are critical and the potential risk that a large hub could swallow up a disproportionate amount of available resources is one that requires careful management. This becomes particularly pertinent in a context where staff at the hub are having difficulty in widening the client base. However the evaluation found that staffing problems hit smaller outreach services harder than larger, centralised services as they could lead to the service being cancelled for a week or more. This lack of continuity discouraged young people.

Setting up a service on the scale of a large central hub creates considerable practical challenges. The Hackney team's experience of trying to find premises illustrates this well (see Section 3). The multi-agency nature of the central hub approach inevitably presents specific challenges arising from the bringing together of staff from different service and professional backgrounds to co-locate and/or deliver.

As with many new services for young people, establishing a multi-agency one-stop shop takes time; it took several years to establish a successful drop-in centre in Bolton. Local staff say that elements that helped in its establishment included: a strong initial vision; high level strategic commitment; funding stability over a number of years; time to evolve at a pace that allowed for change to be managed sensitively; a dedicated team of clinicians with a keen interest in adolescent health; and high levels of participation by young people in developing services.

Developing holistic services often involves reconfiguring existing services. Time is required for patterns of use by young people to change once a service has been reconfigured, for example (as with both the Parallel in Bolton and CHYPS+ in Hackney) from a sexual and reproductive health service to a holistic health service. There appeared to be an element of stigma associated with sexual and reproductive health services (some young people, especially young men, derided them as services for *'slags'*); entrenched attitudes to previous service distinctions thus took time to diminish (see Section 8.2).

b) Neighbourhood-based multi-agency health drop-ins – in innovative settings

Neighbourhood-based one-stop shops were used as the predominant model in Portsmouth, where disadvantaged young people are reluctant to use health services outside their 'patch' and are often unwilling and unable to travel to centralised facilities. Multi-agency drop-in sessions were operating around the city prior to Portsmouth being made a demonstration site in neighbourhoods with high levels of deprivation, one in a healthy living centre and one in a centrally-located Connexions Centre. In order to deliver a holistic service, additional services have been introduced into these centres over the first year of the THDS funding and more services are planned for the second year. In addition three more venues are planned for year two.

Benefits of neighbourhood-based drop-ins

The evaluation found that the advantages of having neighbourhood-based services include: young people not having to travel far to use them; that the service can be located in areas with deprived populations; and young people being able to access services in the vicinity of their home or school so they can avoid explaining their exact whereabouts to their parents. Focusing resources in deprived neighbourhoods avoids resources being disproportionately drained from them to a centralised resource, which could be attracting a less disadvantaged clientele that is willing and able to travel.

Challenges of neighbourhood-based drop-ins

Neighbourhood-based services are unlikely to offer such a comprehensive service as the central hub model and they cannot afford to operate such extensive and flexible opening hours.

"A lot of people want to use the service in such a short time period. This means some people do not get seen. I think providing the service more often would benefit a lot of people." (Young person)

Another challenge experienced by the projects included: finding suitable premises (an issue in Portsmouth, Hackney and Bolton). Furthermore while some young people liked the closeness to home/school that neighbourhood services provided, as explained above, others were concerned about the risk this posed to anonymity: *"lots of familiar faces..."*

As with the central hub, the development of neighbourhood-based holistic services can involve reconfiguring existing services previously seen as a sexual and reproductive health service. Time is required for patterns of service use to change.

c) Mobile one-stop health shop

A mobile drop-in health facility in the form of a specially equipped bus is being tried out in a rural / semi-rural ex-coal mining area in Northumberland where transport links are poor and where communities are spread out with no centre. The facilities on this bus are described in the box overleaf.

The Beat Bus – Young Persons’ Mobile Health Centre

The Beat Bus, which is managed by Doxford Youth Project in partnership with Northumberland Care Trust, offers a roaming mobile health centre providing advice and support to young people. It uses a youth work model to deliver health care. The range of issues addressed includes healthy eating, exercise, smoking, substance misuse, sexual and reproductive health (including Chlamydia Screening) and emotional health. The highly visible bus tours the Blyth Valley area of Northumberland providing sessions on four nights a week. The interior of the bus provides a central meeting and working area. A distinct, separate area is provided for computer/internet access via a laptop whilst the driver’s cab is set aside for one-to-one sessions.

Staff who deliver services from the bus include: youth workers, a young people’s tobacco control worker and drug workers. The team of youth workers also carry out detached work in surrounding streets. There are future plans for nurse-led sessions on the bus although there has been no resolution to the issue of there being no toilet on board, which would be required to expand sexual and reproductive health provision.

The Beat’s innovative approach in engaging with young people has proved to be attractive to young men especially. Ninety-four per cent of young service users surveyed said that they would go nowhere else for the help, support or activity they had accessed if they could not use the resource. Young people we interviewed described how they appreciated the accessibility, facilities and services provided.

“It’s nice, it’s everything, it’s great. You can meet new friends who come to the bus like, a lot of people who wouldn’t have been here before. We can meet them and talk to them about things, it’s a friendly place. [Staff] listen. They ask you things that no one else will ask ‘cos it’s confidential.” (Interview with young person)

“I talk about my weight because Dad’s big boned and I take after him so I worry about that... [Also] he takes tablets because he’s schizophrenic. I’m worrying about that.” (Interview with young person)

Research fieldwork observations

As soon as the bus parked, young people appeared out of the gloom in droves clambering to get on the bus. They helped themselves to health promotion literature, some asked to use the computer and some had come to take advantage of the C Card (free condom) scheme. The cacophony of sound was similar at each of three visits; this subsided when the staff, both male and female, skilfully engaged the young people in guided discussion.

Benefits of mobile facilities

The evaluation found that the main advantage of using a mobile facility is that it brings health facilities to young people in scattered neighbourhoods with low population density or poor transport links, where it would not be economically viable to duplicate geographically fixed but accessible provision. The most common reason given in our survey of service users for choosing to use the mobile unit was that it was easy to get to. 81% of users of the mobile unit gave this reason compared to 58% of survey participants overall giving this reason for using a service.

It also appears to be an attractive model for young people who do not access more traditional provision, especially younger boys. Monitoring data from Northumberland suggests that large numbers of young people have accessed the resource from the outset.

Challenges of mobile facilities

A mobile facility may be unable to offer a comprehensive health service, especially in rural areas where a bus needs to be small enough to enable it to be driven down country lanes. The restricted size of the mobile facility used in Northumberland, and its lack of a toilet, limit what clinical service is possible. For example, pregnancy testing and physical examination is not feasible. The only area available in the Beat Bus for a confidential, one-to-one consultation is the driver's hub. Larger buses, in areas where it would be feasible to use them, would have more space and toilet facilities.

A plan to have a mobile bus in a very isolated rural area in Northumberland was rejected by young people who thought a bus arriving in their village or small town (with a population size of 4,000 or less) would be too visible and compromise their anonymity. In this instance, improving mainstream provision was a more popular solution. The visibility issue in the existing mobile facility was partly addressed by the design on the outside of the bus which does not identify it as providing sexual and reproductive health or substance misuse services.

2.3 Approach 2: Health provision for teenagers in other community settings

As described above, the first approach was to offer young people 'one-stop' health shops. The second approach that operates in the demonstration sites is the provision of services to young people in other community settings. These can include:

- Community centres or education settings as a place to provide traditional health care
- Ways to link health more centrally into work with youth in community centres or education settings.

a) Adolescent health workers delivering an outreach clinical service or health promotion service in community centres or education settings

In demonstration sites, peripatetic adolescent health workers are delivering services to young people in settings where they congregate, such as schools and youth centres, i.e. taking services to young people rather than attracting young people to a service. Generally this outreach work does not comprise a multi-agency, holistic service. These are usually sessions run by single individual health workers or a small team comprising a very few agencies, rather than larger teams of multi-agency professionals.

We include here the 'spokes' of the 'hub and spokes' model, which aim to 'reach out' to young people who are unlikely to access the central hub. In Bolton, the main spokes will be nurse-led drop-in clinics, in four areas of the town, based in non-health settings where a small number of other services for young people (such as Connexions and the Youth Service) would also be delivering services. Unlike the Parallel, none of these existed prior to becoming a demonstration site; establishing them has been a key part of the Bolton plan (see Section 3 for more information). Other ways that health promotion and clinical health services were provided beyond the Parallel are described in Sections 2.2 and 2.3 below. Similarly Hackney is working on a whole raft of initiatives that take services out to young people who are unlikely to travel to the hub. Hackney services are also described in Section 3 below and throughout the report.

Other examples of this outreach model are:

- In Northumberland a young people's tobacco control worker has set up smoking cessation groups in schools and youth centres, and a substance misuse worker is dropping into schools to talk informally with large numbers of young people at break times and make contact with young people who require one-to-one support. Monitoring

data concerning health promotion work in schools shows that large numbers of young people are being reached through class-wide discussions

- In Hackney, Development Workers from the Adolescent Health Service team are offering a holistic 'clinic in a box' service to young people in school settings, whilst in Bolton a clinic in a box is being used by nurses working in the outreach sites.

Clinic in a box – A Tool for Holistic Health Outreach Work

The 'clinic in a box' concept has been developed as part of the outreach site programme – in Bolton and Hackney. Fully supported by clinical governance protocols this tool has enabled the delivery of a mobile contraceptive, sexual and reproductive health, and general health drop-in service to be delivered in non-health settings. In Hackney it is currently used in schools by development workers who are trained to use the equipment by clinical staff in the adolescent health team. In Bolton it is being used by nurses working in the outreach sites. The box contains, for example, equipment such as a BMI calculator, peak flow meter and blood glucose monitor/urinalysis for screening for a range of chronic conditions.

- Also in Hackney, the Advanced Nurse Practitioner and the GP with special interest in young people are running one-to-one clinical sessions and group health promotion sessions at the local voluntary sector centre for young people with learning disabilities
- In Northumberland a nurse practitioner has established a domiciliary service for young people who are looked after. A weekly drop-in is provided at three residential units where holistic advice, treatment and support are provided. Several young people have raised concern about skincare issues and as a result a beautician from the local college is providing some sessions on skin care. The nurse is offering staff working in the units advice, training and support in relation to young people's health issues.

b) Other enhanced health-related provision in non-health settings

The evaluation has found that the demonstration sites are enhancing youth and other community services that promote health and well-being and making them more accessible to young people. For example, money has been channelled to a range of small voluntary projects across northern Northumberland to make existing sports centres more accessible to young people, including girls and young women, in an effort to increase fitness.

Another example of this model is where additional funding has been given to a neighbourhood-based youth inclusion project in Bolton to allow for extra worker-time to run health sessions. The aim is to reach the very deprived young people who access this service who are often marginalised from mainstream health provision.

In addition, the demonstration sites are supporting training of non-health workers. In Bolton, for example, a member of staff from the young people's substance misuse service is being supported to undertake advanced practitioner training. More generally all staff from partner agencies in Bolton are now entitled to take up in-service training on holistic health issues offered by the PCT as part of its core training programme.

In Portsmouth a full-time training co-ordinator is managing a 20-course youth health training programme and follow-up, which has been taken up by education workers, youth workers from the voluntary and statutory sectors, Connexions personal advisers, police and community wardens, amongst others.

Benefits of enhancing health provision in other community settings

The evaluation has assessed that the advantage of the approaches described above to provide health-related services in education settings and community centres is that health

support and information may reach young people who would not access traditional health care. In schools and well-established youth centres this is an effective way of bringing health messages to large numbers of young people at one time. This outreach approach also appears to work well in reaching disadvantaged groups when offered in venues where young people are compelled to attend, such as schools and the youth offending team premises (e.g. in Hackney).

“So how is this service different to the ones that you’ve heard about even if you haven’t been?” (Researcher)

“It’s in school, it works around me. With the other ones it’s appointments.” (Young person)

Outreach services worked well where workers were linked into effective and swift referral networks, and young people who were identified as potentially benefiting from further support were followed up in a sensitive and confidential way. Staff report that Service Level Agreements with key partners such as the Youth Service are, in general, resulting in improved communication between agencies and signposting of young people between services.

Challenges of enhancing health provision in other community settings

In some situations, it took time for young people to start accessing new health-related services in non-health settings. This was particularly the case where services were being developed in venues which were not already well used and where young people were not compelled to attend. It then took time for staff to build up trust and a word-of-mouth clientele.

As with other approaches, finding suitable premises and staffing services also proved challenging in developing the outreach site programme in Bolton (see below).

Challenges to Setting Up and Running Services to promote health in Community Settings: an example from Bolton

Initial consultations with young people on a large housing estate in Bolton identified that they wanted the provision of holistic health drop-in sessions at their school. The school could not provide a dedicated room within school time but provided the facilities after 3.30 pm.

“...one of the issues that need to be addressed with education, is that if they want school nurse time or adolescent health time, then you’ve got to have a dedicated room that’s available in the same place at the same time” (Staff)

Despite being well advertised, an in-house assessment showed little uptake of the service. Further consultation with young people indicated they wanted the service to continue. Uptake remained low and the school-based service was discontinued. A key reason behind low utilisation of the service seemed to be related to some young people’s tight time frame to get the school bus home.

Subsequently, a decision to provide the outreach holistic health drop-in sessions at a youth venue on the estate was ratified. The start date (scheduled in the plan to be within year one of the programme) was reliant on the recruitment of a full-time nurse. However, despite a successful recruitment, the nurse’s start date has been delayed because of the length of time taken to process Criminal Records Bureau clearance procedures.

2.4 Approach 3: Enhancing mainstream NHS provision

The third approach operating in demonstration sites is work that is being done to make primary, community and hospital health services more accessible and appropriate for young people. This includes work in connection with the introduction of You're Welcome quality criteria (see Section 7.1). It also incorporates efforts to improve: services for young people with long-term medical conditions (LTMC), including their transition to adult care (see Section 6.2); Children and Young People's Mental Health Services (CAMHS) (see Section 6.4); and obstetrics and gynaecology services (especially in relation to preventing second teenage conceptions – see Section 6.3). DH directed the sites to have a lead GP, lead nurse and lead paediatrician in order to progress this work, which impacted on their programme plans and funding allocation.

In this approach, specialists who work specifically with teenagers (e.g. specialist paediatricians or GPs), acted as champions and worked with colleagues to spread young person-friendly strategies across their site area, into services that did not specifically have THDS funding. Sites felt that specialists were in a stronger position to influence colleagues in their own discipline, rather than to influence professionals from another discipline.

An example of another approach to enhancing mainstream services is in Bolton where school nurses will be trained to become adolescent health advisors. Once they are skilled up, their role and that of the nurses at the Parallel will be interchangeable, each delivering a similar service at all venues for young people.

Enhancing the mainstream is a particular focus of the Northumberland demonstration site, where geographical spread and low population density make a central resource an inappropriate way of delivering services to young people. This approach is seen as a reliable way of benefiting young people in the long term beyond the life of the pilot; non-core, targeted young people services were seen as potentially more vulnerable to future funding cuts.

For more detail on benefits and challenges to this approach, see the relevant sections referred to above.

Summary

The evaluation identified three main approaches being used in the demonstration sites to address the challenge of enhancing health and related services for young people. While all the sites used combinations of these approaches the emphasis varied between the sites - with Bolton at one end of the spectrum, focusing a major proportion of resources on a central facility for the delivery of a targeted young person's service, and Northumberland at the other end, with a strong focus on enhancing existing mainstream services. This variety between sites is unsurprising given the local diversity in terms of demographic characteristics, policy context and existing service provision. It is also encouraging given that the aim of the THDS programme is to maximise learning about what works best in particular types of settings. Staff were using learning from the first year to modify provision even at this early stage. Each of the models being used has benefits and challenges; while some themes are emerging it is too early for the evaluation to say which mix works best in a particular type of local context.

Learning points – Planning an Approach to Developing Health Services for Young People

The evaluation findings have highlighted some key learning points for others who are aiming to develop or enhance health services for young people.

- There are clear benefits and challenges to particular models of service delivery. Plan for a mix of separate young people's services and enhanced mainstream services – whatever balance current evidence suggests suits your locality best and what young people say they want and will use. Expect services to take time to establish but also build in the flexibility to make modifications based on ongoing learning.
- Build on foundations that are already there by making the best use of what resources exist to create new services or reconfigure services to fill gaps.
- Ensure that all stakeholders (including young people and front-line staff) contribute to planning the approach you take and be flexible from the outset in order that services are accessible and meet young people's needs.
- The elements that seemed key for successful establishment of young people's drop-in services were: a strong initial vision; high level strategic commitment; funding stability over a number of years; workers skilled in adolescent care and support; high levels of developmental participation by young people; and clinicians who were committed to adolescent health.
- Additional elements that benefited delivery of outreach services were: service level agreements with key partners; and swift referral networks.
- Be realistic about time to set up new services, e.g. finding premises; recruiting staff; police checks.
- Be aware that reconfiguring or establishing new services in innovative settings is a long-term and sometime difficult process; this involves a cultural change in young people's and adult's perceptions (when reconfiguring services) and time to build up trust and a word of mouth clientele (new and reconfigured services).

3. OVERVIEW OF PROGRESS MADE BY EACH DEMONSTRATION SITE IN YEAR ONE

All sites were expected to explore different approaches to developing health services that were more effective for young people, particularly targeting the 30% most vulnerable populations. This section looks specifically at the focus of each individual demonstration site and provides an overview of how each site progressed during their first year. Summaries are based on data collected by the evaluation team and enhanced by progress reports submitted by the sites themselves.

3.1 Bolton

Starting point

Bolton has a population of 261,500 of which 35,246 are aged 10 -19 years (2001 census data). It is a multi-racial town with residents from 40 different communities. Approximately one third of the wards in Bolton were in the index of multiple deprivations' 10% most deprived wards in 2000.

The focus of Bolton's health services for young people prior to THDS was a large young people's holistic health centre, the Parallel, which opened in October 2003, in a central point of the town. This was established and developed by a small group of visionary staff working in the context of strong local partnerships. It offers a wide range of holistic health services including specialist targeted services by practitioners working at the Parallel on an outreach basis (see Section 2.2 for a description of the Parallel).

The plan for the THDS programme in Bolton was based on a needs assessment that drew on a range of sources of information, including the views of young people. The essence of the plan was to develop a hub and spokes model of service delivery. The Parallel would therefore continue to be developed as a centre of excellence in holistic adolescent health care, but priority would also be given to extending the reach of the service in order to increase access by all young people including the 30% most vulnerable.

