

Commissioning for Young People in Southwark

Children and Young People's Wellbeing Strategic Framework, Work-stream 5: Young People's Health (10 – 25 years), including sexual health, substance misuse, self-harm and youth violence

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Executive Summary

Young people (YP)(aged 10 – 25 years) make up 21% of the population of Southwark [1]. They are the age group in the UK that has experienced the least improvement in health status over the last 50 years and are the only age group in which morbidity and mortality are increasing [2]. They are also twice as likely as other age groups to attend accident and emergency and walk in services, and local YP report difficult accessing primary care services [3][4]. Of the 10 major risk factors for adult disease, five are initiated or heavily shaped in adolescence (smoking, lack of physical activity, being overweight, unsafe sex and alcohol use), and it is a time of increased risk to health as a result of an increased tendency to exploratory risky behaviour [2][4]. They are therefore a key group for early intervention and prevention.

NHS Southwark CCG and Southwark Council are implementing a Partnership Commissioning Team (PCT), with a focus on commissioning services for population groups using an outcomes based model. Children and Young People (CYP) is one population segment that has been identified that will benefit most from this approach. Alongside the formation of the PCT the formation of the Local Care Networks (LCNs), the Community Education Provider Network (CEPN) and the Clinical Effectiveness Group (CEG), present opportunities to bring providers together in innovative ways to develop and improve services. The Southwark Children and Young People’s Wellbeing Strategic Framework is being developed as a joint framework for commissioning local CYP services by NHS Southwark CCG and Southwark Council, as illustrated in Figure 1.

Figure 1: Components of the Children and Young People’s (CYP) Wellbeing Framework