The organisational structures set up to manage THDS consisted of a strategic steering group and an operations group. Members of the former included senior managers in the key statutory agencies e.g. Assistant Director of Children's Services, Head of Clinical Services Children and Young People, Assistant Director of Nursing, the head of youth services, the medical lead and the lead for teenage pregnancy. The members of the operations group were in general service managers of all the different partner organisations, including voluntary and community sector partners. The day to day co-ordination of the programme was initially carried out by the Teenage Pregnancy Coordinator (TPC) and the nurse lead at the Parallel. Soon after the inception of the programme however the Clinical Services Manager for Children and Families (already on the steering group and with a long history of working for the PCT) was appointed to carry out this role (on two days per week) in place of the TPC and nurse lead.

The specific THDS objectives for Bolton were:

- To further develop the Parallel by refurbishing the building and increasing both the range and quality of services offered
- To extend the 'reach' of the service built up at the Parallel – with particular focus on reaching the 30% most vulnerable in non-health settings. This would be achieved by a range of initiatives including:
 - Establishing four new holistic health drop-ins, each running on a once weekly basis in non-health settings in areas of Bolton assessed to be particularly in need. Two were planned to start in year one and two in year two. They would be staffed

- by a team from a range of organisations including an adolescent health practitioner (nurse), youth workers and Connexions personal advisers and branded under the Parallel name
- Raising both the numbers of school drop-ins and the quality of service provided in them
 - Building on partnerships with other organisations working with young people (for example Bolton Wanderers Football in the Community and a youth inclusion programme project) to enhance their programmes of work with young people to address holistic health issues such as healthy living, sexual and reproductive health and obesity.

Progress in Bolton

Some aspects of the programme have progressed more or less according to plan. For example the Parallel has been successfully refurbished, with updated computerised monitoring systems introduced.

Progress with extending referral mechanisms to specialist services and development of care pathways has continued with the aim, amongst others, of improving transition to adult services.

Delivery of aspects of the 'reaching out' component of the THDS plan is also now taking place. For example:

- A THDS-funded programme of work around holistic health issues is now well established at a neighbourhood-based youth inclusion project; levels of satisfaction were found by the evaluation to be high in both young people and staff involved with this programme
- One of the four outreach sites is running a nurse-led holistic health drop-in session once a week in a non-health setting where youth services, Connexions and a pupil referral unit are also based (see 'Clinic in a Box', Section 2.3)
- A football in the community project is starting to deliver an enhanced service to make their service more holistic.

Other aspects of the outreach component of the plan are still in the planning stages but are progressing satisfactorily for implementation in year two. For example:

- The service level agreement with the youth service for practice placements at the Parallel for newly appointed youth workers is planned and placements will start imminently (See Section 2.2)
- Premises have been agreed for two additional outreach sites in non-health settings and delivery is expected to start early in 2008
- Other examples of initiatives that fit into this 'about to be delivered' category are the work to implement the You're Welcome quality criteria: a new family support service in partnership with the integrated children's service; a second conceptions worker; and the changes to the school nursing service (see Section 7).

Work on raising standards in mainstream services has generally moved forward. For example, a wide-reaching training strategy (which includes the practice placement scheme) is in place and as partnerships between organisations have improved, the training on health issues is being increasingly taken up by non-health staff.

Facilitators of progress in Bolton

- A context of organisational stability. Prior to the programme starting, the local authority had integrated social services, youth services, Connexions, and education into a new Children's Integrated Service. Although health services are not yet part of the integrated

service, there appears to be a history of strong partnership working at both operational and strategic levels

- The Parallel centre has been a well established, acknowledged ‘beacon’ in the field.
- Workers at all levels have been closely involved with the development of the Parallel and act as champions in the field of adolescent health.

Challenges to progress in Bolton

Several key challenges have hindered progress. These are:

- Staffing problems – these include delays with getting new staff into post, due in part to the time taken to complete required recruitment procedures (including CRB checks). This has impeded the progress in the outreach sites such that only one of the two scheduled to begin in year one has started to deliver a holistic health service and even this has been slow to get going
- Sustaining and broadening the reach and impact of participation work by young people. Recruiting new members to the steering group at the Parallel, as past members move on, and extending participation work into other services has proved difficult
- Reaching certain groups of young people; most notably the large Asian population (both at the Parallel and in the outreach services) and boys and young men at the Parallel. Evaluation data is starting to show some success with accessing boys and young men via aspects of the football in the community programme
- Changing young people’s perceptions of what a service offers, for instance from being a mainly sexual and reproductive health service to a more holistic health service. While staff are confident that this is now changing this is not emerging from the evaluation data (young people’s survey and monitoring data)
- In general, partner agencies are fully engaged. Staff report that challenges to engagement have been the result of turnover of key staff in partner agencies at an early stage of the partnership work – before communication pathways had been established. Including responsibilities to maintain communication and reporting in Service Level Agreements and rethinking how and when funding is allocated to partner agencies are being considered as ways to address this challenge.

Summary – Bolton

Bolton had the benefit of having the exceptional young people’s service at the Parallel, with its experienced and committed team, to build on and ‘reach out from’ at the start of the programme. Exciting developments at this centre such as a system of multi-agency training placements have been set in motion. Progress is still required however with shifting perceptions of what the Parallel now offers and reaching particular groups either through the Parallel or other parts of the service. Aspects of the outreach work, to be developed as a key component of their plan, have gone well while others have been problematic. In particular the four outreach sites have been slow to get going, with staffing and premises concerns presenting the main challenges. It is anticipated that the rate of progress will pick up in year two as these issues are now resolved.

3.2 Hackney

Starting point

The London Borough of Hackney has a population of 26,300 young people aged 10 -19. Of these 55% are from BME groups and all the wards in the borough fall within the 10% most deprived in the country. Hackney has high numbers of looked after children and asylum seekers under the age of 18; it also has high rates of family mobility. Further challenges faced by Hackney, as with many inner London boroughs, were the known difficulties relating to recruitment and retention of staff and finding premises. The very existence of these challenges was a factor in the selection of Hackney as one of the THDS sites; there was much to be learnt about processes and outcomes in such an environment.

Prior to THDS a key aspect of Hackney's young people's health care provision was a sexual and reproductive health service (called CHYPS) for young people aged 11 – 25 years. A service was offered several times a week in a dedicated centre called the House and also delivered weekly on an outreach basis in sexual and reproductive health clinics for young people in other parts of the borough. A range of other health-related services targeted at young people based in the statutory, community or voluntary sector, were also in existence, for example the Health Hut at a secondary school (see Section 7.2), Sub 19 - a young people's drug and alcohol service, and Off-centre - a counselling service for young people. Other services providing support to young people included statutory youth services and some well established voluntary and community sector organisations working with young people at risk of disadvantage for range of reasons.

Hackney's THDS plan was developed in close partnership with London Borough of Hackney, Hackney Youth Service, East London and City Mental Health Services (Children and Adolescent Mental Health Services) and the Learning Trust (the not for profit organisation that runs education services for Hackney). The findings from a consultation exercise involving 200 young people from a diverse range of groups, including asylum seekers and looked after children also fed into the proposal. This cross agency involvement was seen as key to sustaining investment in resources for delivering high quality services to all young people and in particular the 30% most vulnerable. It was also key to overcoming the specific challenges faced by this demonstration site.

The management of the adolescent health programme has been organised in Hackney as follows:

- A strategy group comprised of senior managers. Members include a consultant in public health, the General Manager of East London Mental Health Trust, and a manager from the Learning Trust. The Associate Director for Children and Families, City and Hackney PCT leads the strategy group and is responsible for overseeing the programme as a whole. This group holds overall accountability for the programme
- CHYPS+ operational steering group. Members include the THDS service manager and those in the above strategy group. This group holds responsibility for the ongoing implementation of the programme
- A full-time THDS service manager who manages the day to day running of the programme.

The THDS programme plan in Hackney included all of the three approaches to service delivery described on page Section 2 (i.e. developing teenage specific holistic health services in non traditional health settings; out reach work in non-health settings and enhancing mainstream provision.) Key partners included the youth service, looked-after children's services (LAC), CAMHS, health Improvement, school health, plus voluntary sector organisations. Developing a network approach to the delivery of information, treatment and care to young people through close collaboration of all these partners was central to the Hackney plan. As with the other sites sexual and reproductive health, emotional health, obesity and substance misuse were seen as key issues (though it was acknowledged that sexual and reproductive health is well covered locally following some intensive work in this area). Specific target 'vulnerable' groups identified, in addition to those featuring in all the sites were: travellers; particular minority ethnic groups not yet being adequately reached by services (including Turkish, Vietnamese and Asian young people); and lesbian, gay, bisexual and transgender (LGBT) young people.

The Hackney THDS plan was based on a hub and spoke model of service organisation (see Section 2 for discussion of this model). The hub would be in a centrally located setting to serve both as a resource for young people and be a point of multi-agency service delivery to young people. The intention was that agencies/services (including a core adolescent health

team, see Section 2) would be co-located to facilitate access and interagency collaboration. Consultation with young people identified the requirement that the hub should be in a non-traditional service setting.

The spokes would aim to take health information/services to where young people are – with a specific intention of improving access for the 30% most vulnerable in the community. The plan for the spokes included:

- Delivery of health services in non-health settings such as schools and the YOT
- Commissioning specialist services and programmes of work from established community/voluntary sector organisations currently providing support services to young people. Examples include a local voluntary sector centre for young people with disabilities and Shoreditch Spa (see Section 6.4 for information on Shoreditch Spa)
- Partnership work with youth service initiatives such as an LGBT project and two senior health trainer posts, to develop health related work with young people who access services provided by the youth support team.

A number of new posts were identified as important in order to deliver the core activities – these included a full-time project manager for the first six months; a GP with special interest plus extra GP sessional input, a full-time adolescent nurse practitioner, six health trainers (joint appointment with the youth service). It was also a key part of the plan that a young people's group would be established to play a central role in steering the work of the programme.

Progress in Hackney

Significant progress has been made within the first year of the programme. A number of barriers were encountered, particularly in the early stages of the work, which delayed/compromised some aspects of early service delivery (see challenges below). However an accelerated pace of service development was achieved as the year progressed.

Examples of aspects of the programme that are now being delivered include:

- The hub (known as the House) – this is now fully functioning. The adolescent health team is located at the hub with a range of other agencies delivering there on a sessional basis each week (see 'challenges to progress in Hackney' overleaf for explanation of why this change to the plan for co-location came about). The complexity of the process involved in establishing the hub resulted in delays in starting service delivery and in establishing some of the required support systems for staff. However it now offers both drop-in and pre-booked appointments five days a week – where young people can access a range of holistic health services (see Section 2.2 for more detail)
- Outreach by CHYPS+ team in non-health settings – services that are now running include: weekly clinical sessions at the Youth Offending Team (YOT) carried out by the advanced nurse practitioner; both group health promotion work and one-to-one clinical work is being carried out by members of the THDS team at the Huddlestone Centre (a service for young people with disabilities); health promotion and clinical work in schools by development workers (see Clinic in a Box, Section 2.3); and at the Health Hut (see Section 7.2)
- Services commissioned from other organisations – for example, Shoreditch Spa has been delivering both intensive one-to-one health programmes with young people (see Section 6.4) and a rolling programme of six-week cook and eat courses with vulnerable young people
- New health related workers in non-health settings – two senior health trainers funded from the THDS budget are in post and working with the Youth Support teams. They have been receiving training in order to be able to support at risk young people on health matters

- Improved collaboration with other services – for example, CHYPS+ in conjunction with partner agencies organised a health event as part of a celebration of Youth International Day; see also Section 7.2 for work in schools
- Young people's participation – a young people's group meets at the House fortnightly to work on aspects of the programme including information and publicity materials and recruitment of staff. A local specialist agency was commissioned towards the end of the year to support the work around participation and a plan to recruit a Youth Participation worker, joint founded by CHYPS+ and Connexions, is in place.

All of the above were designed to offer holistic services but within these services, workers are targeting particular conditions/needs. These include those identified in the plan, e.g. chronic illnesses including HIV and AIDS, emotional health, as well as for example diet/obesity. The quality of the services being offered is being improved by: new collaborations with specialists in the acute sector (see Section 6.2), staff identifying training needs, establishing new/enhanced referral pathways, developing robust service level agreements with partners.

Facilitators of progress in Hackney

- A strong commitment by senior staff at strategic and operational manager level
- A range of agencies to work with as partners who already have a good reputation with professionals and young people in the area for high quality, innovative work
- A full-time project co-ordinator post
- The establishment of a skilled and highly committed core clinical team
- Commissioning specialist agencies to carry out aspects of the work where members of the team do not have the capacity and/or specialist knowledge to do the work themselves.

Challenges to progress in Hackney

Considerable challenges to the programme have been encountered in Hackney and in year one early service delivery in some aspects of the programme was slow to start. These challenges include:

- A lack of appropriate, affordable premises where key services could co-locate to form the hub. The Hackney team had anticipated a delay in commencing delivery of some services due to the complexities involved in getting a hub established. However, it proved even more difficult than expected to find affordable, appropriate accommodation. A new plan to locate the adolescent health team in the House, the original 'home' of the sexual and reproductive health service, was ultimately devised. Contrary to the original plan there was insufficient space for other agencies to be based at the House, though with refurbishment there was room for a range of agencies to come to the House to deliver during clinic sessions
- Changing young people's perceptions of what a service offers. The evaluation found that young people still see the service at the House as primarily a sexual and reproductive health service. The majority of the 40 young people completing the questionnaire at the House had attended in order to access a sexual and reproductive health service
- The impact of merging an established team into a new expanded team. Staff reported in both interviews and questionnaires that the decision to locate the new holistic adolescent health service on the site of the original young people's sexual and reproductive health team caused considerable concern. Managing the change in terms of the structure of the new team and the roles and responsibilities of the various staff members within it has been complex and delayed early progress. Workforce training and addressing support needs have been flagged by staff at front-line and management level as a priority for year two

- Organisational change in key agencies. The start of THDS coincided with restructuring of both the PCT and the youth service in Hackney. Both caused considerable delay in start up (particularly recruitment) and required creative approaches in order to move forward as quickly as possible (see Section 4)
- A lack of time and specific expertise to devote to youth participation. This meant that this aspect of the plan has been slow to progress
- Delay in getting monitoring systems operating in the House and across the site.

Summary - Hackney

Hackney had a challenging start caused by, for example, the impact of the concurrent re-organisation of the PCT and the search for premises for their service hub. These challenges required the staff to work hard at finding creative solutions in order to minimise the delay to the programme with the strong commitment by senior managers being a major facilitator to progress. The hub is now becoming increasingly well established, though changing young people's perceptions of the breadth of what it now provides remains a challenge. A range of initiatives extending the service out into the community and into mainstream services are now becoming established or soon to become so. It is anticipated that the accelerated rate of progress with service use will continue in year two. Work around participation of young people and workforce training and support is planned as a priority for year two.

3.3 Northumberland

Starting point

The county of Northumberland has a population of 313,000, with 31,400 young people aged 11 to 19 years. The proportion of the population from BME groups is very low (2%); the largest ethnic minority group is the travelling community, consisting of 300 families across the county. Half the population lives in the ex-mining area of the south-east, which is where the deprived wards are focused: 7% (14) of the super output areas (SOAs) in the former coalfields are in the worst 10% in England. In the rural west and north of the county, pockets of deprivation are masked by relative affluence. Major issues facing young people in these areas are isolation and difficulty accessing services.

Northumberland became a demonstration site because it was a rural area, where there was a strong tradition of partnership working and user participation in planning and evaluating services. Prior to being a demonstration site, health provision for young people was dispersed across the county, including through some one-stop shops provided by the voluntary and community sector, and through school nurse or GP services. Hospital services, including GUM services, had been located outside the county, in Newcastle, but were relocated within Northumberland prior to the start of THDS.

The plan for the THDS was drawn up by a small management group after a series of stakeholder meetings throughout the county to find out what gaps required filling in terms of service development. The heart of Northumberland's plan was: to engage young people in developing services that would be of long-term benefit to young people beyond the life of the programme; to build on existing foundations to enhance services that were already there; to fill gaps that mapping exercises identified; and to make mainstream provision more teenage friendly.

Planning and development of the THDS programme was linked into the children's and young people's plan, with a focus on sexual and reproductive health, drugs and alcohol, mental health, healthy eating, young people with long-term conditions and transitions from children's to adult services. Improved access to services was aimed to be achieved by:

- Employing a full-time participation worker to help ensure that young people's involvement remained at the heart of service development

- Setting up two mobile units in rural areas
- Refurbishing existing drop-ins where necessary
- Providing additional open access clinics where gaps had been identified
- Developing initiatives around existing sports and leisure facilities
- Focusing on vulnerable or high risk groups that had been identified, including young people in the care of the local authority, young travellers and young people in isolated rural areas
- Improving access to treatment and support for young people and families affected by long-term conditions, with a focus on epilepsy, diabetes, complex health needs and mental health. Specialist workers would lead on this work
- Establishing other specialist posts, which included a young people's tobacco control worker, and a primary care alcohol and substance misuse nurse.

Management structures in Northumberland were open and inclusive in order to involve as many partners as possible and avoid duplication of provision. The strategic steering group consisted of senior management staff from key partner agencies within the health service, family and children's trust, youth service and voluntary sector. In addition bi-monthly network meetings were held that were open to all workers across the county involved in delivering aspects of the programme. Network meetings were extremely well attended and fostered feelings of ownership and involvement amongst front-line staff. In addition, there were management groups to support a particular area of work, for example concerning the promotion of You're Welcome criteria or mental health work. Although there was a nominal co-ordinator, day-to-day co-ordination was in effect carried out by a small team of managers and a senior clinician.

Progress in Northumberland

Most aspects of the programme have progressed more or less according to plan. A significant amount of worker time has been engaged in mapping work, identifying gaps and making recommendations for future provision, particularly around mental health provision and services for young people with long-term medical conditions. The views of young services users and their carers have been central to this work (see Section 7.3). Staff aim to take forward recommendations in the second year and look at ways of redesigning services or workers' roles to reflect what they have learnt.

Work to set up or enhance young people-centred services in primary care, community and educational settings is on target, and young people are accessing the new facilities. For example, according to local audit, the new Beat mobile youth resource saw over 3,000 young people from a deprived part of the county up until October, 60% of whom were young men.

The young person's tobacco control worker, who was reported to have delivered education and support services to over 650 young people in school, youth and community settings, is developing referral pathways to enable better access to support and is evaluating a model of group work interventions. Our survey from users of the Beat mobile resource indicated that young people were being helped in relation to smoking cessation.

A number of initiatives are targeting the 30% most vulnerable young people in the local population, including work with homeless young people and young people looked after by the local authority (see Section 6).

Work around You're Welcome is progressing with a range of services including community paediatricians (including in transition clinics), GPs, school nursing and pharmacies. This work has included the development of a tool kit, similar to the national one, with criteria for services to benchmark themselves against, and the offer of training and support for services.

Confidentiality policies are being scrutinised, with input from young people, and there will be support to improve them (See Section 7.1 for further information on You're Welcome)

“There's a commitment [to] making sure that services are accessible to adolescents and that they have a right to have those services. That [attitude] wasn't there before or it wasn't as strong before. The culture [is changing] and the kind of the view of, 'Well it isn't just about having a play area for the toddlers and a disabled toilet for people that need that' but actually 'What are we doing for adolescents?' ...The number of young people that have had their voice heard, as well, that must have a massive impact.” (Health service manager)

Three new health drop-ins have been set up, one in primary care, one in a college and one in a high school; and opening hours for GUM services have been extended into the evenings, and include youth worker support. Other work that is being delivered as planned includes: work in schools to support active participation in the National Healthy Schools Programme; work around reducing second conceptions (see Section 6.3); and a more structured approach to multi-agency training. The demonstration site has been able to gather together people working in rural areas to see what has been learnt in the past and where to go next. The main challenge has been identified as being around psychological well-being and engaging young people in a way in which they are not labelled as having mental health problems.

Facilitators of progress in Northumberland

Progress has been facilitated by a number of factors:

- Good partnerships between agencies working with young people
- Young people's participation at the heart of service planning and delivery, with a full-time participation worker
- A bottom-up and inclusive management style
- A diverse team working on youth health issues, including: senior clinicians in community and primary care; service managers from the family and children's trust and the primary and community care trust; and workers from the voluntary and community sector
- A realistic and pragmatic approach that built on enhancing current targeted and mainstream provision and ensuring developments were sustainable.

Challenges to progress in Northumberland

- Fitting the co-ordination of THDS around other aspects of a role, especially in a context of reorganisation where roles have expanded. This issue has been addressed by co-ordination being carried out by a small team and by an inclusive, bottom-up management style
- Organisational change within the primary and community care trusts – partners change and it is unclear where the power lies. For instance, child health is being seconded from the health services to the children's trust, which is destabilising for staff, such as school nurses and health visitors
- Despite partnerships being strong in Northumberland, structural difficulties have been encountered in working across organisations. For example adolescent mental health services fall outside children's services and it has been difficult to build strong links with mental health services
- Staffing issues - there has been a freeze on recruitment within the NHS which has delayed appointments. There is a problem of people on fixed-term contracts moving on to secure employment. One way of easing the staffing problem has been to employ staff in the voluntary and community sector (see Section 4). Efforts are being made to mainstream the participation post. In other cases, existing staff with permanent contracts have taken on additional work in relation to young people's health, so their posts will be secure even if their hours reduce at the end of the programme funding

- Time-limited funding provided for this specific programme - this has constrained what work can be set up within the ethos that developments must be sustained and embedded in the mainstream. It is difficult to provide firm evidence of impact in a short amount of time
- More generally, working in an insecure funding climate where public health funding is vulnerable to reallocation to support PCT financial deficits. Cuts in related fields, e.g. around youth work in rural areas and substance misuse
- Working with particular disadvantaged groups, e.g. young travellers or BME groups (because the latter is such a small group it is difficult to involve). (See Section 6.1 on ways of engaging young travellers.)
- Access to specialised, hospital health services – these cannot be developed cost-effectively locally because of low population density. The demonstration site has no control over acute and specialist hospital services, but because of this staff have been able to focus more on developing a young people-friendly culture in primary and community services
- A plan to have a second mobile health resource in a very isolated rural area in Northumberland was rejected by local young people who thought a bus arriving in their village or small town would be too visible and compromise their anonymity.

Summary - Northumberland

At the end of the first year of being a demonstration site, Northumberland made good progress in making its plan operational, helped by a diverse and committed core team, with a shared ethos and excellent working relationships. All work was founded on the area's strong tradition of ensuring young people's participation was at the heart of service development. Northumberland is in a strong position to focus over the coming months on taking forward recommendations that have arisen from mapping work that was completed in the first year amongst a number of vulnerable groups.

3.4 Portsmouth

Starting point

The City of Portsmouth has a population of 190,210 of whom 95% are white (average for England and Wales is 92%). The largest BME group is Bangladeshi (1.4%). There are 13,480 11 to 16 year olds (2001 census data). It ranked 88th out of 354 local authorities in the Index of Multiple Deprivation 2004, but there is wide variation at ward level. Twenty seven out of Portsmouth's 123 SOAs are in the 20% most deprived in England.

Before the advent of the Teenage Health Demonstration Site programme, Portsmouth had a strong strategic commitment to young people's health in the form of a ten-year strategic plan, *Lifestyles of a generation – Portsmouth City adolescent health plan 2006 – 2016*. Portsmouth's 2006/07 children and young people's plan accorded first priority to improving adolescent health. Strategic partnerships between the PCT, local authority and voluntary sector were strong. However, for the six month lead up period prior to when THDS services were to commence in November 2006, there was no adolescent health lead manager in place to drive the action plan forward on the ground.

Portsmouth's THDS action plan was based on local needs assessment and consultation with young people. The focus over the first year was to deliver innovative, targeted services to priority vulnerable groups. Mental and emotional health was identified as a key area on which to focus attention, as was support for young people up to 19 years who were or had been in the care of the local authority. In terms of existing services, there were two neighbourhood-based young people's drop-in centres in parts of the city that served disadvantaged populations, developed in partnership with the Teenage Pregnancy Team, Connexions, substance misuse services and the PCT. A core part of the THDS plan was to

expand the services delivered from these drop-ins, so that they provided an accessible, holistic service for young people, and to develop three more drop-ins in other parts of the city that served disadvantaged populations. Portsmouth aimed to use the additional capacity that THDS afforded to provide support to an enhanced school nursing service, and forge links between services delivered by health services, youth services and school health.

Portsmouth's programme was located within the City Council. The organisational structure set up to manage THDS strategically was a team of senior managers from the PCT, children's services, education, the youth service and the voluntary sector. Adolescent health team meetings attended by operational staff were held regularly. The site co-ordinator was the Health Improvement Manager - Children and Young People; part of post's broad remit was to lead on adolescent health, including the role of teenage pregnancy co-ordinator. The site co-ordinator appeared to have been granted much strategic influence by senior managers, and was key to driving forward the programme.

Progress in Portsmouth

The adolescent health lead, who was recruited in November 2006, spent the first few months rebuilding strategic relationships, revising the action plan and setting up a more realistic timetable for developing core services and targeted work. In some key areas where the foundations were there, such as sexual and reproductive health, teenage pregnancy, and mental and emotional health support, Portsmouth was able to move forward relatively quickly with additional resources, to deliver an enhanced service for young people.

From November 2006 disparate sexual and reproductive health and substance misuse services were brought together and delivered from the two existing drop-ins. The first new health professional in post was the adolescent mental health worker who was seconded from CAMHS in January 2007 to deliver the emotional support service, You Count (see Section 6.4), from schools, the drop-ins and through outreach. A training coordinator has been in post since April 2007 and the continuing professional development programme is reaching a wide range of staff in health and related fields.

There were delays, however, in recruiting other staff and protracted lead-in times for planned expansion of services (see Section 4). There were delays to plans to 'backfill' a nurse post for children looked-after, which would have enabled the post-holder to devote time solely to young people aged 12 – 19 years. Recruitment of the lead adolescent health nurse was also delayed. She began work in July 2007 to provide support to front-line health practitioners working with young people, such as community nurses and school nurses. She has been developing policies about transition from acute to community services and transition from children's services to adult services, and has been supporting the planned expansion of the school nursing service, for example by organising a training schedule and arranging supplies for school nurses.

By October 2007 the two-hourly drop-in sessions at the two centres staffed by sexual and reproductive health nurses, school nurses, substance misuse workers and Connexions were each attracting between ten and thirty young people a week. An additional session was available weekly at both centres for young people wanting to access the looked-after children's nurse or You Count emotional support service, either by appointment or dropping in. Increasing numbers of young people were using the emotional health and well-being drop-in although the CLA drop-in was under-subscribed. A lead GP has been promoting a planned monthly drop-in clinic that will run from the two functioning drop-ins from October 2007.

An external consultant has been employed to progress work around You're Welcome criteria. A locally designed self-assessment tool concerning You're Welcome had been developed. Twelve GP practices and a number of specialist services (sexual and

reproductive health, substance misuse, CAMHS, community nursing) were in the process of using this tool to assess their services. A number of pharmacies intend to provide contraception to young people.

A wealth of other services was being developed by autumn 2007 but was not yet operating. These included: two future neighbourhood drop-ins, fast tracked services for young offenders (with a YOT health post from November 07), improved services for young people with long-term medical conditions and disabled young people, health promotion using football as a way to engage excluded young people (with worker in post from October 2007), services around sexual exploitation, and an expansion of the You Count service. There were plans to expand the number of school nurse sessions offered for secondary schools from the neighbourhood drop-ins. The aim is for school nurse drop-ins to operate in or near all secondary schools by the end of the 07/08 school year. Partnerships with schools are being developed on a school-by-school basis, and agreement has yet to be reached with a minority of schools. The GP drop-in will be piloted over six months to March 08. More capacity within the Healthy Schools programme will allow more focus on the programme for secondary schools over the 07/08 academic year.

Facilitators of progress in Portsmouth

- Added capacity – specialist staff and a co-ordinator. A significant part of the latter's role as adolescent health lead was devoted to taking forward the THDS action plan
- In addition to adding capacity, having a dedicated co-ordinator helped to bring things together, pulling together the PCT and local authority
- Effective multi-agency working
- Strategic focus on adolescent health, and being located within a ten-year strategic plan; being a demonstration site – which has put weight behind what practitioners are doing
- Making key young people's health posts permanent, which was possible because of the long-term strategic commitment. This led to more interest in the posts that were advertised and hence more experienced staff being recruited, albeit after delays.

Challenges to progress in Portsmouth

A number of key issues have hindered progress:

- Staffing and recruitment issues - the process of recruiting new staff or 'back-filling' posts to release existing staff to focus on teenage health has been protracted in most instances. This has been due to a variety of reasons, whether this was the time involved as a matter of course in following normal protocols or specific instances where unusual delays occurred. It proved possible to unblock some of delays because of strategic commitment, but it was time consuming to set about the unblocking process (see Section 4)
- Strategic frameworks not yet being in place. For example Portsmouth's obesity strategy is in the process of being developed by the PCT. A strategy for addressing young people's obesity would link into the overall strategy
- Drawing up protocols, policies, etc. Preliminary work on drawing up protocols and developing policies was necessary before services could become operational, but proved time consuming. For example, work on transition policies (see Section 6.2)
- Premises issues - There were considerable difficulties finding suitable premises to locate three of the planned neighbourhood drop-ins. One of the proposed sites was in a new extension to an existing building, and adolescent health staff had no control over the timetable of the building programme which was subject to delays
- Needs assessment not yet carried out (e.g. re asylum seekers, BME groups and sexually exploited young women)
- Commissioning processes - such as those involved in relocating GUM and specialist contraceptive services for young people to the young people's drop-ins - were protracted because adolescent health staff had to gather detailed evidence from young people and

other services users to justify the change, before agreement could be reached with commissioners

- Changing young people's perceptions of what a service offers. For instance, the evaluation found that young people still use the reconfigured drop-ins primarily as a sexual and reproductive health resource
- Working in a funding climate where the whole health prevention agenda is under threat, for example potential cuts in substance misuse grants, the teenage pregnancy grant losing its ring fencing. Developing specialist services is difficult when non-core services are vulnerable to cuts.

Summary - Portsmouth

Portsmouth has spent much of the first year making up for time lost in there being no adolescent health lead in place in the six month lead-in period to carry out preliminary work before the THDS started in November 2006. Work over the first year in laying the foundations for the future was eased by strong strategic commitment and a champion co-ordinator driving the programme forward with great energy from the centre. A notable success was the You Count emotional support service; many other services are poised to deliver in the second year.

Overall Summary

The evaluation has found that in the first year the demonstration sites were beset by challenges in making progress on their plans to develop improved health provision for young people. Survey data collection reflected this: the evaluation found there to be small numbers of young people accessing many of the new services that were not operating prior to THDS. However, passionate and committed managers and front-line staff had worked hard, in some cases after a slow start, to overcome challenges and were now in a position to build on foundations that they had established in the first year to take their plans forward over the coming months.

4. STRATEGY, STRUCTURE AND MANAGEMENT OF THE PROJECTS

A specific objective of the Health Demonstration Site Programme is to model strategies for commissioners on how to manage collaborative and sustainable partnerships that support adolescent health improvement. This requires a network of different agencies to work together to provide strategic management of the adolescent health agenda and the demonstration site programme as a key component of this. The management of this multi-agency collaboration at operational level was also an important aspect of the demonstration site programme.

This section will cover the findings of the evaluation relating to strategic and operational management issues. It will include information on: strategic partnerships; THDS management arrangements – both in terms of management boards and the role of the co-ordinator; the management culture and managing issues around starting the programme.

4.1 Project structure and strategic partnerships

All the projects were working closely at a strategic level with senior managers from a range of agencies. The projects differed however in their strategic and structural arrangements. For example the Portsmouth programme is located within the City Council and has integrated the strategic management of the programme into existing structures and partnerships in order to maximise sustainability. In the other three sites the project is based within the PCT and each has established a specific group of senior managers to steer the programme.

The evaluation found that the multi-agency nature of the THDS programme, at strategic level, was seen as a positive and successful aspect of the programme in year one. THDS managers in all the sites reported high levels of commitment from their senior colleagues in other agencies. It was felt that having this commitment, in terms of both time and ideological support for the adolescent health agenda, is paying dividends in terms of increasing both the profile of adolescent health in the area and the focus on working towards a holistic approach to health.

The evaluation showed, however, that achieving and sustaining effective partnerships, at all levels, was complex and challenging, in the first year of the programme.

“A lot of the planning, a lot of the preparing for the THDS depends on how good your information and your links with other services are...I mean we had always been quite good at working with our partners, however probably the level of partnership you require for the THDS starting, we needed to work quite hard getting there and for everybody to have the same vision, the holistic approach and what that really meant is complex.” (Staff)

4.2 Management boards

All the sites had regular THDS meetings for senior staff. Strategic and operational managers met either as separate and/or combined groups. Members of these groups include senior management staff from key partner agencies within the statutory, voluntary and community sectors. For example, members included heads of the youth service and Connexions, directors of various local authority divisions and leads for education. Public health specialists and teenage pregnancy co-ordinators were also often involved.

The responsibilities of these groups of managers included: holding accountability in terms of the overall delivery and profile of THDS, and linking the work of the programme in governance terms to the key strategic structures in the site. Where the terms of reference

included an operational component, management groups also had direct responsibility for programme implementation.

Facilitators

Facilitators to success with this aspect of the work included:

- Having senior staff from agencies in all the sectors (statutory, voluntary and community) represented on boards
- Securing commitment from these managers to attend regular management meetings for the programme and to champion the work via other routes available to them
- Drawing on the different skills and options available to managers in the various sectors to facilitate progress – including change management skills to minimise the impact on staff of changes to their work environment/role.

Challenges

Members of these boards reported finding the work very challenging. Specific challenges that were mentioned were:

- Dealing with the unsettling effects of change to services/roles on front-line staff
- The high expectations of DH in terms of rate of progress and shifting priorities
- The sheer amount of time that they needed to commit to supporting the initiative.

4.3 Site co-ordinator role

In addition to management boards, management in the sites included a site co-ordination role. The site co-ordinator role was in general to oversee the day to day running of the programme – including line management of staff. Management arrangements for staff were often complex. There was no clear demarcation for staff between ‘demonstration site work’ and work that related to teenage health but fell under a different administration, such as the PCT or children’s services. This was to be expected because the demonstration sites aim to enhance not replace existing services. Some staff were seconded from mainstream services, where previously they were working in the same field but delivering to a wider age range, usually from birth to 16, 18 or 19 years. Forty percent of the front-line staff who completed our questionnaire were paid some or all their salary from the programme budget; and some staff who considered that they contributed significantly to the programme were not paid from this budget. Some members of staff had more than one manager; in general this had not created difficulties.

Two main models for the site co-ordinator post existed.

Model 1 (3 sites): A manager in a strategic post is the designated THDS co-ordinator, in addition to other management responsibilities;(for example the head of children’s clinical services; the teenage pregnancy lead).

Model 2 (1 site): The co-ordinator role is carried out by a full-time service manager with the work overseen by a more senior member of staff.

Benefits and challenges

Advantages and disadvantages were discussed by staff in relation to both models. Model 1 had the advantage of being in a position to have direct influence at a high level and, given the temporary nature of the funding, had advantages in terms of sustainability. Also, being such a senior post meant that the post holder could often facilitate the evolution of the post to meet the changing demands of the THDS programme

“We are learning as we go in terms of what management structure to put around it to check that the speed is maintained” (Staff)

However the post created further demands within already demanding roles and was also vulnerable to changes in the other roles of the post holder.

“Six months in to the [THDS] programme we are restructuring and I am actually likely to inherit more staff” (Staff)

Model 2 had the advantage of the post holder being able to focus purely on the work of the THDS programme without distractions from other areas of responsibility. However, concerns about the long-term sustainability of the post meant that a less senior post was created than some thought the role required.

Facilitators

A distinct difference between the sites was the fact that in two sites the co-ordination role was taken on by an existing long-standing member of senior staff, while in the other two sites the role was carried out by a new member of staff. In one of the sites there has been turnover in the role during the first year of the THDS programme. To have been working at a senior level in the area, prior to the programme commencing, was seen by some to be a major advantage, particularly in the early phases.

All co-ordinators have found the role very demanding in terms of time – buying in consultants to do specific pieces of work is a solution that Hackney and Portsmouth are employing (see for example: Section 5.2(d); Section 7.1; and Section 7.3). Northumberland has addressed the demands by sharing out specific areas of management responsibility between three managers.

4.4 Management ethos

The evaluation found a substantial difference between sites in terms of staff perceptions of the management ethos. This was mainly with respect to the levels of inclusivity present in their programme. For example front-line staff were asked about their involvement in shaping THDS services. In Northumberland 12 of the 14 staff completing the survey agreed that they had been involved, this compares with 25% or less of the 34 staff completing the survey in the other sites.

Challenges

Bringing together multiple agencies, individuals and areas of work in new or closer partnerships is inevitably complex. This is particularly the case when time frames are short. Front-line staff perceived the management ethos to be excluding and top down when they felt they had had little involvement in both the initial and ongoing decision-making processes. In these sites there was more of a division between meetings for managers and meetings for front-line staff.