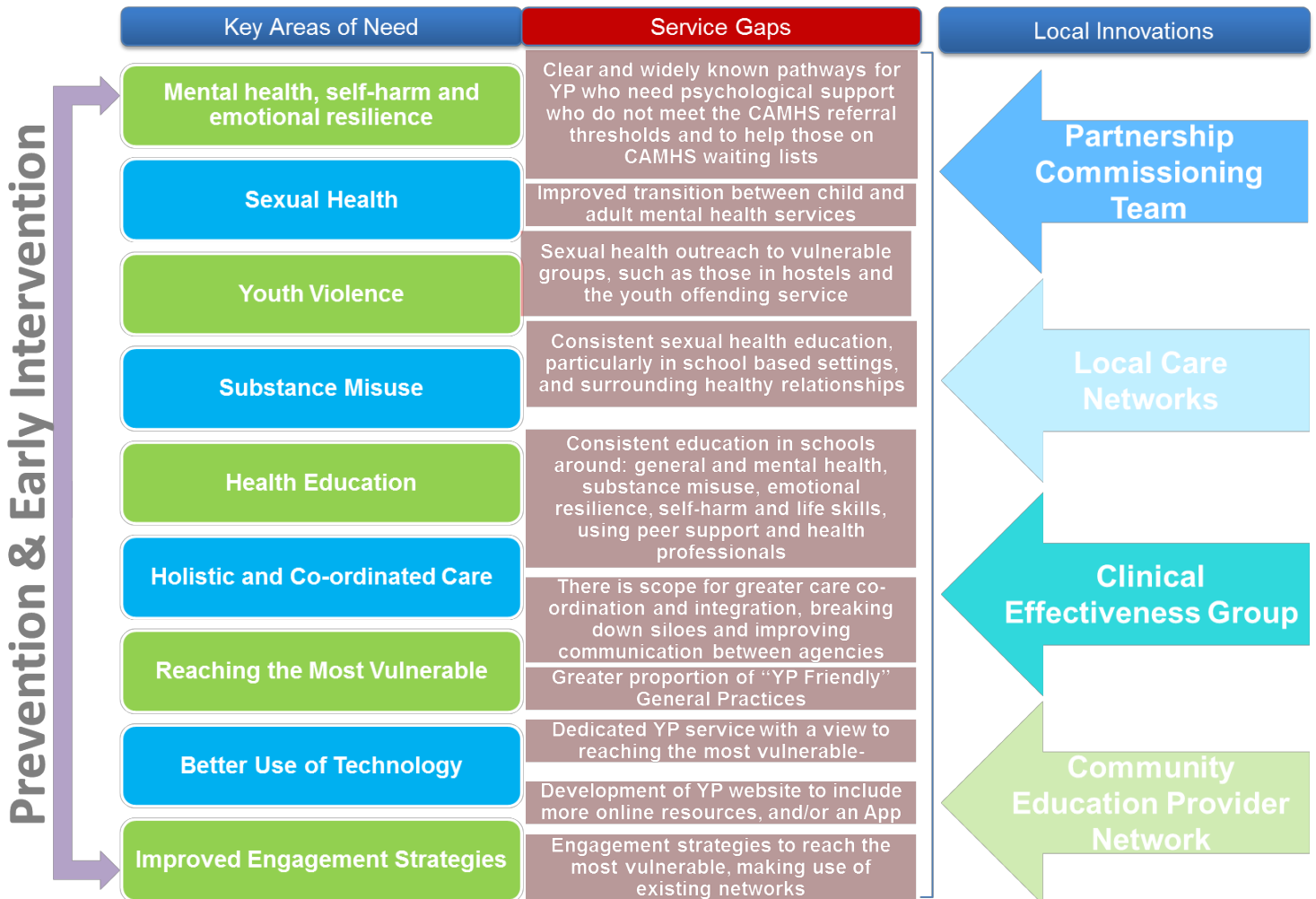


In Southwark the risky behaviours of; self-harm, substance misuse, youth violence and sexual health have been identified as important issues both by engagement work with YP, and by the Joint Strategic Needs Assessment (JSNA) completed by public health in conjunction with the Children and Young People’s Health Partnership (CYPHP) [4]. Obesity and lack of Physical activity are also considered to be important risks in this population. In response to this, one of the 7 priorities identified in the CYP Wellbeing Strategic Framework is: Young People’s Health 10-25 years, including sexual health, substance misuse, self-harm and youth violence. This report was completed in order to review the existing service provision for this cohort, identify service strengths and gaps, and opportunities to enhance services to improve the health and wellbeing of YP in Southwark.

The service current state was reviewed using service mapping, and key areas of need were identified following a review of key documents and engagement with stakeholders. Semi-structured interviews were undertaken with professionals and a focus group and workshop with YP were held. A service

outcome evaluation model was developed from this data, and strengths and gaps in service provision identified. Key areas of need identified are shown mapped to service gaps, and local innovations that could contribute to service improvement in Figure 2. Overarching this is the need for prevention and early intervention.

Figure 2: Key areas of need mapped to service gaps and opportunities to improve services



A review of evidence regarding alternative service designs was undertaken in order to identify evidence of best practice, and service enhancement opportunities identified. These were then presented in the form of recommendations for consideration by the CYP Commissioning Development Group (CYP CDG). These recommendations are as follows:

Recommendations:

1. Maximise Prevention and Early Intervention

- ✓ Work with public health colleagues to implement effective interventions for this cohort
- ✓ Implementation of the Healthy Child Pathway (0-19) as this will build protective factors against risky behaviours and their harms, by strengthening individual, community, family and school factors.
- ✓ Investigate whether the community and family engagement component of Health Promoting Schools programme could be strengthened, and look at delivering health promotion messages consistently across school, family and community components.

- ✓ As part of this, consider commissioning voluntary sector organisations working with YP, in partnership with healthcare professionals (e.g. a local GP Surgery), to assist in providing health education in schools, making use of peer support. Ideally, part of this service would include up-skilling staff and providing education for parents. Interventions could be targeted by gender, and at transition points. A similar service could also be commissioned in colleges, universities and job centres in order to reach the 18-25yrs age group
- ✓ Training of the health and social care workforce (e.g. GPs, Practice Nurses etc.) in brief advice or motivational interviewing on risk behaviours (including smoking, substance misuse, sexual health, self-harm, youth violence, diet and physical activity)
- ✓ Consider introduction of a “Teen Health Check” template, possibly linked to a Key Performance Indicator (KPI) in order to encourage GPs to ask about issues such as sexual health, substance misuse, smoking, youth violence, physical activity and self-harm, and give an opportunity for brief advice or motivational interviewing. CYPHP have developed a template which could be used for this purpose.