“There’s never been a problem with the presented model, the presented scale of the work, we all knew that needed to be done... For me personally it was about managing that change and that wasn’t managed effectively. This thing was managed very much from the top down, you’d be asked for your opinion and then it wouldn’t be taken into consideration.” (Staff)

“It’s a syndrome of being told rather than being consulted.” (Staff)

We also found that managers of some smaller agencies, commissioned to provide a specialist service to young people as part of the programme, feel out of touch with the programme as a whole in some sites. They said they were not aware of any established mechanisms in place to support regular, effective cross agency/service communication. The manager of one voluntary sector agency said in her experience communication from ‘the

centre' was via the odd email; she would have liked more opportunities to keep in touch with THDS developments and share experiences.

Facilitators

Where levels of involvement were reported as being high the culture was felt to be one of inclusivity at all levels and at all stages. One way that this was achieved in Northumberland was by having regular 'network meetings' that were open to staff of all levels and relevant organisations.

"I think we started off with a very broad stakeholder process that enabled people to contribute to the original plan and [then] I established those staff network meetings that allowed people to come together and share what it was they were doing and kind of meet other parts of the project and understand how they fit into the whole." (Staff)

Circulating minutes from management meetings widely and making these meetings open to front-line staff to attend when there were issues of particular relevance and interest on the agenda were facilitators that were discussed.

4.5 Managing the start of the demonstration site programme

The evaluation found that starting the programme presented many challenges. As a result some services in all the sites had a delayed and/or slow start.

Challenges

Specific challenges that were reported included:

- The impact of a context of organisational change and/or budgetary cuts that coincided with the start of the THDS programmes in Hackney, Northumberland and Portsmouth. For example budgetary cuts in key departments in the City Council in Portsmouth delayed the recruitment of new staff while substantial change took place in Northumberland Care Trust and the youth service in Hackney. This created a range of problems including: recruitment freezes and uncertainty about how structures would evolve

"When there is a rapid pace of change outside you and the organisations around us there is other anxiety about who, 'Have we got the right partners brought in?', because partners keep changing and ...no one seems to know who has got the power anymore." (Staff)

- Dealing with the complex and often slow process of recruiting new staff.

Staff in Portsmouth described how the process of staff recruitment can be extremely protracted in large organisations. Developing protocols within the NHS bureaucracy takes up to a year; staff on recruitment panels have to undergo recruitment training; and once new staff are in post they are required to go through a lengthy induction process. Some new staff required training before they could deliver a service to young people. There was difficulty recruiting specialist staff to time-limited posts, especially in context of reorganisations in neighbouring PCTs where staff didn't want to lose out on redundancy payments by applying for a new job.

Delays in recruiting to a health promotion post led to the brief for the job being changed, and thus more delays. Managers were concerned to get the right person in place with qualifications and experience; at times they had to re-advertise which delayed recruitment.

- Commissioning processes

Staff in Portsmouth described the long time-frame required to relocate services in order to provide a 'one-stop' neighbourhood service for young people. This had been the case for relocating specialist GUM services and specialist contraceptive services within the young people's drop-ins rather than delivering them through generic provision. Evidence had to be gathered from young people and other service users to justify the change, before agreement could be reached with service managers, and PCT and hospital trust commissioners.

'[In order to] extend the services that are offered through the drop-in sites ...we've had some negotiations with GUM Medicine... a lengthy commissioning process that I had to go through with the PCT commissioners and with the service manager, the hospital trusts... to get to an agreement... [Also] we asked the contraceptive service to do a review across all of their community drop-ins for all age groups to understand which services were being used and which weren't, if there was any free resource that we could relocate to [the young people's drop-in]. We've then also surveyed nearly a hundred young people [and other] existing clinic users from a range of services to see if they would have a preference ... because it was being perceived as closing a service and opening a new service in another area, rather than relocating. So we've had to go through this process of convincing the commissioner that there is a need... They're lengthy things, they don't happen quickly and even with funding... the PCT pay those services under their block contract [which] means that they ...can't dis-aggregate [their monitoring figures]... so we've had to kind of do that... It's very complex.' (Portsmouth health service manager)

- Establishing the required level of partnership working (see above)
- The time taken to shift organisational cultures
- Finding suitable premises (see Section 3 – Bolton, Hackney and Portsmouth)
- Managing the potentially destabilising effect on staff when existing services are reconfigured.

Facilitators

Key facilitators that were either experienced or suggested include:

- Build in the scope for flexibility in the way management tasks are approached. As discussed above this is facilitated by having senior managers from multiple types of agencies as members of management boards. For example NHS recruitment freezes coincided with the critical first few months of the programme in three sites. Northumberland solved the problem by switching the funding for a number of key posts from the PCT to voluntary/community sector organisations. These organisations then employed the required staff rather than the PCT – an outcome that in retrospect was thought to have had beneficial effects in terms of maximising both joint working and a coherent multi-agency strategic approach. Hackney addressed the recruitment problem by making the programme co-ordinator post temporary and recruiting via an agency
- Acknowledge and plan for a slow start.

Staff commented in both the questionnaire and interviews that a slow start to a new or enhanced programme of work of this scale and complexity was not only inevitable, it was good practice. In their opinion, good programmes of work, as well as the specific services within them, naturally take a long time to evolve.

"What I see is ...having the great opportunity of a bit more resource, primarily in terms of time for people to pull together what's already known and implement what

we'd like to do if only we had the time. I think that's what I really see as a thing to pull off." (Staff)

"I think the pilot is the kick-start to everything...having experienced how long it's taken [a pre-existing service] to develop and evolve into the service that we've got now I think the next few years the [new services] will do the same." (Staff)

A staggered lead-in time, where preparatory work receives some funding in advance of the main funding for the programme, was suggested as a way of easing the process.

"If I was the government ...I would look at funding probably over 3 years and a very small amount of funding for partnership development in year 1 and then delivering for two years of something, just because you can stand a chance of being more effective, being clear, having time ..taking more of a commissioning approach." (Staff)

- As stated above, a service culture that is based on inclusivity of staff and also young people was viewed as a major facilitator.

Summary

The evaluation found that the collaboration across agencies at strategic and operational management levels was considered, in all the sites, to be a very positive aspect of the THDS programme so far. Different models for the site co-ordinator role have been adopted across the sites – no clear overriding advantages for one model over the other were identified at this stage in the programme though seniority and previous knowledge of the area were reported as key facilitators. An inclusive ethos emerged from the data as a consistent facilitator at all levels of management. Managing THDS required a level of time commitment, often unanticipated by those planning the programme. This applied to managers involved at both strategic and operational levels. Furthermore the challenges of getting a programme of this complexity off the ground were considerable. Greater acknowledgement of, and planning for this, was a key evaluation finding.

Learning Points- Management of THDS

Strategic partnerships and THDS management boards

- Include high level managers in key partner organisations across statutory, voluntary and community sectors. This maximises 'buy in' by those with power and influence to facilitate change.

Site co-ordinator role

- This role requires: dedicated time by one or more individuals operating at a senior level; sophisticated service management skills, including those in managing change. When time frames are short a past knowledge of the area/service is beneficial.

Management ethos (culture)

- Foster an inclusive, bottom-up approach to the planning/management of the programme – this includes involving young people and front-line staff at all stages.
- Build in systems, from the start, that promote effective communication between all parties throughout the life of the programme, through for example: regular meetings that all staff are encouraged to attend and contribute to with the focus being on a bottom-up approach; enabling front-line staff to attend management meetings to feed their experiences and views into the planning process; circulating minutes of management meetings around all staff groups.
- Prioritise change management support - for example employ senior staff who are experienced in /or given training around change management.

Managing the start

- Allow a realistic amount of time for preparing the 'ground' and overcoming challenges – this will have far reaching impact on the later success of the programme.
- Prioritise establishing high levels of engagement with partners right from the start.

5. LOCAL SERVICES DELIVERED AS PART OF THE HEALTH DEMONSTRATION SITE PROGRAMME

In this Section we will outline how services were organised at a local level. We will provide information about how services were made more accessible and friendly to young people; and look at staff roles and workforce issues.

5.1 Making services more young; people-friendly

The evaluation has identified that the demonstration sites have worked in a number of ways to make services more accessible and appropriate to young people, by developing innovative ways to engage young people, improve opening times, enhance premises and employ experienced staff.

a) Engaging young people – referrals and access

All sites have taken account of young people's views about what services they want and would use and have worked to make services and individual staff more accessible to young people. Sites have:

- Encouraged self-referral and broadened referral networks more generally. Staff were aware that when GPs and social workers acted as a gateway to mainstream services, many young people failed to attend appointments and others slipped through the net
- Located many services so that they were particularly accessible to disadvantaged populations. The most common reason young people chose to use a particular service rather than going elsewhere (apart from not knowing where else to go) was because the service was easy to get to (58%). Evaluation data suggests that neighbourhood-based services and outreach services were particularly accessible to young people who used them. Just over half of the front-line staff that we surveyed were engaged in outreach work
- Taken account of prior consultation that found drop-ins to be popular with young people. Monitoring data suggests that young people were accessing holistic and specialist services by drop-in and by appointment. Two-thirds of front-line staff surveyed worked in drop-ins.

A number of drop-ins were attracting high numbers of young people, including those that were well-established before the programme began. At this early stage, drop-ins were proving an inefficient way of providing a service when not well used, as they did not maximise use of staff time. Evaluation data suggests:

- It may take time to build up a clientele in a drop-in, especially where word-of-mouth referral is key
- It is challenging to broaden the client-base in drop-ins that are attempting to shift from a focus on sexual and reproductive health to holistic provision
- Specialist drop-ins may be especially challenging to establish because young people may be wary of identifying themselves in a way that leaves them open to being labelled or stigmatised.

In Portsmouth take-up was low in a neighbourhood-based drop-in for young people looked after by the local authority so group-work options were being explored as an alternative. Clinic time was building up in an emotional health and well-being drop-in after the worker had persevered for a few months and made himself available to young people in a flexible way.

Where relatively low numbers attended clinics, staff were able to spend more time with individuals. This created a valuable opportunity to carry out in-depth holistic health

assessments with young people who had dropped in to access a single service for a specific reason (most commonly sexual and reproductive health) and introduce them to other service providers who could offer them different forms of support.

b) Opening times

The evaluation has determined that opening times are key to service uptake: those young people surveyed who expressed a view about improving services commonly mentioned that they would like more flexible opening hours. Evaluation data showed that younger adolescents value sexual and reproductive health, substance misuse or counselling services that are open at hours that can be absorbed into the normal school day (lunchtime, or during after school activity time) so that their parents are not aware that they are attending. Older young people want services to be open after work / college or at weekends.

In general, the sites were catering to these desired opening hours, but so far had found this was more realistic operationally in the centralised hub services. Neighbourhood drop-ins had more restricted hours, although they chose these to suit their target clientele. Outreach services tend to be open at a time that suits the host organisation.

c) Premises and facilities

The evaluation found the type of premises to be important. Young people we surveyed commonly expressed a desire for a bigger space and better facilities (more computers and chairs, and “a lick of paint”). The layout of the interior was important to young people.

Some sites were channelling a fairly large proportion of their budget into capital expenses to develop and refurbish premises. For example, resources were used to improve the reception area of the Parallel in Bolton. Acquisition of suitable premises has been hampered by restricted availability, especially in Hackney, Portsmouth and for the outreach sites in Bolton.

Anonymity was important to young people. By and large, they do not want shop-front premises that are too visible to parents and neighbours. Young people are not reliant on seeing somewhere in passing: data from the young people’s survey shows that by far the most common way of finding out about a service was via friends (53%), with the next most frequent being via a teacher (11%).

In one school the evaluation team noted the stigmatising effect caused by the use of a waiting area that did not afford anonymity and privacy. A large group of young women were waiting to be seen at a lunch-time nurse-led drop-in. The waiting area was adjacent to the school’s main reception. Staff continuously used it to access a corridor, leaving the door open. A young male student laughingly shouted loudly through the open door, “*I know why you are here. You all have the clap*”, which caused the young women visible distress.

d) Young people’s relationships with staff – confidentiality and staff attitudes

Relationships with staff were key to users’ positive assessment of services and confidentiality was an overriding concern to young people we surveyed. ‘Trust’, in the strict sense of adherence to codes of conduct relating to confidentiality, was consistently identified by young people who used services as a principal factor in their relationship with staff.

In interviews, surveys and informal discussions with a researcher from the evaluation team, young people expressed trust that the consultation aspect of the service that they were attending was confidential. It was observed that young people were universally afforded respect which in turn was reciprocated.

Young people gave a few examples of concerns about confidentiality being compromised. Examples include inappropriate booking-in procedures and staff discussing details of cases over the phone in a waiting area.

With a few exceptions, written policies on young people's entitlement to a confidential service, including any limitations to confidentiality with regard to child protection, were not noticeably on display at venues that the evaluation team visited.

Staff involved with the programme spoke of the lengths to which they were going to work out ways to engage young people that did not stigmatise them. For instance, the evaluation team observed a worker from Northumberland approaching groups of school students during break times for informal health-related discussions as a way of engaging a young person who needs further help, in such a way that other young people were unaware that follow-up work had been arranged.

Facilitators

The evaluation data suggests that the following factors are key for making services more young people-friendly:

- Flexibility in methods of engaging young people - drop-ins and by appointment
- Flexibility in the range of places and types of settings - ideally young people can access the same member of staff in a range of different locations
- Flexibility in referral systems - bypassing traditional referral pathways through the GP or social worker. Fostering self-referral, word-of-mouth and referrals from a range of agencies
- Incorporating those elements that are most important to young people: premises that are easy to get to; a friendly, non-judgemental approach; confidentiality; a range of activities being available alongside health provision; opportunities for young people to be with their friends; and flexible opening hours
- Well-trained staff - concerning You're Welcome quality criteria (see Section 7.1), young person-friendly practice, common teenage health conditions and effective support pathways for young people (see Section 5.2).

5.2 Staff roles and workforce issues

This section describes and evaluates how staff are operating at a local level in the four sites, in terms of their role, qualifications and recruitment, and support needs

a) Staff roles

Staff operated in the sites in a number of ways as part of multi-disciplinary teams. Table 1 below outlines the different staff roles identified by the evaluation, and highlights who carried out this work.

Table 1: Staff roles identified by the evaluation

Role	Range of staff
To provide strategic direction to the THDS pilot as a whole, or a particular component of it	- service co-ordinators - GPs or medical consultants - service managers
To co-ordinate a service	- service co-ordinators - service managers
To map, develop or improve mainstream provision	- nurses (some specialising in adolescent health and some in another speciality, such as children-looked-after or sexual and reproductive health) - GPs or medical consultants
To provide clinical sessions or outreach work	- nurses (some specialising in adolescent health and some in another speciality, such as children-looked-after or sexual and reproductive health) - GPs or medical consultants - practitioners providing support to pregnant teenagers and teenage parents - substance misuse workers - youth workers - mental/emotional health workers - sports and leisure workers - housing workers
To deliver staff training	- nurses (some specialising in adolescent health and some in another speciality, such as children-looked-after or sexual and reproductive health) - GPs or medical consultants - practitioners providing support to pregnant teenagers and teenage parents - substance misuse workers - youth workers - mental/emotional health workers - sports and leisure workers - housing workers - training consultants
To support young people's participation in shaping services	- youth participation workers - youth workers
To carry out administration	- administrative/reception staff/caretaker

Skill mix within adolescent health teams

Staff in a number of the sites were of the view that it was valuable to have consultant paediatricians, lead GPs, adolescent lead nurses and mental health workers at the heart of the demonstration site teams. These people had the authority to influence fellow professionals and spread youth friendly practice beyond the core team.

Sites introduced GP sessions within young people's drop-ins as a means of improving access to the service that GPs offer. In areas where GP sessions were held in young people's drop-ins and clinics from the outset, the trend over time has been for less GP input than originally envisaged and for specialist nurse time to be commensurately increased. Reasons for this have generally been that the increasingly skilled nurse workforce that sites are acquiring (through recruitment of specialists and/or training members of the current team) can offer the level and range of expertise required for much of the work that

traditionally would have been seen as the domain of a doctor. Nurses in the sites are also relishing the scope the programme has created for nurse-led work in a range of non-health outreach settings in the sites.

b) Staff support and change management

The evaluation found that front-line staff felt most supported where:

- There was a bottom-up and inclusive management style
- Regular network meetings were held that were open to all staff
- Multi-agency steering groups had been set up for work areas
- One-to-one clinical supervision was available on a regular basis and when required
- They received clinical support and guidance, with clear clinical governance procedures in place
- There was excellent partnership working and a closely shared ethos about work aims.

Findings suggest that the process of change involved in setting up or reconfiguring services ran more smoothly and caused less stress amongst the workforce where front-line staff:

- Were included in strategic decisions and changes were not imposed on them
- Were adequately informed about and trained in new roles and working practices
- Were offered clear direction and support in new and evolving roles
- Felt valued and secure in their jobs.

Managers were aware that anxious staff were less likely to work positively with young people.

“A lot of the issues around young people’s health isn’t so much information and expertise as attitude. And in order to be really welcoming of young people and to be willing and able to really work positively with young people on the issues they present you with, you need to have the slack and you need to be feeling confident yourself. If people are stressed out of their heads and feeling anxious about their jobs then they physiologically are not in a place to take on a complex 14 year-old’s multiple issues. Rather than thinking, ‘Oh my God!’ they want to be thinking, ‘Super, this is an exciting challenge. How can I help this young person thrive?’” (Clinician)

c) Qualifications and experience

The evaluation found that site co-ordinators and service managers felt it was important to employ staff with qualifications and experience to minimise delays in delivering a high-quality service, even if they have to re-advertise and postpone recruitment. It was seen as essential to have experience of working with young people and to hold an ethos of valuing young people. At times it was difficult to recruit specialist staff to time-limited posts.

Young people have participated in employment panels in some sites and had a major say on who would be recruited; on occasions their choice has been unexpected which showed that staff assumptions about the best person for the job were sometimes off-key with young people’s own views.

d) Training

Training delivery

All sites were delivering multi-agency training around young people-friendly practices and youth health issues. Much of this training was provided by the PCT and had been available before the advent of THDS, but its content and delivery was enhanced with the programme’s instigation.

Training was available on:

- Confidentiality issues
- Communicating with young people
- Information about local young people's services and referral pathways
- Treating common teenage conditions, such as acne.

Various elements of training were required by all staff working with young people (such as confidentiality issues) whereas other elements were customised for particular professional groups.