2. Provide Appropriate and Accessible Health Services for YP

i. Strengthening Existing Services and Pathways

- ✓ Clear, straightforward, and widely known pathways for YP not meeting the CAMHS referral thresholds and on waiting lists, and communication of these pathways to care workers and YP. This should include improving the pathway for transition between child and adult mental health services
- ✓ Investigate the possibility of providing referrals from GP Surgeries into voluntary sector counselling and other voluntary sector services
- ✓ Consider whether services for vulnerable YP (child in need, youth offending system, CAMHS etc.) could be brought together, or have a single point of access so there is “no wrong door” for vulnerable YP or referrers
- ✓ Engage with General Practice to discover enabling factors and barriers to them becoming “YP Friendly”, and develop a plan to promote this approach. There is an opportunity to collaborate with the CYPHP in their work on this.
- ✓ Strengthening existing services for CSE and raising awareness of referral pathways

ii. Workforce development

- ✓ Training of the health, education and social care workforce in supporting adolescents with emotional distress, and enabling them to direct YP appropriately to available services, both face-to-face, online and apps.
- ✓ Training of the workforce to identify those at risk of CSE
- ✓ Training and education for GPs to improve understanding of YP’s needs and feelings. This could be done in partnership with the voluntary sector and co-produced with YP
- ✓ Training the workforce on the subject of children and young people who self-harm

iii. Improved Resources

- ✓ Production of clear information on service options for YP that can be given to them in leaflet form and online
- ✓ Further development and promotion of the Southwark YP website: whtvr.org
- ✓ Consider producing a Southwark YP App with resources covering self-harm, mental health, sexual health, youth violence, substance misuse, smoking etc., ways to access confidential advice, and quick polls and surveys so YP can have a say in services. There is an opportunity to collaborate with CYPHP who have produced an App, rather than developing something de novo.
- ✓ Explore other methods of information dissemination, technologies and tools

iv. Consideration of New Services

- ✓ Consider commissioning a targeted health outreach service to vulnerable young people, which could also address their sexual health, and other holistic health and wellbeing needs. This could include looked after children (LAC), homeless and learning disabled YP and those in the youth offending service (YOS) and supported accommodation. CYPHP are piloted the use of a LAC nurse to work with hard to reach and out of borough LAC. This service should be reviewed with the intent of assessing it's suitability for commissioning in 2018/19
- ✓ Further engagement work to assess viability of providing sexual health and contraception services in schools. Engagement results thus far on this subject have been mixed.
- ✓ Consider using school nurses to provide sexual health advice using a telephone service. CYPHP are piloting this service and so a review could be undertaken to assess suitability for commissioning in 2018/19.
- ✓ Investigate commissioning voluntary sector organisations working with YP, in partnership with healthcare professionals (e.g. a local GP Surgery), to provide health education in schools, making use of peer support. Ideally, part of this service would include up-skilling school staff and providing education for parents. A similar service could also be commissioned in colleges, universities and job centres in order to reach the 18-25yrs age group.
- ✓ Consider commissioning either a holistic "one-stop-shop" youth hub for health, or an outreach approach with pop-up clinics in places YP already go (schools, colleges, job centres, youth groups, youth offending service etc.) There is evidence that both these approaches are valuable in reaching vulnerable YP, but each has advantages and disadvantages. The most effective model is likely to be a "hub and spokes" model, with a central youth hub and outreach services stemming from that. However there is a paucity of data on cost effectiveness for a "one-stop-shop" youth hub, and in the absence of this it is difficult to justify the expenditure that would be required, particularly given the current financial climate. Pop-up clinics in places YP already go provide a way to offer a holistic youth-specific service without the cost of real estate that would be required for a hub. Evaluation of cost-effectiveness of this model could then be used to justify the cost of a hub further down the line. NHS Southwark CCGs local plans for primary care to be delivered at scale also offers an option for providing YP specific services for a larger

practice population, and this would contribute to research and evaluation of service models. Discussions could be had with the federations regarding providing a clinic for YP alongside the existing extended access services, perhaps with a mixture of walk-in and pre-booked slots, and making use of a GP and youth worker. This would offer an opportunity to provide brief interventions on risk behaviours and promote healthy lifestyles.

- ✓ With the advent of Multi-Speciality Community Providers there is an opportunity to consider how this cohort could benefit from an integrated community multi-disciplinary team.

3. Further Understanding the Needs of YP – Engaging with Vulnerable YP

- ✓ Work in partnership with schools and voluntary sector organisations to engage with vulnerable YP through existing networks, using surveys, workshops and focus groups
- ✓ This work could be used to co-produce multi-media health promotion campaigns with YP, and to gauge demand for dedicated YP services.

Suggested Next Steps

1. Form a multidisciplinary steering group
2. Develop logic models to assess how services map to improving outcomes
3. Engagement with stakeholders, schools, voluntary sector organisations and the health and social care workforce in order to test and refine recommendations
4. Undertake a detailed analysis of costs, including affordability and market capability in order to prioritise recommendations

3. Introduction

The Southwark Children and Young People's Wellbeing Strategic Framework is being developed as a joint framework for commissioning local children and young peoples' (CYP) services by NHS Southwark CCG and Southwark Council. Priority work streams were identified as a result of work done by public health in the joint strategic needs assessment (JSNA), and one of the 7 priorities identified is: Young People's Health 10 – 25 Years, including sexual health, drugs misuse, self-harm and youth violence. This report was commissioned by the CYP Clinical Lead and Commissioners in order to inform this priority. The existing provision for this population will be reviewed and service enhancement opportunities identified that offer the best opportunities to improve the health and wellbeing of young people (YP) in Southwark.

Aims

1. Service current state review

- Undertake a review of existing service provision and quality in Southwark for:
 - Young people (YP) between the ages of 10 to 25 in Southwark, with a particular focus on those who are:
 - In need of sexual health advice, guidance and treatment
 - Involved in, exposed to, or at risk of getting involved in drugs misuse
 - Involved in, exposed to, or at risk of self-harm
 - Involved in, exposed to, or at risk of youth violence.
 - The families, friends, households, and support-networks of the population cohorts above.
- Review services across health, education and social services, including commissioned, charities and volunteer organisations, focusing on equality of offer across the borough and identifying any paucity of service provision
- Identify key areas of need for this cohort – engaging with key stakeholders, reviewing engagement work and published data, and developing personas to frame and focus issues
- Develop a service outcome evaluation model, presenting findings as return on investment i.e. service cost as a ratio to both quantitative and qualitative outcomes
- Identify strengths and gaps in service provision – using the information captured through the service mapping, identification of key areas of need and stakeholder engagement, mapped to borough demographics, service location and service outcome evaluation results to identify disparity across service provision and so where services should require further investment.

2. Service future state design

- Undertake a review of current evidence regarding alternative service designs that are being used both locally, nationally and internationally to provide optimum outcomes for this cohort
- Identify pooled commissioner funding available to this cohort
- Identify service enhancement opportunities – using the information captured as part of the service current state review.

Expected Outcomes

- Prioritised list of improvement opportunities for consideration by the CYP CDG, looking to improved outcomes for the target population

Evidence of need

There are 62,766 YP between the ages of 10 and 25 years in Southwark and this represents 21% of the borough’s population [1]. YP have experienced the least improvement in health status in the last 50 years, and are the only age group in the United Kingdom (UK) in which morbidity and mortality are increasing [2]. They are twice as likely as other age groups to attend accident and emergency and walk in services [3]. Engagement work in Southwark shows that YP in the borough report reluctance to access primary care services, and that they experience difficulties when they try to do so. They feel that services need to be better co-ordinated and promoted, and that the workforce (across health and social care and education) should be better equipped to support YP’s health, with more health promotion and information being delivered in schools [4].

The age range of 10 to 25 years is commonly used to define adolescence, as there is a tendency in society towards earlier onset of adolescent behaviours, later adoption of adult social roles and brain development can continue till the age of 25 years. Of the 10 major risk factors for adult disease, five are heavily shaped in adolescence (smoking, lack of physical activity, being overweight, unsafe sex and alcohol use), with 75% of lifetime mental health disorders (excluding dementia) starting before the age of 24 years [2]. Adolescence is a time of increased risk to health, as a result of an increased tendency to exploratory risky behaviour. This is due to both susceptibility to peer pressure and the rapid brain changes that occur at this time [4].

The risky behaviours focussed on in this report are: self-harm, substance misuse, gang violence and sexual health. Local engagement work suggests that YP believe these to be major health and social challenges, and they have been identified by the JSNA as being important issues [4]. When considering risky behaviour in this cohort it is also important to consider smoking, obesity and lack of physical activity as these are significant risk factors for adult disease. A summary of the demographics of these behaviours is shown in Figure 3.