There was a general feeling amongst front-line staff working in the demonstration sites' adolescent services that when they received training it was beneficial and high-quality. Providing in-depth, specialist training was seen as a way forward for sustaining the ethos of the programme by embedding good practice via skilled-up staff.

Facilitators for training delivery

Staff perceived training to work particularly well when it:

- Was invested in as a priority from the start
- Was free at the point of use to non-clinical staff from partner agencies as well as members of the core THDS clinical team and other PCT staff
- Was publicised widely to partner agencies
- Was delivered at staff workplaces. GP practice teams were more likely to take up training when it was offered at the practice in lunchtimes after practice meetings
- Incorporated the experiences of young people using the enhanced services and staff working within them
- Was delivered by a range of health professionals. Half the front-line staff we surveyed provided some training to other professionals. GPs and paediatricians, particularly, said they had greater understanding of the mind-set and working pressures of colleagues from their own discipline. They were of the view that they could act as champions with their peers in promoting youth friendly practice
- Used young people's health centres to provide placement opportunities. For instance, the Parallel young people's health centre in Bolton provides practice placement opportunities for youth and health care professionals in the area to gain skills in relation to young people's health. Staff on placements are working in rotation at the one-stop shop to both deliver a service to young people and to learn as they do so, thereby improving the quality of their own practice and moving on to spread good practice elsewhere.

Barriers to training

- Insufficient investment in training
- Lack of time and competing priorities in the hectic start-up phase of the programme.

Training needs of front line staff

The proportion of front-line staff who felt their training needs had been met in relation to working with teenagers varied greatly between sites, ranging from one site where all front-line staff felt their training needs had either been met or had training planned to another site where most staff felt their training needs had not been met. Areas of training that had been covered with satisfied staff included: adolescent health awareness; early intervention; common health conditions; when to worry; care pathways, including referral routes to specialist tier-three services; risk and developing resilience; and relaxation and stress management for young people. Packages of training were available at two different levels: basic understanding; and greater knowledge of conditions and support, including evidence-based information.

In the site where satisfaction concerning training was highest:

- Young service users (including vulnerable young people) had a significant input into training materials and training events
- Multi-agency training steering groups were set up to identify training needs of front-line staff and design training packages
- Training was made freely available to staff, including regular up-dates
- There was an inclusive ethos and staff at all levels felt a real sense of ownership in a joint enterprise.

Example of an Adolescent Health Training Programme

Portsmouth City's Adolescent Health Training Programme offers free training on a variety of health topics including sex and relationships, substance awareness and mental health to anyone working with young people within the City of Portsmouth.

The courses have been designed for a wide range of participants including community nurses, doctors, youth and community workers, outreach workers, Connexions staff, staff from local authorities and staff and volunteers from the voluntary sector.

Since launching in April 2007 the programme has offered 16 courses relating to health and young people on a continuous cycle, training over 200 multi-agency staff by October 2007. Some courses are locally or nationally accredited and others enable staff to offer interventions to young people within agreed city protocols and guidelines.

The Adolescent Health Partnership believes that all practitioners working with young people should undertake tier one training in Substance Misuse, Sex and Relationships and Mental Health as a minimum, and those practitioners who work directly with young people regularly should undertake tier two training as well. A line manager's signature is required when booking onto a tier two course to ensure that the manager is committed to releasing staff to attend not only the training, but city-wide supervision sessions for ongoing support.

The partnership of course facilitators represents local authority, primary care trust and voluntary sector colleagues. The co-ordinator of the training programme supports facilitators to deliver each course by:

- Providing administrative support such as venue and participant bookings
- Co-ordinating participant evaluation and follow-up
- Working with each course facilitator to reflect on prospective changes after a course has been offered, in light of participant feedback
- Promoting the programme via email and a training bulletin, which will be produced two or three times a year.

Facilitators

- Having a dedicated full-time training coordinator post.
- Having a single point of contact enabling practitioners to access a variety of related training in one place.
- Having a coherent system for follow-up with participants, for example by informing staff about other areas of the training programme they haven't explored or that they might be interested in, or reminding staff from tier 1 courses about tier 2 courses.

Summary

The evaluation found that the demonstration sites are working hard at establishing, on a micro and macro level, what seems to be most successful in terms of service delivery, for example, of settings, a mix between drop-in and by-appointment services, and balance of types of staff. Setting up and running services that achieve sustained use by young people is highly skilled, specialist work. A core clinical team comprised of specialists in the field is critical to success both in terms of delivery to young people and to raising standards in other services. Prioritising staff training is important – this should be inclusive of all staff involved with the work and be offered through a range of approaches.

Learning Points - Local Service Delivery

Making services more young people-friendly

- Involve young people from the outset in planning, delivering and reviewing services on the ground, including staff recruitment (see Section 7.3)
- When developing services bear in mind that young people value drop-in services where they can come with friends, which have flexible opening hours and which are not perceived to be stigmatising or non-confidential. They chose services because they are easy to get to and they have heard of them by word-of-mouth
- Build in the facility for services to be able to change in response to what appears to be working and not working for young people
- Provide access to multi-agency training, including training placements, to up-skill the workforce about specific health issues as well as the best ways of making a service young person-friendly.

Workforce issues

- Have champion adolescent lead nurses, lead GPs, paediatricians and mental health workers at the heart of the adolescent health team.
- It is important to employ staff with qualifications, experience and an ethos of valuing young people, even if this delays recruitment, and thus the start-up of a service. Specialist nurses can increasingly provide the bulk of clinical health services both in health and non-health settings.
- Prioritise investment in training for staff from the start – setting up and running successful services for young people is skilled and specialist work.

6. WORKING WITH KEY TARGET GROUPS

This section covers evaluation findings on work that is being developed in the four demonstration sites in relation to particular groups of young people. All sites, including the most heavily populated part of Northumberland, share high rates of deprivation. They were all committed to working with the DH target of focusing on the 30% most deprived and vulnerable young people in their areas and all planned to target vulnerable groups. These groups included:

- Young people not in education, employment or training
- Young people in the care of the local authority
- Young people with long-term medical conditions
- Young people with disabilities
- Pregnant teenagers or teenage parents
- Young carers
- Young people excluded from mainstream education
- Young offenders
- Homeless young people
- Black and minority ethnic young people
- Young travellers
- Young asylum seekers
- Lesbian, gay, bisexual or transgender young people
- Young people whose behaviour put them at risk.

The proportion of young people falling into different vulnerable groups varied between the demonstration sites. Additionally the sites chose within their plans to give different levels of focus to particular target groups, depending on prior needs assessment. As a result the types of specialist staff roles seen as a priority for THDS funding varied from site to site. For example, Portsmouth placed mental and emotional support, and support to young people in the care of the local authority as a particularly high priority. A focus on reaching young people from travelling communities was highlighted by Hackney and Northumberland, and on reaching BME populations by Bolton and Hackney.

In this section we start by looking at vulnerable groups in general, then focus in more detail at the work being done in relation to: young people with long-term medical conditions (DH target); young people wanting support around emotional and mental health (a priority for all sites); and repeat conceptions amongst teenagers (DH target).

6.1 Addressing the needs of the most vulnerable

The evaluation has found that the sites are working towards addressing the needs of the most vulnerable young people in a number of ways. For example:

- Encouraging vulnerable teenagers to access young people's holistic drop-ins, e.g. by clinical staff accessing them via outreach work (see Hackney Section 3) and inviting them to attend a one-stop-shop service at a later date
- Employing specialist front-line staff, e.g. a specialist nurse in Portsmouth for children in the care of the local authority
- Setting up special-interest support groups or specialist drop-ins
- Enhancing other services which vulnerable young people attend, through funding of: joint staff training; increased worker time within the service; or outreach work by teenage health workers, e.g. Youthwork4health in Bolton has received funding to employ a youth worker for an extra day a week – this day has a health focus.

- Detached work, for example by an emotional support service which works alongside detached youth workers with homeless young people, in foyers or supported accommodation (see You Count box Section 6.4).

Staff in the demonstration sites said that some services for vulnerable groups have been easier to develop as the foundations were already there. The extra capacity that THDS funding has provided has enabled them to move forward quickly to enhance service provision. In other cases, it has been necessary to identify and map the situation on the ground (in terms of services and populations), and determine what young people want before setting up a service. Where these mapping exercises have been carried out, this has been a time consuming process (e.g. for addressing the needs of young mental health service users in Northumberland or asylum seekers in Portsmouth). However, it is only by doing this preliminary work that appropriate services can be developed with groups who have not been targeted before.

Pattern of service use by vulnerable groups

The evaluation has found variation across the demonstration sites in the proportion of young people using services who are from particularly vulnerable populations. Monitoring data of one-to-one contacts between young people and staff in THDS-related services in September 2007 showed that the percentage of vulnerable young people with at least one of a number of risk categories¹⁴ was 43% of all young people seen. This figure fell to a third of all contacts when excluding BME young people with no other 'risk' factor. Evaluation survey data likewise suggests that young people from certain vulnerable groups are accessing services in the demonstration sites (see box below).

Risk categories from young people survey data

Out of 622 young people using a THDS-funded service:

- 13% were Black or mixed Black/White and 5% were from another Minority Ethnic group. Hackney had a different pattern from the other three sites, where 61% were Black or mixed Black/White and 20% were from another BME group
- 5% lived in temporary accommodation
- 13% lived with neither of their parents
- 15% of those aged 16 or over were not in education, training or employment
- 20% considered themselves to have a disability or long-term health condition (ranging from 12% in Hackney to 26% in Portsmouth). The most common conditions were asthma (n=48), dyslexia (n=17) and mental health problems (n=12).

Source: THDS evaluation: Young people survey data Sept 07

It was also evident from evaluation interviews that some extremely vulnerable young people were using specialist adolescent services within the demonstration sites.

¹⁴ NEET; Child looked after; LTMC; teenage pregnancy / parent; carer; excluded from mainstream education; young offender; traveller; homeless; BME; asylum seeker; LGBT; risky behaviour.

Young Person's Story

"The area I'm living in now, it's a bad area, there's like a lot that goes on and there's only a few decent people in it but the decent people don't live like near me. I don't see myself as healthy cause I smoke and drink. I drink like Saturdays and Sundays about 3 to 4 litres... Coming here has calmed me down a bit because I used to be kind of tarty even when I was about 11 and I weren't happy about it. I used to go with like any boy who was there." (12-year-old young woman)

Evaluation monitoring and survey data suggests that the four demonstration sites have had less success with engaging young people from the following vulnerable groups:

- Asian young people and other Minority Ethnic groups (apart from Black African and Caribbean young people)
- Asylum seekers
- Travellers
- Young carers
- Lesbian, gay, bisexual or transgender (LGBT) young people.

In some cases this is because there are not significant numbers of young people from these groups in the local population (e.g. BME populations in Northumberland; asylum seekers in Northumberland and Portsmouth; travellers in Portsmouth). In other cases staff described how work with vulnerable groups can be time consuming and require a long-term focus before any impact is apparent. In the initial year they have been unable to spend sufficient time to engage these groups.

The demonstration sites have indicated to the evaluation team that plans are underway to try and address many of these gaps in the second year of the programme. For example some early work with travellers has started in Northumberland taking an initial approach of building trust with families by working on their concerns first before raising health issues with them. In Bolton where work with LGBT young people in a health setting has been slow to get going, a partnership approach to this work is being discussed with the youth service. Portsmouth has begun to work with a local diversity forum about health needs of BME young people. The forum has identified a need for better health information and guidance as a priority, and a joint SRE conference is being planned. Staff have indicated that the lack of access of services by the Asian community in Bolton will be prioritised as a focus. In Hackney work has begun on developing services that reach Jewish young people attending independent schools, where healthy schools criteria do not apply.

6.2 Working with young people with long-term medical conditions

Demonstration sites were expected to develop services for young people with long-term medical conditions (LTMC), including a focus on transition from children's to adult services. Different approaches have been taken in the sites to make NHS provision more accessible and appropriate to young people with these medical conditions

The evaluation has found that work on improving services for young people with LTMC is still at an early stage; three sites feel they have needed to spend time on developing more clarity about what they were trying to achieve. Often working groups have been convened to conduct scoping exercises. The views of young people with chronic conditions formed the basis of recommendations drawn up to improve services in Northumberland (see Section 7.1). Sites were looking at how recommendations that had been drawn up from mapping exercises could be taken forward.

Despite the work with young people with LTMC being at an early stage, we have identified that three approaches were being taken on the ground:

- Creating access in innovative settings to services for long-term medical conditions, to reflect evidence that drop-in services are more acceptable to young people than consultations by appointment
- Making hospital and community NHS provision more accessible and appropriate, including CAMHS and paediatric services
- Improving transition to adult health services.

Each of these three approaches are discussed below.

a) Access to services for long-term medical conditions in innovative settings

The demonstration sites were beginning to operate new services in innovative settings to provide a service to young people with long-term conditions who are accessing drop-ins.

- One model was to employ specialist clinical staff who were based in mainstream services to deliver on a sessional basis in community-based, teenage-specific settings; for example having an epilepsy nurse consultant run sessions at a young person's drop-in (at the Parallel in Bolton)
- Another model was to train health workers who were working in young people's drop-ins in issues relating to LTMCs, such as a GP with special interest in young people's health. Additionally, this approach focuses on strengthening links between young people's drop-in staff and hospital-based specialists, so that drop-in staff are supported with appropriate back-up.

These models were not mutually exclusive within sites – and often the first approach contributed to the second as a result of the partnership-working between clinicians.

Staff who had hoped that young people with LTMC would have started using their holistic drop-in service to address issues that they had concerning their condition were disappointed with progress to date. Monitoring data confirmed this view: staff recorded that only a handful of young people (1%) accessed services with a concern about their long-term condition; and only 1% of interventions with young people covered LTMCs. However young people's survey data showed a more positive picture: 5% of survey participants said they had been helped in managing a long-term medical condition

"It would be good to have a diabetic 15 year old come through the door and we work on that, but that's just not happening." (Doctor)

Challenges

Bringing LTMC services out of hospitals to a community level required a complete change of culture – amongst young people and hospital consultants. This was especially the case because the work cut across hospital and mental health trusts and primary and community services. Staff felt that the situation may be eased by disparate children's health services being integrated through children's trusts

- Not a high enough volume of clients with a particular condition accessing drop-in services. Six per cent of our sample of young service users wanted help with a long-term medical condition, but this covered a wide range of conditions. Numbers wanting help for each particular condition were extremely small. Some staff felt that it was a better option to strengthen links between hospital consultants and clinical staff in drop-ins rather than encourage consultants to work in the new community settings.

“If we had a clinic for thalassaemia or sickle cell that had a high volume of clients, then probably it would be worth it [for a consultant to come to the community], but if you have a walk-in service when actually people turn up every day of the week, it’s more complex. [Yet] for the 11 to 19 year olds the culture of having a walk-in service works better than having appointments based on consultation. So in that sense I think it’s probably a good idea for us just to work with what we have got and to strengthen the links between us and the chronic services, so this support is always there and there is a very good communication system.” (Consultant in public health)

At this early stage we do not have evidence of the relative merits of the two models.

b) Making hospital and community NHS provision more accessible and appropriate for those with long term medical conditions

Work that was being done in connection with promoting You’re Welcome quality criteria impacted on young people with chronic conditions, whether this was in primary or community care or in hospital trusts. Examples of relevant work being done in the demonstration sites include: setting up young people’s out-patient clinics that were separate from children’s clinics; training paediatricians (for example, about referring to the range of services available, or about common teenage conditions); shared care of patients between hospital-based specialists and clinical staff in specialist adolescent services. An example of the last mentioned is work being done with young people with HIV in Hackney.

Challenges

Challenges and facilitators to making mainstream provision more accessible to young people with LTMCs, including improving transition, is covered in Section 7.1.

c) Improving transition to adult health services

Work on transition to adult services for young people with LTMCs was at an early stage in the demonstration sites. In Northumberland recommendations are being drawn up based on the experiences of two groups of young people with complex physical and learning disabilities, and their parents and carers: one was a group in their early twenties reflecting on the shift to adult care and the other was a group in their teens talking about what they wanted to happen. Young people with diabetes and their parents have been involved in informal consultation in an outpatients department in Northumberland around their specific needs in relation to transition services. This consultation has resulted in youth-work input into the service.

In Portsmouth the adolescent health nurse is in the process of canvassing views of community nurses about what they require in order to improve support to young patients around transition to adult services. She will then work with young people to find out what they would find useful, by sitting in on clinics and talking to young people and their families. Despite strategic commitment, each part of the process was taking time. She anticipated that the process of developing and ratifying these policies would take six months.

6.3 Work on repeat conceptions in teenagers

The relatively high incidence of repeat conceptions in teenagers with a history of a previous pregnancy is well documented¹⁵. It is also known that many young women in this situation have not made an active decision to become pregnant again and that they are at high risk of

¹⁵ (SEU report on Teenage Pregnancy 1999)

poor outcomes. The Department of Health asked the sites to develop services to support teenagers at risk of repeat conception as part of the THDS programme as a means of furthering learning on potentially effective ways of addressing this issue.

The evaluation found that sites have completed, or are in the process of carrying out, scoping work around the issue of prevention of repeat conceptions in teenagers. Below we provide two different examples, from Hackney and Northumberland, of the scoping exercises undertaken and subsequent different models to be adopted for addressing the issue.

Example 1: Reducing Second Conceptions in Teenagers

In Hackney, the Children and Young People's Services commissioned research from an independent research group to inform their decision about how best to address this issue. This project gathered data from local staff working at all levels in sexual and reproductive health, maternity and abortion services and from staff in areas of the country that had been successful in reducing rates of repeat conceptions. The commissioned research team also drew on their past experience of working with young people. Recommendations from this study included the following:

"Provide intensive one-to-one contraceptive support to all young women pre and post maternity or abortion (provided in clinic, outreach and domiciliary settings)".¹⁶

The Hackney team decided to create a dedicated full-time nurse post, funded from the THDS budget - to start in Autumn 2007. The post holder's role includes offering an intensive pre and post support service to adolescents experiencing either a birth or termination and working closely with the termination and midwifery service to improve current practice with young people.

Example 2: Reducing Second Conceptions in Teenagers

In Northumberland a steering group was set up to address the issue of reducing second conceptions in teenagers. Members of the group came from a range of services and professional groups. A series of reviewing and mapping activities were undertaken which included: a survey with staff in key services around their expectations of who is providing contraception; and a consultation exercise with young women post termination and post birth. This work was led by a Lead Nurse for Contraception. Money was provided to back-fill her post for several months to allow her to focus on this work.

This work showed that a lot of inaccurate assumptions had been made about the contraceptive and counselling services that young people were receiving post-termination or during pregnancy/after birth. The resulting action plan aimed to redress this by enhancing existing provision. This approach was chosen, instead of the creation of a new post, to maximise sustainability and impact over a wide geographical area.

The action plan included:

- Increasing the number of nurses delivering contraception
- Supporting the establishment of an emergency contraception service in pharmacies
- Improving accessibility of /services offered in key clinics
- Tightening existing pathways such as those following termination or childbirth into the sexual and reproductive health service
- Considering realignment of an existing nurse post to offer a domiciliary service to young women; producing a post termination pack for young women

Producing a post termination pack for young people.

¹⁶ *Reducing repeat teenage conceptions: a review of Practice*, Hallgarten L and Misaljevich N; Hackney Children's and Young People's Services; 2007

Portsmouth is in the process of completing a scoping exercise, including consultation with young women accessing the unplanned pregnancy clinic. Bolton has taken a similar approach to Hackney, with the appointment of a full-time nurse. As with Northumberland, the other three sites are also involved in other initiatives that will impact on repeat conceptions, for example the setting up of emergency hormonal contraception (EHC) services in pharmacies. Portsmouth is launching EHC services in 25 out of 30 pharmacies from April to December 2007.

Challenges, facilitators and benefits

Staff in a number of the sites reported that this is an area of work that has received little attention to date and also cuts across a number of services that have historically, in some areas, worked more in parallel than in partnership. They were therefore pleased to have the opportunity to focus on it, but were clear that a well-conducted scoping exercise, that includes all the key stakeholders and draws on sources of existing and new data, is critical in order to establish an accurate baseline position and inform service development plans.

As shown in the above examples the scoping exercises proved to be very useful. Staff in both Hackney and Northumberland reported benefits beyond the immediate learning that led to their respective service development plans – most notably the improved communication between the various agencies/services that had so far sustained and ‘borne other fruit’ beyond this specific piece of work.

This is a target group where individuals within it will often be very vulnerable with wide ranging support needs that cannot be readily categorised. Service responses therefore need to have an extensive reach to maximise access as well as the scope for a very intensive, one-to-one service.

While the feedback on progress of the service developments that have been made is encouraging so far, at this interim stage it is too early to assess the relative benefits of the different models.

6.4 Emotional and mental health support for young people

The evaluation found that support for emotional and mental health emerged across sites, from both young people’s and staff perspectives, as a priority focus for service development. This included support for young people with mental health ‘problems’ and those with lower level emotional issues. Prior needs assessment in some sites revealed this area as one where there was a gap in provision that needed to be addressed.

Some staff felt that referral pathways through to mainstream CAMHS services did not serve young people well.

“When I worked as a school nurse you just didn’t refer [young people with mental health problems to CAMHS] because you knew they weren’t going to get seen and it was trying to manage them with a GP until they were old enough to go into adult services where they would get seen.” (Health service manager)

Staff said they were aware that young people were not comfortable asking for help from mainstream services when they were distressed. Instead they were picked up by the system at a later stage when their behaviour posed a problem to parents, teachers or the police. Unsurprisingly young people often failed to take up appointments that adults made on their behalf in clinical settings that they perceived as uncongenial.

Staff views, that current provision for young people’s emotional support was inadequate, were reinforced by data from the evaluation questionnaire with a sample of young service

users. A frequent area of expressed 'unmet need' amongst this group of young people concerned support for feelings about body size, emotional problems, sex and partner relationships, and family relationships.

"I just don't feel comfy because my Mum and Dad...I didn't feel loved." (Young person)

Portsmouth had prioritised emotional and mental health support from the outset by employing a senior mental health worker to work with young people, as prior needs assessment had identified this as a gap in provision. Elsewhere, the demonstration sites were working with innovative community providers. Despite perceived gaps in provision, staff were very proud of some of the work being done as part of the demonstration site programme in the field of emotional and mental health (see boxes below). There were signs in the young people's questionnaire data that Portsmouth was having impact in this area (see Section 8). Other sites mapped need in their first year as a demonstration site and were hoping to develop services through the second year of the pilot.

Example 1: Emotional Support Service

Hackney: Shoreditch Spa – one-to-one intensive emotional support programme

Shoreditch Spa is a Hackney-based charity which specialises in delivering programmes to support mental and physical well-being in young people. THDS funding has been used to fund Shoreditch Spa to provide an 18-week healthy lifestyle programme to particularly vulnerable young people on a one-to-one basis. GPs refer young people who they think will benefit and an individually tailored programme is devised which incorporates, for example, healthy eating, exercise, complementary therapies, counselling and self-help support for individuals with low mood. This programme has been targeted at:

"those who need it the most in terms of particular health-related issues. Typically the young people have had weight and mental health issues. [Support is available in a] safe context where people don't feel shame, [and are not] embarrassed and bullied. Our approach has been to develop very practical approaches where we can work with people, supporting and developing their skills, knowledge and confidence and experience in order that they can make healthy choices for the rest of their lives." (Staff)

In addition, Shoreditch Spa has been funded from the THDS budget to deliver a programme of six 'cook and eat' sessions to groups of young people deemed to be particularly at risk.

Young people at Shoreditch Spa who participated in the evaluation commented:

"It's a really nice place and the people are friendly".
"I was shy but there's no need at Shoreditch"
"It has really helped me"
"It helped me to find confidence".

Example 2: Emotional Support Service

Portsmouth: You Count

A senior adolescent mental health worker has been seconded from CAMHS to develop the You Count counselling service for 13 -19 year olds. Early in his post the worker devised consent and confidentiality guidelines, referral protocols and pathways. The model for You Count was based on evidence of successful work elsewhere at the Market Place, a young people's information and counselling service in Leeds. Young people helped shape the service and there is ongoing consultation with them about their satisfaction with the services. There is collaborative work with schools and other agencies - the worker spends a regular time each month in schools, working with staff as well as young people.

As well as collaborative work with schools, the counselling service is located in the neighbourhood-based young people's drop-ins. The worker goes out to young people in supported accommodation and youth groups, such as for LGBT young people, and works alongside detached youth workers. He expressed that he felt comfortable about working with the young person initially without involving their parents, even young people with serious levels of depression or self-harm, because of the specialist experience he had gained from working with CAMHS. CAMHS provides the worker with clinical supervision, support, including support from child psychiatrists, and opportunities for continuing professional development.

Confidentiality is at the heart of the services. The worker described how he supports young people through the process of devising their own treatment plan until they feel empowered enough to share this with their parents. The young person decides where a consultation takes place - this can be at the skate park, a cafe, at home, wherever a young person feels comfortable being seen. They are encouraged to engage with all aspects of their care and choose the issues that they want to explore and the level with which they feel comfortable. They have free access to their notes and a say in what is written about them. The service is publicised via posters in every GP surgery in Portsmouth, a young people's magazine, the local newspaper, Portsmouth's young people's website, Connexions and in schools.

Referral is more flexible than under the traditional system where young people are referred via GPs through to CAMHS (up to 16 years) or adult mental health services. Young people refer themselves to You Count or referrals come directly via families, schools, youth offending teams and a range of other agencies. The worker feels that self-referral suits groups who are hard-to-reach, including young men. The aim is to assist young people within a week, at most. Observation from a research visit to a secondary school noted the speed and efficacy of the referral process between a school nurse and the CAMHS service. The school nurse expressed her sense of relief and satisfaction at the fast response time to her request for an urgent appointment for a pupil.

Our survey of You Count service users was of seven young women and three young men who had accessed the service in school settings. Nearly all (9) had been referred by a teacher. The young people indicated they wanted help around a wide range of health issues, including diet, weight, fitness, contraception, smoking and alcohol misuse, as well as emotional issues. When asked if they got what they wanted from the service, all the young people who answered (nine out of ten surveyed) said they had, although they expressed a degree of 'unmet need', concerning alcohol misuse and bullying particularly.

A number commented on what they liked most about You Count:

"Letting out my feelings."

"They are really helpful."

"It's confidential"

"Friendly, easy to talk to."

"Understanding."

"I can control my anger better."

"It's a good way to get help for most, if not all, problems."

The reason they gave most frequently for choosing to use the service rather than go elsewhere was that it was confidential (70%). None knew anywhere else they could go to get help. The only improvement wanted by one young person surveyed was:

"More appointments."

Challenges and facilitators

Young people in this target group can be hard to engage because of the stigma attached to having mental health problems, yet early intervention is often vital to prevent a young person's situation escalating. In the demonstration sites, it helped to bypass traditional referral pathways by encouraging self-referrals and collaboration with schools and services working with marginalised groups. Staff suggested that engaging groups of young people in discussion about emotional issues can help address the problem of stigma and help young people feel easier about seeking help.

A key point that was conveyed to the evaluation team is that it is important that staff make it evident to young people that services are confidential and use an approach that empowers them.

It is important to reach and support young people with serious emotional issues that have potentially life-threatening consequences. The experience of the demonstration sites showed that it is therefore essential to have experienced staff who have clinical supervision and support from CAMHS. Building good working links with CAMHS can be challenging due to mental health services being organisationally separate from other health services. Some sites were aware that in their area this would be a long-term process, but Portsmouth's experience where those links are in place, suggested that close collaboration reaped dividends.

Summary

The evaluation found that many of the young people currently accessing the range of multi-agency approaches being offered are 'vulnerable'. Some highly innovative work with particular at-risk groups has been enhanced with extra resources and is clearly proving successful with young people. However reaching certain specific groups remains a major challenge – these are particularly vulnerable and marginalised young people whose specific needs have historically been neglected by service providers. Hence there is no existing baseline from which to work. The main progress in year one has been in scoping the work to be undertaken with certain groups - sites are starting to select approaches based on these scoping exercises which will be developed in year two.

Learning points - Working with Key Target Groups

General

- Invest in scoping exercises that are specific to different groups. Staff with local knowledge are well placed to lead on these – but must be given the time to give the work the priority it requires. Involve young people with relevant experience as well as a range of staff at different levels in all the partner organisations.

Vulnerable young people

- Take a multi-agency approach. Many organisations that target young people are accessing those who are most vulnerable; provide support to these organisations to incorporate a holistic health focus in their work
- Identify particular groups, within the 'whole', who are not being reached

Long-term medical conditions

- Allow time to raise awareness amongst young people that services are available in new settings and to establish partnerships with specialist colleagues, who may lack knowledge about young people's specific needs despite expert knowledge about their speciality

Repeat conceptions

- Young people in the target group can be harder to reach and engage. Ensure the chosen plan for the service level response allows for targeted work that is both intensive and flexible.

Emotional and mental health

- Encourage self-referrals and referrals from teachers and youth workers by reaching out to young people in educational and outreach settings and collaborating with staff in these locations. Engage groups of young people in discussion about emotional issues to help address the problem of stigma and help young people feel easier about seeking help
- Make it evident to young people that the service is confidential and based on an ethos of empowerment.

7. LOCAL DELIVERY ISSUES: You're Welcome; health in schools; participation of young people

This section focuses on the work being done in the demonstration sites to meet the You're Welcome quality criteria; to increase the links between health and schools; and to increase young people's participation in health service development and delivery.

7.1 You're Welcome quality criteria

The demonstration sites have responsibility for leading on the implementation of the You're Welcome quality criteria in local community, primary, specialist and secondary health care that young people may use. The You're Welcome quality criteria lay out principles that will help these services raise the standard of what they offer young people. The evaluation staff interview data supported the need for such an initiative and saw it as a key route to sustaining positive change in provision for young people beyond the life of the demonstration sites programme. In interviews, young people were critical of standards of care they had received in many hospital and community services.

"What other services do you think young people need?" (Researcher)

"Like doctors where they don't tell your mum and dad...a doctor for adults and a doctor for children." (Young person)

Sixty-six per cent of survey participants who answered the relevant question said that if they could not visit the specialist adolescent service they had used that day, they would go "nowhere else" instead to receive services.

Progress

The work on You're Welcome in all the sites so far has been mainly planning the approach to rolling it out and preliminary work on raising awareness in a range of types of service. However, in Portsmouth, You're Welcome self-assessment has been completed of the children's community nursing service. Additionally in all the sites there are a small number of services ready to undertake self-assessment. Other services are signing up to making changes in preparation for self-assessment. In Hackney, for example, sign-up is in progress with GP practices to do the following three things: a confidentiality workshop for all practice staff; a template for a practice leaflet for young people; provision of a youth notice board in the practice waiting area. The expectation is that the process of You're Welcome self assessment will be well underway over the next few months and continue throughout the next year and beyond. Most sites are particularly focussing on work with GP practices initially.

The demonstration sites have taken different approaches to the organisation of the programme of work around You're Welcome. In Bolton, Hackney and Northumberland doctors, who are part of the core clinical adolescent health team in the sites, have been central to both the planning and the delivery of the work with services to promote engagement and work towards self-assessment. Portsmouth has taken a different approach and has commissioned an experienced external training consultant to take the work forward.

Challenges, facilitators and benefits

Staff who were particularly closely involved in the work around You're Welcome were clear that the planning and logistics involved in rolling it out were complex and time consuming. While mindful of the demonstration site timetable, staff were clear that they were doing their best in the time available and felt that rushing the process was likely to jeopardise success. Reasons given for the complexity included: winning the hearts and minds of staff that were not convinced of the need for a specialist approach towards young people in terms of raising

standards of health care; cost implications for making identified changes to services; lack of time in services that were highly pressured; and feeling bombarded with demands from many directions.

Findings from the evaluation support the view that both initial engagement and sustained commitment by services to raising standards will be best achieved if the process is made as easy and supportive as possible for the services that they work with on the You're Welcome quality criteria. This should be approached as something services want to do rather than feel pressurised and compelled to do. Examples staff gave of ways to achieve this include:

- Starting with services that are known to be interested and committed. This allows the staff from the demonstration sites who are leading on the work to test out their approach in a sympathetic environment before facing more challenging ones
- Taking the information and the training to the services rather than expecting staff to travel to receive it – for example Hackney staff attended practice meetings in GP surgeries to talk about You're Welcome
- Viewing it as a gradual and organic process – both to make it a manageable task for those trying to implement the process and to ensure staff in services engage in a sustainable and positive way

“The You're Welcome process has got to be one that services enjoy going through and really want to do and if it's something they feel they're having to fit into little boxes...and it's all about central government, it'll kill the soul of what people want to achieve.” (Doctor in adolescent health team)

“If you take an approach where you plonk a big tool kit on the table and say to a GP here it is you do it, it's cumbersome and might put some of them off.” (Doctor in adolescent health team)

- Involving young people in work around raising standards of services. This will send powerful messages to services about the rights and capabilities of the target group. There was also a view that the voices of young people are “*harder to ignore than those of staff*” (doctor). Examples of ways of doing this include young people undertaking reviews of services. In Portsmouth, for instance, a mystery shopping exercise is due to take place early in 2008. In Northumberland a service review was undertaken (as described in the quote below) and young people delivering training to health professionals around recent General Medical Council guidelines, is currently another route being considered

“A group of 10 young people (diabetic) age range 13 to 17 went to do a service review of a diabetic clinic in hospital. [The] focus [was] on look and ambiance of the waiting room, also literature available, leaflets etc.” (Participation worker)

- Staff from a range of disciplines in Bolton, Hackney and Northumberland considered that having doctors from the adolescent health team involved in both the planning and the delivery of the roll-out of You're Welcome is a key factor for achieving successful engagement by medical staff in the services being targeted.

This work is at too early a stage to determine the success of the sites in rolling the You're Welcome quality criteria. However the planning process and awareness-raising work has proved useful in terms of forming links with other services – for example the GP practices in the area – and advertising the work of the adolescent health service.

7.2 Health in schools

One of the basic tenets of the demonstration sites was to develop innovative health and well-being services in educational settings, and promote working links between the health and education sectors. More specifically the demonstration sites were required to help drive forward the National Healthy Schools Programme.

Innovative work on health in schools

In three of the sites the implementation of the demonstration site action plan contributed to a major strategic shift in the way work on health in schools was being organised in the area. For example, Bolton now plans to have an adolescent health service with one co-ordinated management structure that integrates the secondary school nursing service. There will be a new division between secondary school nursing and primary school nursing. Adolescent health nurses will rotate between schools and other parts of the adolescent health service, including a central adolescent clinic, in order to pool learning and expertise.

In Portsmouth the demonstration site was supporting the expansion of the school nursing service, for example by: organising a training schedule for school nurses to prepare them to take a more public health-focused role in secondary schools; facilitating network meetings; and linking school nurses into the neighbourhood drop-ins where they will be operating clinics for students from local schools.

The demonstration sites have been developing innovative ways of working in partnership with schools. For example, in Hackney adolescent health professionals are going into schools to deliver a service to students individually or in groups; they are providing support to the PSHE curriculum or the school nursing service; health drop-ins were being set up or expanded within schools or out of school. Established school-based health services are being enhanced as part of the initiative (see box below).

Example: Health in Schools – The Health Hut

The Health Hut, which is based in a prefab within the school grounds of a large secondary school in Hackney, provides a multi-agency holistic health service for young people. It became operational in April 2007. The agencies involved work on an outreach basis. They include: Connexions (personal adviser with a special interest in adolescent well-being), a young people's substance misuse service and members of the CHYPS+ team. A project officer, funded by the drug and alcohol team, co-ordinates this Health Hut and a similar one. The ethos is based on taking the holistic health services young people say they want, to them in a non-health, confidential setting, both during and after the school day. Health Hut staff described how they encourage young people to access the services provided, help out generally, act as peer mentors and to use the facility informally as a supportive space.

Young people participating in the evaluation survey at the Health Hut said:

"I'm glad they have brought a Health Hut, now people will be able to get help."

"I felt welcome coming here."

"[They] help me with my problems."

"[I like] confidently being able to speak to someone."

"Its fun and you learn more things."

Suggestions for improvement were "*more staff*" and "*bigger space*"

They appreciated that the Health Hut was "*friendly*" and "*comfortable*", engendering feelings of "*safety*".

Hackney plans to become involved in delivering the health curriculum in a local school, by running school-based workshops focusing on health themes in the curriculum and hosting groups of students at the House for short sessions led by relevant health-centre staff. These sessions would provide an opportunity for young people to become familiar with a health setting, help them understand how the service operates and what it can offer them, as well as providing learning about their health and well-being. If successful the model will be suggested to other schools.

The National Healthy Schools Programme

Demonstration sites have provided more staffing capacity with the aim of accelerating the Healthy Schools Programme, with more secondary schools reaching National Healthy School Status more quickly.