Figure 3: Summary demographics for risky behaviour in YP in the United Kingdom (UK) & Southwark

Self-harm	Substance Misuse	Youth Violence	Sexual Health	Obesity
<p>UK</p> <ul style="list-style-type: none"> □ 2nd most common cause of external preventable death in YP [4] □ 20% of 15yr old in the UK reported self-harming in the previous year in 2013 [5] 	<p>UK</p> <ul style="list-style-type: none"> □ 2/3 smokers start before age 18yrs [65] □ 29% 15yr olds reporting drinking alcohol in the previous week [5] □ 23% 15yr olds report taking a drug in the previous year [5] 	<p>UK</p> <ul style="list-style-type: none"> □ 3rd most common cause of external preventable death in YP [4] 	<p>UK</p> <ul style="list-style-type: none"> □ Highest incidence of sexually transmitted infection (STIs) in the 16 – 24 age group [2] 	<p>UK</p> <ul style="list-style-type: none"> □ Levels of overweight or obese 10-11yr olds increasing to 33.2% in 2014/15 [9]
<p>Southwark</p> <ul style="list-style-type: none"> □ 310 cases of self-harm/para-suicide among YP per annum from GP data (but probably under-reported)[4] □ Hospital admission rates lower than the England average (150 vs 346/100 000) but increasing [4]. 	<p>Southwark</p> <ul style="list-style-type: none"> □ Average drug use in secondary school pupils 9% [6] □ Use thought to be higher in older adolescents and skunk identified as a significant local issue by stakeholders (skunk is high strength cannabis) [4] □ Lower than England average hospital admissions for alcohol and substance misuse [7] 	<p>Southwark</p> <ul style="list-style-type: none"> □ 17% of male pupils reported being a victim of violence in the past year in 2014 (higher than the England average) [6] □ Higher than England average first time entrance into youth justice system [7] 	<p>Southwark</p> <ul style="list-style-type: none"> □ Higher than England average chlamydia detection rate among 15 – 25yr olds (but also higher testing rates) [7] □ Higher than England average rate of teenage conception [7] □ Lower than England average proportion teenage mothers [7] □ Lower long acting reversible contraception (LARC) uptake than England average [8] 	<p>Southwark</p> <ul style="list-style-type: none"> □ Higher than England average levels of Obesity with 43.2% of children aged 10-11yrs classified as overweight or obese [9]

Policy Relevance

National

With the NHS Five Year Forward View there has been a change in focus towards commissioning for population groups (rather than on a provider basis), and on the basis of outcomes that matter to them. Priorities specifically set for YP include improving access to services, and supporting the delivery of recommendations set out in Future in Mind. [10][11] These recommendations include:

- Focus on prevention and early intervention
- Taking a more holistic approach
- Better co-ordination and integration of services
- Provision of age appropriate services for adolescents
- Improved use of voluntary and digital services
- Use of peer support schemes and schools outreach
- Implementation of the “You’re Welcome” criteria

Opportunities to enhance services for YP in Southwark in order to align them with these recommendations will be identified in this report.

Local

The NHS Southwark CCG Five Year Forward View states an ambition to emphasise prevention and early action, and to focus on contracting on the basis of populations [12]. NHS Southwark CCG and Southwark Local Authority are implementing a Partnership Commissioning Team, with a focus on commissioning services for population groups using an outcomes based model. Children and Young People (CYP) is one population segment that has been identified that will benefit most from this approach. In addition the development of the Local Care Networks (LCNs) represents an exciting opportunity to bring providers across the borough together in order to design and deliver services in an integrated and co-ordinated way.

The stated underpinning objectives of the Children and Young People’s Wellbeing framework are; hearing and acting on the voice of the child, early intervention and prevention and reducing inequality [12]. Five of the ten main risk factors for adult disease are initiated or shaped in adolescence, and Southwark has a higher number of 16-18 year olds not in education, employment or training (NEET), and higher levels of child poverty than the England average [7]. Therefore intervening in this group is crucial for early intervention and prevention, reducing inequalities, and building healthier and more resilient communities.