Young people's health professionals have led well-attended events for school staff in Northumberland and Portsmouth (who were provided with supply cover) to support schools to achieve healthy school status. These included workshops on sexual and reproductive health, physical activity, transforming school food, drugs and confidentiality. Staff who attended gave positive feedback about these events and felt that what they learnt would support them in achieving healthy school status more quickly and more thoroughly. Young people participated in these events in order to reflect views on current provision and changes required and to feed back proceedings to other students.

In Hackney young people's health specialists are being brought together with the Healthy Schools team and school nursing to become the Health in Schools Team thus collaborating in a unified approach to all strands of work around improving health via schools.

Challenges to work in schools

- Ethos of a minority of head teachers and school governors, especially in faith schools.

The majority of schools appeared positive about working in partnership with health providers to promote public health in schools. However, a main challenge to schools' work arose in forging links with a minority of head teachers and school governors who had strong reservations about, or religious objections to, developing provision regarding substance misuse or sexual and reproductive health, particularly contraception. The evaluation team was aware of instances where heads: cancelled PHSE sessions concerning substance misuse or sexual and reproductive health; were unwilling to allow health drop-ins on school premises, or barely tolerated them; and were not open to advertising sexual and reproductive health or substance misuse services on school websites.

In these instances, health professionals in schools worked behind the scenes and gathered evidence to dispel fears amongst staff and parents, or compromised, for instance by providing a holistic drop-in but accepting that it could not be advertised. In Northumberland all complaints from parents that health messages encouraged promiscuity were followed up sensitively and speedily through one-to-one discussions between the parent and health professional concerned, such that parents' views were turned around.

- Poor drop-in facilities

The evaluation team noted that personal interactions between nurses and young people were excellent in schools visited. However the facilities provided for drop-in clinics were not ideal and frequently compromised confidentiality. Young women had to leave the consulting room in order to use toilets some distance away to provide a urine sample. A researcher overheard the comment "pregnancy test" said by those in the waiting room as a young woman left the consulting room carrying a sample bottle.

In two schools that the evaluation team visited all pupils stay outside school premises at lunchtime. In one school visited young people accessed the consulting room via the playground.

7.3 Young people's voice

The value of young people's participation

A high standard of young people's participation in the development, management and review of health and youth support services is a key goal for the demonstration sites to achieve. This is seen to be crucial to ensuring high quality services that meet their needs. The participation standards sites are required to work to are those set within Hear by Right. The Hear by Right tool has been developed by the National Youth Agency and is described as:

"a tried and tested standards framework for organisations across the statutory and voluntary sectors to assess and improve practice and policy on the active involvement of children and young people".¹⁷

The importance of active participation by young people is demonstrated in both the staff and young people's views.

"I think participation work grounds the whole thing. It means that its not just professionals smart ideas... It makes a massive difference to the tone of services" (Doctor)

"Do you think young people should be involved in setting up services?" (Researcher)

"Yeah, I think it'd be a good idea, then you've got young people doing it, so more people get involved, be a better place out there if people get involved and done something." (Young person)

"How would you involve...?" (Researcher)

"Advertising, doing posters and that with the kids doing it. If it's an adult does it [young people] don't really look at it." (Young person)

Approaches to participation

At the beginning of the programme the demonstration sites had different levels of, and approaches to, young people's participation. These ranged from preliminary plans for a young people's participation group in Hackney, to well-developed existing participation support structures and strategy that made participation by young people central in Northumberland.

Staff in all the sites referred to consultation exercises of some description undertaken to inform their THDS plan. The most extensive was carried out in Northumberland as described below:

"We actually did a bit of work before the THDS money proper came through, we had a bit of money, which we used to employ somebody to pool all the information together that we had around what young people had been saying about mental health and sexual health. [We] took it to the next stage really and got the key messages out but also sort of suggested things that a participation worker might usefully do within THDS." (Health service manager)

¹⁷ www.nya.org.uk/hearbyright

The evaluation identified two main current models of participation work. These were both intended to function at demonstration site, as opposed to, service level.

- The involvement of a wide range of different young people with different interests and experiences – supported by a full-time participation worker/ with the participation co-ordinator for the Family and Children’s Trust at the core in a strategic role (Northumberland)
- Establishing a core group of young people who do the bulk of the participation work on a range of issues – supported by a part-time participation worker (Bolton and Portsmouth) or an outside group brought in on a consultancy basis (Hackney).

Staff views on whether or not young people’s participation had been improved ranged across the sites: with 100% agreeing in Northumberland that this had improved; but the responses for the other three sites ranging between 10 and 58%. Staff who were interviewed in Northumberland worked from the principle that young people’s participation should be integral to the programme (see box overleaf). Facilitators for achieving this integration included:

- Resourcing a full-time participation worker from the start of the programme who could be flexible and go to the young people rather than expecting them to come to the service
- Involving a wide range of young people (not the same people for each piece of work)
- Involving young people throughout the process in setting priorities/agendas for the work of the programme and many of its component parts
- Demonstrating to young people that their input has had influence
- Supporting staff in making ongoing participation central to their service.

“There are individuals within youth work who are just exceptional in terms of their understanding of young people’s participation and what it really takes to involve all young people and not just the able ones. I think my number one thing [in terms of getting services right for young people] would be around participation and respect for young people – particularly disadvantaged young people.” (Doctor)

Barriers that were encountered with participation work were spoken about primarily in relation to the core group model – these were:

- Problems with recruiting and retaining young people to participation groups
- Lack of interest from young people on participation work around health issues

“I think the main difficulty, it’s been around not necessarily engaging [young people] first time round but about making it a kind of, sexy enough thing that they want to come back and back and back because actually that’s quite a hard thing to sell because when you’re talking about adolescent health, it’s quite a dry subject sometimes.” (Youth worker)

- Under resourcing this aspect of the work at the start of the programme
- Staff charged with responsibility for this work as an ‘add on’ to their main work felt they had neither the time nor skills to be effective.

The challenge of getting wide representation from a cross section of the community was one discussed in relation to both approaches. There was agreement also about the continual challenge of ‘rolling’ recruitment of young people as a result of them transferring to adult services at age 19.

Bolton and Hackney have recognised the deficiencies of this part of their service and have plans to develop their approach – for example Hackney has now engaged a specialist agency to carry out some work on a consultancy basis and has also pooled budgets between THDS and Connexions to create a shared youth participation worker post. In

Portsmouth, staff report that after much hard work and perseverance a group of young people that has a site-wide remit is now becoming established; in addition, young people have worked successfully with local media: writing articles for a widely distributed young people's magazine; and helping to design the young people's health website.

Northumberland Model for Participation

From the outset Northumberland focused on using the opportunity that being a demonstration site presented to focus on incorporating existing best practices into a cohesive, sustainable young peoples' participation strategy.

The starting point for this work was a mapping exercise involving a wide range of stakeholders. As a result: existing workers roles were redesigned to set up processes enabling young people to be central to the development, management and review of services; a management structure was put in place; a youth participation worker was recruited. The participation worker's role included supporting young people's participation directly as well as supporting staff in all agencies to improve practice in youth participation.

This strong focus on young people's participation now runs through many agencies in the county, steered by a county-wide Participation Operational Group (POG) and Participation Strategy Group.

Monitoring forms completed by each part of the adolescent health service include questions about young peoples' participation and these reports are shared with participation staff to follow up

Recently a budget of £20,000 has been allocated to young people to use on work around creating incentives for local GPs to improve access to their services. This work will be supported by the THDS participation worker and lead GP. One additional element to this work is a training programme incorporating new British Medical Council guidelines with primary care jointly delivered by the lead GP, Training & Policy Development Worker and local young people. Using this bottom-up and inclusive approach young people can fully participate in shaping GP services. The intention is that services will be 'mystery shopped' by young people to ensure access is maintained.

Other initiatives include:

- Young people's media group (see example overleaf)
- The creation of a blog capturing the experience of mental health problems
- User-friendly leaflets and information on long-term chronic conditions like diabetes
- Newsletter
- 'Furry Box' patient/service user feedback mechanism developed by young people to encourage feedback on services/training etc
- Producing a directory of services.

Examples of Participation Work in Northumberland



Media Group - Vocality In Your Locality - Doxford Youth Project

A group of six young people set about rebranding their local Teenage Health Service and have applied for copyright for the logo they designed - T.H.S. The logo will be used by Northumberland Care Trust when highlighting teenage health services. The group also created, in the form of a blog, a fictitious character - an 11 year old young woman called Amy who suffered with obsessive compulsive disorder - and documented her experience of CAMHS. The blog was scheduled to be launched through a presentation for World Mental Health Day to a large audience of young people, teachers and health professionals.

Asked by a researcher from the evaluation team what improvements they would like, young people responded *"bigger space"*. Individuals who were asked what they liked about being part of the media group responded:

"Fun, friendly "

"Being involved in projects"

"They have been amazing and the people are very friendly"

When asked what was the best thing about attending the service, young people replied: *"[We] make friends, organise things for ourselves"*.

Staff views on other examples of participation work

"Young people have been developing job descriptions and will be involved in the interview process....now, they've built young peoples' participation into all of their senior manager job descriptions.....they wouldn't think of employing people without involving young people in that process" (Staff)

"Just a little example was this group of young people with chronic diseases – they did a brainstorm for the youth worker and then passed on to me about what they wanted – and I was able to use that in training with a group of 30 paediatric registrars the following week and was able to feed back to the young people, just saying thank you very much, it made a difference to be hearing from young people." (Clinician)

Summary

The evaluation found that the programme's contribution to supporting You're Welcome and the Healthy Schools Programme was at a relatively early stage. There were, however interesting examples of collaborative work in education settings. It is too early to evaluate the relative merits of different approaches in these two areas of work. In terms of increasing young people's participation in health service development and delivery, the evaluation found that Northumberland's model of involving a wide range of different young people working on different projects and supported by a dedicated participation worker worked better than establishing a core group of young people that carried out the bulk of the work.

Learning points – Special Local Delivery Issues

You're Welcome

- Allow adequate staff time for planning the approach to roll out and raising awareness and interest in staff in other services. Involve staff who will be most successful in gaining the 'buy in' of colleagues – for example doctors who have a special interest in adolescence for work with medical staff in other services such as GP practices
- Make the process of working towards meeting the You're Welcome standards as easy, meaningful and well supported as possible for services. For example take information and training to the service rather than expecting staff to travel to meetings; adopt an approach with services that is gradual and organic rather than rushed and imposed.

Health in schools

- Strengthen partnerships between health services and schools by supporting school nurses, for example by offering training, and delivering aspects of the PHSE curriculum
- Work flexibly with schools and be prepared to work gradually to overcome resistance around introducing a sexual and reproductive health and substance misuse agenda into schools.

Young people's participation

- Participation work needs to be a priority for resources at the outset – both in terms of time and skills
- Participation work should be viewed as central to the programme – influencing all aspects of it on an ongoing basis
- Work to involve as many young people as possible, with different groups focussing on different issues/projects rather than a single core group carrying out all the work. Consider recruitment a continuous process in order to achieve sustainability.

8. BENEFITS OF THE PROGRAMME SO FAR

This section covers emerging data on how successful the THDS programme has been at this interim stage, on an individual level for young people. In particular it covers: the views of both staff and young people on impact on young people's health needs; who is using THDS services and to what extent; young people's reported satisfaction with services and views of staff on wider service issues; the challenges of showing benefits of the programme. The data is presented on several levels: globally across the four sites; at site level where appropriate; and at service level where sufficient young people took part in the survey to make the findings meaningful.

This section focuses on perceptions of benefits to *individual* young people; to explore the progress made at service level and across localities and the potential benefits that these changes have had, see Section 3 for an overview of progress within the four demonstration sites in year one.

8.1 Perceptions of impact on health needs

Front-line staff were asked in their questionnaire what level of impact they feel the work undertaken as a result of the THDS plan is having on young people in their area in relation to a range of outcomes. Key findings are shown in the table below.

Table 2: Survey of front-line staff

Most impact	Least impact
<ul style="list-style-type: none"> • Sexual and reproductive health • Mental and emotional health • Support for teenage parents 	<ul style="list-style-type: none"> • Management of long-term health issues • Substance misuse

Young people were asked in the questionnaire survey if they had wanted help around a range of health and personal issues in the previous nine months, and if they had received help or not concerning these issues during that time. Key findings are shown in the table below. It is important to note that this data was gathered from service users. It is not possible to extrapolate from our sample what 'met' and 'unmet need' is in the general population of young people in the four areas, including amongst the most disadvantaged groups who are generally regarded as difficult to engage.

Table 3: Survey of teenage service users

Highest areas of 'met need'	Highest areas of 'unmet need'
<ul style="list-style-type: none"> • Sexual and reproductive health (contraception; pregnancy testing and support about pregnancy options; sexually transmitted infections – advice, testing, treatment) 	<ul style="list-style-type: none"> • Body size and diet • Exercise / fitness • Emotional problems • Sex and partner relationships • Family relationships • Smoking cessation

'Met need' also appeared high concerning pregnancy and parenthood support, substance misuse, long-term medical conditions and being bullied, although numbers wanting help around these issues were low (ranging between 3% and 7%), so are less reliable indicators. Some small differences in the young people's data emerged between the demonstration sites, most notably that young people in Portsmouth expressed more 'met need' than young

people in other sites concerning sex / relationships issues and emotional problems, especially family relationships, and concerning exercise / fitness. Amongst the Hackney sample, there was less expressed unmet need concerning smoking cessation than elsewhere.

Comparison of the findings from the four biggest services from the young people's survey

The following findings compare data from the young people's survey, in terms of demographic background, health background and service use, regarding one service from each of the four sites. Services were chosen for comparison as being the service in each site where most young people responded to the survey.

CHYPS + (Hackney) - 53 service users were surveyed

Demographic background of users: six out of ten were young women; nearly all from families living in rented or temporary accommodation; 21% were white British, 57% were Black or mixed Black/White, 11% were Asian/Asian British. The average age of those completing the survey was 16.4 years, with a range between 12 and 19 years.

Health background; A fifth of those responding said that they had a disability or medical condition (including asthma, eczema, epilepsy and dyslexia). Three quarters were sexually active, with the mean age of first sex being 15 years. Nearly one fifth had experienced an STI in the last nine months. A third said they were cannabis users; half had been drunk in the last three months.

Service use: the top five health issues about which young people were seeking help included: fitness, diet and nutrition advice; information on sexual relationships, contraception; and housing issues. Actual help was received most around the issues of sexual and emotional health. Greatest unmet need appeared to be around fitness and diet issues and housing. The users chose this service primarily because it was easy to get to, promised confidentiality, and didn't require appointments. Of those who responded to the question, three quarters said that they had received what they wanted from the service, 15% said their needs hadn't been met, and 10% said they hadn't wanted any help. Nearly nine out of ten would recommend this service to a friend.

The Parallel (Bolton) - 124 service users were surveyed

Demographic background of users: 86% were young women; just under half from families living in rented or temporary accommodation; 94% were white British. The average age of those completing the survey was 16.7 years, with a range between 14 and 20 years.

Health background; 15% of those responding said that they had a disability or medical condition (including asthma, diabetes, autism, epilepsy, ADHD and dyslexia). Over nine out of ten were sexually active, with the mean age of first sex being 14.5 years. Less than one in ten had experienced an STI in the last nine months. Just over a quarter said they were cannabis users; nine out of ten had been drunk in the last three months.

Service use: the top five health issues about which young people were seeking help included: contraception; weight issues; pregnancy options; emotional support; and diet/nutrition advice. Actual help was received most around the issues of contraception, pregnancy options and STIs. Greatest unmet need appeared to be around fitness and diet issues and emotional support. The users chose this service primarily because it was easy to get to, promised confidentiality, and didn't require appointments. Of those who responded to the question, three quarters said that they had received what they wanted from the service, 3% said their needs hadn't been met, and 22% said they hadn't wanted any help. Over nine out of ten would recommend this service to a friend.

Paulsgrove drop-in (Portsmouth) - 64 service users were surveyed

Demographic background of users: Nearly nine out of ten were young women; nearly two thirds were from families living in rented or temporary accommodation; 98% were white British. The average age of those completing the survey was 15.3 years, with a range between 12 and 18 years.

Health background; Nearly a quarter of those responding said that they had a disability or medical condition (including asthma, ADHD, panic attacks, visual impairment, heart condition, cerebral palsy and dyslexia). Just under half were sexually active, with the mean age of first sex being 13.1 years. None of those answering the question said they had experienced an STI in the last nine months. Just under 10% said they were cannabis users; eight out of ten had been drunk in the last three months.

Service use: the top five health issues about which young people were seeking help included: weight issues; diet/nutrition; sexual relationships; emotional support; and smoking cessation. Actual help was received most around the issues of emotional support, and sexual and family relationships. Greatest unmet need appeared to be around contraception. The users chose this service primarily because it was easy to get to, promised confidentiality, and you could come with friends. Of those who responded to the question, just over half said that they had received what they wanted from the service, 30% said their needs hadn't been met, and 18% said they hadn't wanted any help. Over nine out of ten would recommend this service to a friend.

The Beat Bus (Northumberland) - 36 service users were surveyed

Demographic background of users: Just over a quarter were young women; nearly three quarters were from families living in rented or temporary accommodation; 97% were white British. The average age of those completing the survey was 14.7 years, with a range between 11 and 17 years.

Health background; Just over one in five of those responding said that they had a disability or medical condition (including ADHD, kidney problems and dyslexia). Just over four out of ten were sexually active, with the mean age of first sex being 12.9 years. Just under one in ten said they had experienced an STI in the last nine months. Just over a quarter said they were cannabis users; two-thirds had been drunk in the last three months.

Service use: the top five health issues about which young people were seeking help included: smoking cessation; diet/nutrition; fitness; sexual relationships; emotional support; and sexual relationships. Actual help was received most around the issues of smoking cessation and fitness. Greatest unmet need appeared to be around diet and emotional support. The users chose this service primarily because it was easy to get to and you could come with friends. Of those who responded to the question, just over a third said that they had received what they wanted from the service, 19% said their needs hadn't been met, and 44% said they hadn't wanted any help. Just over nine out of ten would recommend this service to a friend.