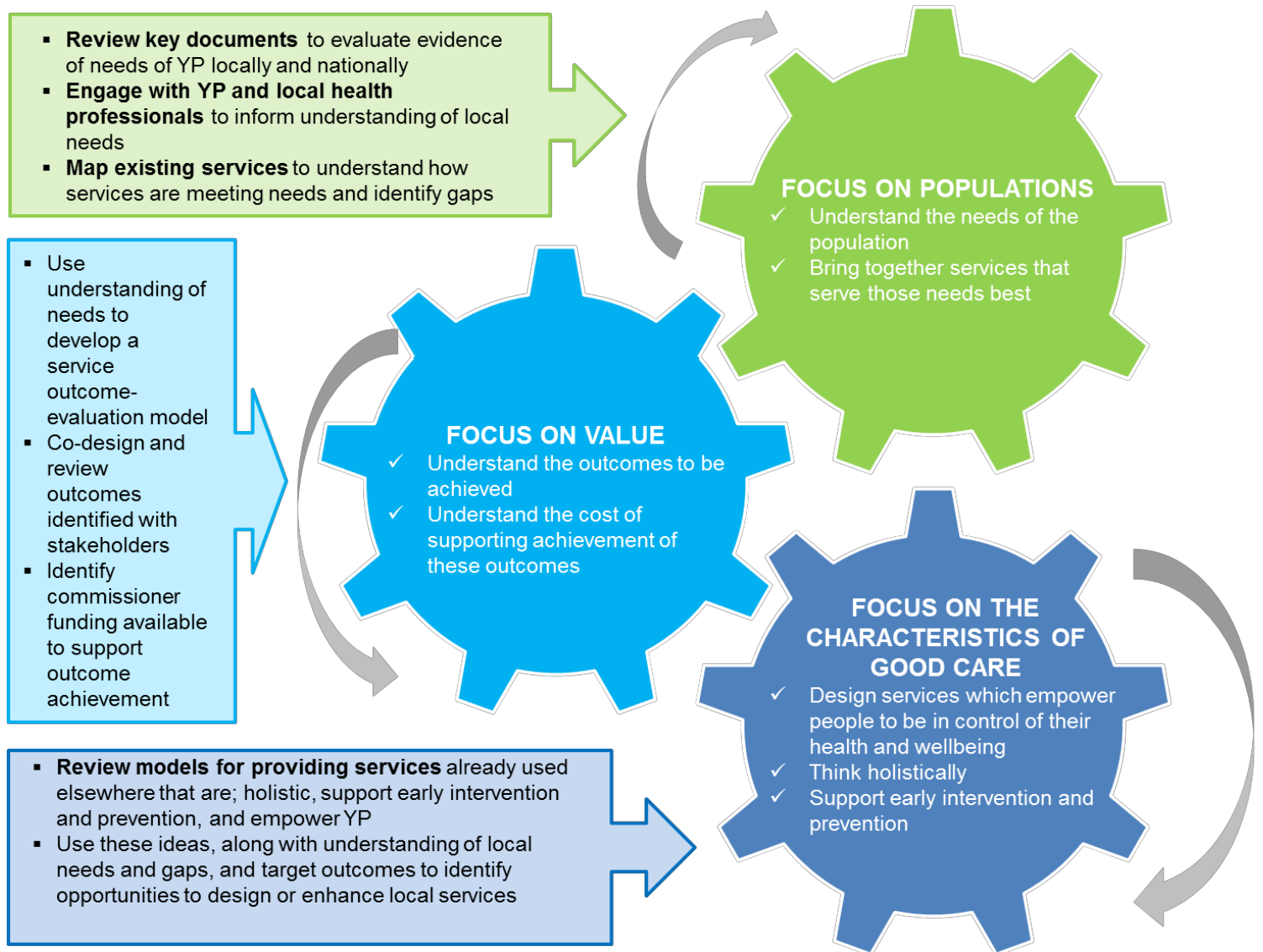
Scope

This report considers young people’s health with a focus on; sexual health, self-harm, youth violence and substance misuse. It does not address in detail other priorities that apply to this population (including accidents, long term conditions and issues facing vulnerable groups) as these are addressed by the other 6 priorities in the CYP strategic framework.

4. Methodology

Figure 4 shows how the methodology aligns with the three key principles for commissioning services outlined in NHS Southwark CCG's Five Year Forward View [12].

Figure 4: Project methodology and how it aligns with the three principles for commissioning services outlined in NHS Southwark CCG's Five Year Forward View [12]



Methodology used for the steps in bold is outlined below.

Review of Key Documents

Key high-level documents were identified; looking at reports commissioned by the Department of Health, the Chief Medical Officers Report, reports released by Southwark CCG and Local Authority regarding Young People's Health and Wellbeing, and those recommended by stakeholders. Information in these documents was used to inform meetings with stakeholders, and to contribute to the identification of key areas of need. A list of documents reviewed is included in Appendix A.

Stakeholder Engagement

Stakeholders were mapped using an interest –influence matrix, in order to identify the full range of stakeholders and prioritise stakeholder interviews. The stakeholder map can be found in Appendix B.

Views were sought from stakeholders using a variety of methods

- Semi-structured interviews with 16 professionals focused on describing and evaluating current service provision, identifying key areas of need and other key stakeholders, and brainstorming around service improvement opportunities. An engagement log can be found in Appendix C with details of interviews in Appendix D.
- A focus group with 6 vulnerable YP, with a focus on identifying key areas of need and service issues. A full report can be found in Appendix E.
- A workshop event “My Voice Counts”, attended by 23 YP, at which personas reflecting the target risk behaviours, and other issues facing youth in Southwark were adapted by a theatre company and used to frame and focus discussion. These personas were developed using clinical experience and feedback from stakeholders. They are included in Appendix F. This event also made use of text polls and table discussions. A full report can be found in Appendix G.

Service Mapping

Services have been mapped as part of the Children and Young People's Health Partnership (CYPHP) needs assessment [4], and further service mapping has been undertaken by the CYP Project Manager at NHS Southwark CCG. Stakeholders were also asked about what services are available. This work was synthesised and been used to identify service strengths and service gaps.

Service Models Review

Service models for youth were reviewed using; information from the CYPHP needs assessment [4], the RCGP champions for health youth project [3], a literature review, and signposting by key stakeholders.

5. Service Current State review

Overview of Service Mapping

Service mapping was reviewed alongside stakeholder interviews to give an overview of the current service state. Selected quotes from professionals (in blue) and YP (in purple) are included in speech bubbles.

Primary Care

There is evidence to suggest that 70-90% of YP visit their GP at least once a year [4]. In an audit of the last 20 sessions of my own booked appointments 20% were booked by those in the 10-24yrs age bracket (data in Appendix H), although whether this data is generalisable across Southwark is not known. YP at the focus group felt that GPs were doing a great job overall but were too busy to pick up some problems with YP, especially with respect to mental health. There is variation across Southwark in GP appointment systems, and some of these were seen as being more useful to YP, such as telephone triage leading to appointments or advice being offered on the day. However telephone systems can also be problematic for YP who might not have credit on their phone or be able to answer during the day. Local YP report that they struggle to make appointments with their GP, and have concerns about confidentiality [4]

One practice in Southwark is making changes in order to implement the advice from the Royal College of General Practitioners for becoming “Young People Friendly” [3]. Reception staff attended a training session focussed on YP, a YP information board was created in the waiting room, a YP survey added to their Facebook page, and a member of the reception team was appointed a YP champion.

The Well Centre in Streatham sees YP from across the South London area, including Southwark (although this service is not commissioned by NHS Southwark CCG). It has the advantage of offering a drop-in format, and being set up to cater to the needs of YP – allowing them access to a GP, Youth Worker and Children and Adolescent Mental Health Service (CAMHS worker) in one place. They have developed a “Teen Health Check” in order to help identify risky behaviours. As yet there is little data on how this service impacts on outcomes.

“We are still discovering ourselves; you automatically think nothing is wrong, are you exaggerating, should you really be there [at the GP practice]?”

“I would like to have a GP I know”

“We need a YP template or teen health check, and to make general practice more YP friendly”

Child and Adolescent Mental Health Services (CAMHS)

Local data suggests that currently only 23% of predicted need is being met by CAMHS [4], and stakeholders felt that waiting lists were too long and referral thresholds too high for this service. CAMHS transformation money is being used to place a youth worker in A&E for self-harm, for training A&E staff in brief interventions and therapeutic assessment training, and to fund a post scoping a hub for child sexual assault. They are also providing training for foster carers, workforce for the early help service, a further CAMHS worker in the youth offending service, and work in schools in terms of training about body image, resilience and prevention using a whole school approach. Stakeholders also report a lack of transition from CAMHS to adult mental health services.