Discrepancies in staff data and young people's data - for example the finding that impact on substance misuse was seen to be high by young people and low by staff – may be the result of methodological issues, for example, staff findings will be influenced by what proportions of staff in particular roles completed the questionnaire, and the proportion of young people wanting help concerning substance misuse was low. However it may be the case that it reflects optimism by young people who see the potential for their needs being met through THDS services versus the views of workers who do not underestimate the enormity of the task of influencing an issue of such scale and complexity – as illustrated by the young people's accounts:

“What if anything has led you to do these things?” (Researcher)

“My friends at home do these things but my friends at school don't. ...I grew up in pubs and my family are like alcoholics. It's hard to get away from it when it's happening in the home”...(Young person)

8.2 Numbers and types of young people using services

The numbers and types of young people using the range of different adolescent services funded by the THDS programme were monitored over two separate two week periods in the first year of the evaluation, with three more monitoring periods scheduled for the remainder of the evaluation. This report includes data from these first two monitoring periods. The data available at this stage generally shows a trend, in services that have been monitored, in the direction of increased numbers of young people accessing services and increased types of services being used between June and September 2007. It also shows that while sites are exceeding their target of reaching the 30% 'most vulnerable' young people they are not reaching some specific vulnerable groups.

Staff questionnaire data shows that staff in all the sites think the specific vulnerable groups they are most successful in reaching are teenage parents and pregnant teenagers. They said they are least successful in reaching disabled young people and BME young people. Given the high priority given to teenage pregnancy and parenthood via the Teenage Pregnancy Strategy over recent years, this early data may, at least partially, be influenced by the situation prior to the demonstration site programme.

Hackney staff report greater success in reaching BME young people than the other sites. This is unsurprising given the relatively high proportion of BME young people in Hackney compared to the other sites; this is an area of work that Hackney services have historically developed high levels of expertise in. The Hackney team have identified, however, at least one group - Jewish young people attending non state schools - who are not currently using services. Plans are being developed for a multi-agency programme to access this group.

Evaluation data highlights that patterns of service use by young women and young men are markedly different. There is a tendency for girls and young women to access holistic health centres, especially those that evolved from sexual and reproductive health provision. This is illustrated by the proportions of young people completing the evaluation survey. For example at the Parallel, in Bolton, 86% of participants who completed the survey were young women compared with 14% of young men. In the House in Hackney the figures were 61% and 39% respectively. However, the data shows that boys and young men are being accessed more successfully via a mobile unit and sports schemes. For example, at a youth club in Bolton where a football in the community scheme is operating the proportion of young women and young men recruited to take part in the survey were virtually equal. This finding supports the plan to broaden the range of health issues addressed through the activities offered in such non-health settings (see Section 3 for more information on the plans and progress of sites on this issue).

Due perhaps to this dissimilar pattern of service engagement, there was a number of other gender differences in the answers given by sample services users we surveyed (see box overleaf).

Gender differences in young people surveyed

- Mean age of female service users is 16 years and male service users is 15 years
- Young women exercise less (22% said they 'never exercise' compared with 10% of young men).
- 10% of young women exercise six days or more compared with 33% of young men
- Young men are more likely than young women to have never been drunk in the last three months (43% v 22%)
- More young women have ever had sex than young men – 71% v 45%.
- More young women wanted help with weight issues – 39% v 17%
- More young women wanted help with contraception – 46% v 15%
- More young women wanted help with sex or sexual relationships -35% v 16%
- More young women wanted confidential services - 48% v 22%
- Young women were more likely to know somewhere else to go for support – 40% v 22%

Source: THDS evaluation: Young people survey data Sept 07

8.3 Young people's satisfaction with services

Young people's satisfaction with services in the demonstration sites is high. This emerges from both the questionnaire and the interviews. What young people had most liked about using the specialist adolescent services was:

- The friendly, non-judgemental and helpful staff
- A friendly / fun atmosphere
- That it was confidential
- The range of activities that were available
- Being with their friends
- Being able to talk to someone
- Receiving advice / a check-up
- Geographical accessibility.

Around a third of young people chose to use one of the demonstration sites adolescent services rather than going elsewhere because: it was confidential (36%); and staff were friendly (33%). Nearly all the young people (91%) found staff very easy or quite easy to talk to and 94% would recommend the service to a friend.

"Tell me things about [this service] that you like?" (Researcher)

"I feel like it's more confidential. [At another service] they just leave the doors open [to the rooms]. No, it don't feel secure or anything and I don't feel like I can trust any of the staff, I like them but I don't feel I can trust them and I just go to [this service] instead." (Young person)

"If you are willing, can you tell me why you are using this service today?" (Researcher)

"They are friendly and you can talk to them about anything. It's confidential, one-to-one, so they don't even tell work mates. Some services tell work mates, who tell their work mates, so everyone knows..." (Young person)

Example: Young Person’s Interview

This 16 year old sees herself as fat and doesn’t eat. She started smoking at 10 and smokes up to 20 cigarettes a day.

“I don’t drink that often but when I drink, I drink loads. Like about 5 shots...like 3 vodkas and coke and half a bottle of Lambrini, bottle of WKD.”

She is not interested in changing unhealthy practices. She was referred to the service by her support worker at [another service] *“cause I was stressed at home and I cut myself.”*

She views media depiction of the amount of teenage pregnancy as accurate but the media *“shouldn’t like pick on them and everything”*. The five teenage mums she knows *“are really good mums”*.

She likes using the service because the staff are *“friendly and welcoming”*, it is easy to get to, and the atmosphere is *“comforting”*. She trusts that it is confidential *“unless something serious is happening like I’ve been assaulted or sexually assaulted then I know they have to take it further but if I tell them I’m having problems at home, then they have no right to say anything so they won’t”*.

Thirteen percent of young people surveyed (81 out of 622 young people) mentioned something that they did not like about using the adolescent service they had accessed. The aspect they most commonly disliked was the long wait to see staff. When asked what one thing they would improve, young people most commonly mentioned having more doctors and nurses available. Only five out of 81 young people mentioned dissatisfaction with issues concerning interactions with staff – four that they were not listened to and one that there was no male doctor available.

8.4 Staff views on impact on wider service issues

When staff were asked about the impact that being a demonstration site had on wider service issues, key findings were:

Table 2: Views of front-line staff on areas of greatest and least impact: survey data

Areas where greatest impact	Areas where least impact
<ul style="list-style-type: none"> • improved local provision • value added to existing services • the promotion of partnerships 	<ul style="list-style-type: none"> • clarification of referral pathways between service providers • enabling front-line staff to be involved in shaping services • promotion of positive workforce development

These findings from staff on areas of greatest impact across services were consistent across the sites. Those on areas of least impact were much less consistent across the sites (see Section 5 for more information on promotion of positive workforce development and Section 6 for more information on involvement in shaping services.)

Senior staff in all the sites who were interviewed were strongly of the opinion that the profile of adolescent health had increased substantially since the THDS programme started and that there was real commitment to maintaining this across services, beyond the two year period of being a demonstration site.

8.5 Challenges to showing benefits of the programme

In general staff feel very confident about the value of the THDS programme but hold the view that it is too early to expect to show a tangible difference.

“I think this is a great initiative but the expectation of quick results is short-sighted.”
(Staff)

There is a shared confidence, however, across all the sites that in the second year of being a demonstration site, impact will be more evident and key messages about what works and what doesn't will become clearer.

“[We are] starting to have a more coherent story to tell about what's working and maybe what hasn't worked, that could contribute to learning beyond just our local network or even national network.” (Staff)

“I think the momentum's really building up now ready to turn into a bit of a juggernaut.”
(Staff)

Summary

It is encouraging to see some positive trends emerging in terms of perceived benefits of the programme at the level of individual young people. However, these findings should be treated with a degree of caution at this interim stage in the evaluation. Later in the evaluation when more services have been implemented, more data gathered and more comprehensive analysis undertaken, then the findings will be more robust. At that stage it will be easier to untangle potential explanations for variable perceptions of effectiveness between types of adolescent services.

Learning points – Benefits of the Programme

- Some benefits of the programme appear to be starting to emerge as perceived by both staff and young people and as shown in the evaluation's monitoring of service use – however in a programme of this complexity and scale it is unrealistic to be able to show much at this relatively early stage.

9. CONCLUSION AND SUMMARY OF KEY LEARNING POINTS

Conclusion

All the stakeholders, including young people, participating in the first year of the evaluation of the Teenage Health Demonstration Site programme were in agreement that improving the quality of health provision for adolescents is an important and urgent task. There was also agreement, however, that this is very challenging work: level of need is high and complex to address; much of the current provision inadequate; and expectations of what needs to be achieved are ambitious. Significant barriers to progress have presented in all the sites in year one – but solutions have been found and at this half way stage a vast array of different types of services, many of which are highly innovative both in their own right and in the way they ‘mix in’ with other services, are being delivered or are poised to start. It is the Evaluation Team’s view that the effects of the hard, painstaking work carried out by the sites in year one will start to be seen more clearly over the remainder of the programme and will generate learning that will make a rich contribution to the knowledge base of effective ways of addressing the challenge of enhancing health and related services for young people.

Summary of learning points

In assessing the data collected in the first year of the Teenage Health Demonstration Site programme, the evaluation team have identified the following key learning points. These are based either on our assessment of what appeared to have led to greater success in year one and/or the reflections of stakeholders on what they have learnt and how they would advise others to proceed in the early phases of developing holistic, appropriate health services for young people.

Pre planning stages for developing adolescent health services

Strategic level

Involve a wide range of multi-agency partners, with high level managers in key partner agencies signing up to active involvement and ideological support. Strategists at the core of the programme need the time and skills to make the process of developing high quality health services for adolescents one that includes all stakeholders and minimises the destabilising effect that change can have on staff and users of services.

Mapping/needs assessment

Create dedicated staff time for mapping current provision for young people using sources of existing and, if required, new data from a range of stakeholders. This is critical to ensuring that plans are based on the best evidence available.

Lead in time

Allow a realistic amount of time for preparing the ‘ground’, including establishing relationships with partner organisations, engaging young people in dialogue and overcoming early challenges – this will have far reaching impact on the later success of the services.

Planning and early development

Mix of services

Devise a programme of work that is realistic in both the short and longer term. Work from the principle that focussing on enhancing existing services, wherever possible, is generally easier than creating completely new ones. Different potential approaches range along a spectrum that extends from one large central targeted service (hub) to improving mainstream provision. Weigh up the relative benefits of the different approaches and select the mix of services that is most appropriate to your locality.

Management

The management of the programme requires high levels of skill and dedicated time. Senior managers with skills in managing complex programmes of work that involve significant change for all stakeholders in challenging structural environments should be engaged. A bottom-up, inclusive approach to management is critical.

Multi-disciplinary teams

The core adolescent health team should be multi-disciplinary at all levels. At service delivery level invest in clinicians who are/or will become specialists in adolescent health. Their role in the team, and beyond, will be to deliver the highest quality services to young people but also to act as champions for the work and teachers of other workers.

Frontline staff

New and reconfigured services require a skilled, well supported workforce which, along with young people, is at the centre of decision-making processes about services.

Young people's participation

Participation by young people should be central to planning, development and review of the programme. Support for this should be adequately resourced from the start in terms of both staff time and skills.

Reaching vulnerable groups

Map current provision for vulnerable groups, with their input. Take services to marginalised young people in order to help them engage – encouraging them to self-refer to existing services is a long-term process.

Focus of the work

Sexual and reproductive health is currently a key focus of the work being carried in the THDS. This is partly historical. Key areas of unmet need to emerge are mental/emotional health and eating/obesity.

Improving the quality of mainstream provision

Make the process of making mainstream services more young person friendly as easy, meaningful and well supported as possible for services who are dealing with competing priority groups. Adopt an approach that is gradual and organic rather than rushed and imposed and has the input of young people's views.

10. ISSUES FOR CONSIDERATION IN YEAR TWO

1. The evaluation found strong evidence from sites that it has been a complex process to develop the teenage health demonstration sites so far. Time is required to plan a strategy and transform this into successful practice on the ground. This process has worked best when sites have felt able to give the time they deem necessary to achieving it. This view seems in contrast to some expectations at a national level of how much can be accomplished in a short amount of time, and to an observation from the DH that sites have commented that pressure from DH has been helpful. Could consideration be given to trying to reach a joint understanding of what the priorities for achievement should be during the remaining year of the programme?

2. Data from front-line staff in some sites indicates that they have not been involved in shaping services as much as they would have liked. Staff also thought that methods for involving young people in some instances had not been as successful as they would have liked them to be. Could consideration be given to ways of enhancing participation of both young people and front-line staff over the coming months?

3. The evaluation found that young people (and staff) reported a strong bias towards sexual and reproductive health services, rather than towards more holistic ones. Where the sites are developing holistic services, they are reaching young women more successfully than young men. Young men are being accessed considerably less than young women and generally in ways that are less holistic. During the year ahead could sites focus on: finding ways to extend the service young men are receiving; and prioritising holistic services for both young women and young men?

4. It emerged that certain groups of vulnerable young people are not yet being reached by services. Groups which require additional focus include: Asian young people in areas of high Asian population; young people with long-term medical conditions; young people with disabilities; looked after young people; young offenders; travellers. Could priority be given to developing ways that these gaps could be addressed?

APPENDIX

METHODS AND PARTICIPANTS

Methods

The aims of the evaluation were to assess:

- Short term intermediate impact (such as changes in accessibility and uptake of services)
- Young people's and health professional's satisfaction with services and their perceptions of potential impacts
- The process involved in the planning and the implementation of the programme.

The evaluation uses both qualitative and quantitative data collected through a diversity of methods. It is steered by an advisory group which includes staff from the THDS; young people in the sites are also involved in steering the evaluation.

Data collection from young people

Young people using services over a six week period in September/October 2007 were asked to complete a short self completion questionnaire after attending a session at the service site. The services selected had been identified as having benefited to some extent directly or indirectly from THDS funding. They were supported to complete the questionnaire by researchers where required. The aim was to recruit 200 young people, in this survey round in each THDS and repeat the process in June 2008.

Over the course of the two years of the programme, we are also undertaking 25 interviews with young people in each THDS. Interviewees are being purposively selected to ensure that views are gathered from a range of young people including: service users and non users; young people in groups known to be most vulnerable. These interviews are semi-structured and taped (if the young person consents to this).

Young people taking part in the survey and interviews were given a £5 voucher as reimbursement of their time and to thank them for their participation.

Data collection from service providers and other stakeholders

A postal questionnaire survey was carried out with front-line staff in Oct 2007 with a second survey to be conducted in April/May 2008. The aim is to purposively select interviewees to ensure a diversity of perspectives. Twenty five service providers and other stakeholders in each site will be interviewed. In addition we are carrying out quarterly telephone interviews with the main site coordinators to ensure that we obtain on going updates regarding service developments and delivery.

Monitoring

Staff are being asked to record basic details of all the young people who they have contact with (for example ages, demographic characteristics, health needs and service provided) during a two week period every three months (five times over the period of the evaluation). This information is collected on a short paper form. Two versions of the form are used, one for 1:1 contacts and one for recording group sessions.

Observational data

Members of the research team will spend a minimum of 8 days in each site observing project activities in order to see, at first hand, services delivered to young people and additional activities such as staff training. Field notes are being used to record the details of these observations.

Economic commentary methods

The evaluation will consider:

- What the costs of providing the programme are.
- How costs and the different models of service delivery are related.

Participants

Young people survey

	Global	Bolton	Hackney	Northumberland	Portsmouth
Number	622	197	117	184	124
Female	66%	74%	59%	53%	77%
Mean age	16.6 yrs				
Housing					
Rented	55%	59%	71%	41%	55%
Owner occupied	40%	41%	17%	55%	39%
Other (inc. LAC/homeless)	5%	1%	12%	3%	6%
Ethnicity					
White British	82%	94%	19%	98%	98%
Black or mixed Black/White	13%	3%	61%	0%	2%
Other	5%	3%	20%	2%	0%
Disability / LTMC*	21%	17%	19%	23%	28%
Unhappy	10%	10%	13%	5%	13%
No exercise in past week	18%	20%	25%	10%	19%
5+ portions fruit / veg.	12%	13%	10%	14%	14%
Drunk 1x week or more	28%	37%	9%	36%	18%
Smoke regularly	33%	38%	19%	29%	42%
Cannabis 1x a week or more	8%	9%	16%	2%	5%
Consulted GP in past 9 mths	77%	75%	78%	78%	78%

* Most common conditions were asthma (n=48), dyslexia (n=17), mental health problems (n=12)

45% of 11 to 15 year olds (n=312) reported they had had sexual intercourse. Of those who reported their age at first sex, over half (52%) were 14 year or younger and 10% were under 13 years.

Young people interviews

Number of participants

	Global	Bolton	Hackney	Northumberland	Portsmouth
Number	42	7	11	12	12

Characteristics of participants

Age range	11 – 19 (mean 15)
Housing	22 council 11 owner occupied 4 homeless or 'looked after'
BME	10 (24%)
Disability / LTMC	9 (21%) = 3 with dyslexia, 2 asthma, 1 epilepsy, 1 with mental depression and 2 with non specified conditions

Front-line staff survey – October 2007

Number of participants

	Global	Bolton	Hackney	Northumberland	Portsmouth
Number	48	13	10	14	11

Other characteristics of participants in frontline staff survey

'Relationship' to THDS budget	Service employed by - most frequent first	Type of approach
Paid from THDS budget (all or some of salary/sessions – 44%) Not paid from THDS budget – other relationship e.g. work closely with THDS team – 56%	Health (77%) Youth service; Sport and leisure; Education Social services Police/youth offending Other	67% drop in 54% some outreach work 65% group work 67% one to one/face to face

Staff interviews

Number of participants

	Total (all sites)	Managers (including site co-ordinators)	Front-line staff
Number of individuals interviewed once or more	28	18	10
Numbers of interviews carried out	33	23	10

This document is available in a range of alternative formats; please contact the Institute of Education's Marketing and Development Office for assistance.

Telephone: 020 7947 9556

Email: info@ioe.ac.uk

First published in 2008 by the
Social Science Research Unit
Institute of Education, University of London
18 Woburn Square
London WC1H 0NR
Tel: 020 7612 6367
www.ioe.ac.uk/ssru

Founded in 1990, the Social Science Research Unit (SSRU) is based at the Institute of Education, University of London. Our mission is to engage in and otherwise promote rigorous, ethical and participative social research as well as to support evidence informed public policy and practice across a range of domains including education, health and welfare, guided by a concern for human rights, social justice and the development of human potential.

The views expressed in this work are those of the authors and do not necessarily reflect the views of the Social Science Research Unit or Department of Health. All errors and omissions remain those of the authors.

This report should be cited as:

Austerberry H, Sawtell M, Ingold A, Wiggins M, Arai L, Strange V, (2008) *Evaluation of the Teenage Health Demonstration Sites Programme: 1st Annual Report 2007*. London: Social Science Research Unit, Institute of Education, University of London.
ISBN: 978-0-9559087-0-5