“Everything is meant to be perfect [in reference to the way life is portrayed on social media] so you feel resentful that you need to go to the doctor for mental health problems”

“There are problems with CAMHS waiting lists and referral thresholds”

“We need better early intervention mental health work”

Educational settings

Southwark Healthy Schools Programme uses an evidence based framework to deliver health promotion in schools, and there is a PHSE teaching programme for school nurses so that they can support sex and relationships education delivery within schools. However, stakeholders report there is a lack of consistent offer in schools. YP at both the focus group and workshop events reported a disparity in terms of what is being offered in educational settings in terms of health education (between schools, academies and the private sector) particularly with respect to sexual health. Local Authority employed school nurses offer drop in services in schools but what is offered in academies and the private sector is more variable. This has implications for safeguarding as well as accessing services. Universities offer counselling services and there are drop in GP clinics at Lewisham Southwark College. YP in the focus group suggested that training in more general “life skills,” building emotional resilience, and reducing the stigma surrounding mental illness would be useful in schools. They suggested that using a combination of health professionals and peer support would be an effective way to enable this.

There is transformation plan funding to build capacity and develop the workforce in schools, and to bring education and local CYP mental health services together around the needs of the individual child. CYPHP are developing a programme to promote emotional resilience in schools.

“Unless education regarding substance misuse, knife crime and sexual health is on the radar for academies to teach then it may not be in the curriculum”

“There should be more crossover between education and health – more time for health in the curriculum, listening more to what teachers are saying, health professionals in schools...”

Voluntary Sector

There is a lot on offer from the voluntary sector for YP, and good examples of voluntary sector organisations working jointly with both primary and secondary care. For example it is possible to refer YP from primary care to Faces in Focus for counselling services. Redthread, who co-founded the Well Centre also provide the Youth Violence Intervention programme in London’s four Major Trauma Centre hospitals. Youth workers are embedded in Accident and Emergency Departments to engage with 11-25yr olds who are victims of violence. This includes King’s College Hospital in Southwark. The London Gang Exit Programme provides additional support for YP involved in gangs. Stakeholders report that there are communication problems with the voluntary sector. There is a lack of information about quality of service provision, and a lack of understanding of what services are on offer in the voluntary sector within the health and social care community. Voluntary sector organisations can also struggle with funding, particularly in an uncertain financial climate.

Sexual Health Services

A review of sexual health services for YP across is currently being undertaken across Lambeth, Southwark, and Lewisham. Mapping of services reveals that there is a lot on offer across the borough in terms of sexual health services. This includes the innovative online service SH:24, which provides online access to sexual health testing kits 24 hours a day, 7 days a week. The kits are delivered by post accompanied by a free-post return envelope. Results are sent by text, and their website also includes accessible sexual health information. Wise Up to Sexual Health (WUSH) is a team of nurses providing outreach sexual health services to young people in Lambeth and Southwark, they work closely with different agencies and aim to reach vulnerable youth.

Stakeholders report that there is a lack of joined up offer, especially with respect to vulnerable young people. Particularly there is no outreach work to hostels, supported accommodation and the youth offending service. There is a dedicated service for those at risk of child sexual exploitation (CSE), funded by the Community Safety and Troubled Families budgets and provided by The Safer London Foundation. They provide both therapeutic interventions to young people who are experiencing CSE, but also do some work to try and prevent it. The pathway for referral to this service is not widely known but they are over capacity. The Child House Model is being piloted at the Camberwell Haven to provide better support for those who have been victims of CSE.

“There is a need for healthy relationships education”

“We’re meant to learn about this at school but we don’t – in Year 7 PSHE, we were just told to stay away from sex”

“Chemsex” (sex occurring under the influence of drugs) is perceived to be particularly prevalent in Southwark, with men who have sex with men (MSM) being twice as likely to report using the drugs associated with chemsex (crystal meth, mephedrone and GHB/GBL) in Lambeth Southwark and Lewisham (LSL) than elsewhere in London (sample aged 21-53yrs). This is associated with increased sexual risk taking and men have been hospitalised due to overdoses and report psychological side effects. Men in LSL report that they are comfortable accessing drug information and harm reduction services from sexual health services [13]. There is little evidence regarding demography and so impact on YP specifically is not known. Afterparty is an organisation supported by the Elton John Aids Foundation, and they provide a specific service for chemsex in London, including outreach and self-testing kits [14].

Drug and Alcohol Services

Insight Southwark provides the YP (under 19 years) substance misuse service in Southwark, including phone support, a drop in service, one to one appointments and group workshops. They also offer sexual health advice, advice about housing, employment and education, LGBT support, and have a music studio. They are based on Old Kent Road, and so YP from elsewhere in the borough would need to travel to access this service. This could cause problems for YP who cannot go to certain “no-go areas”.

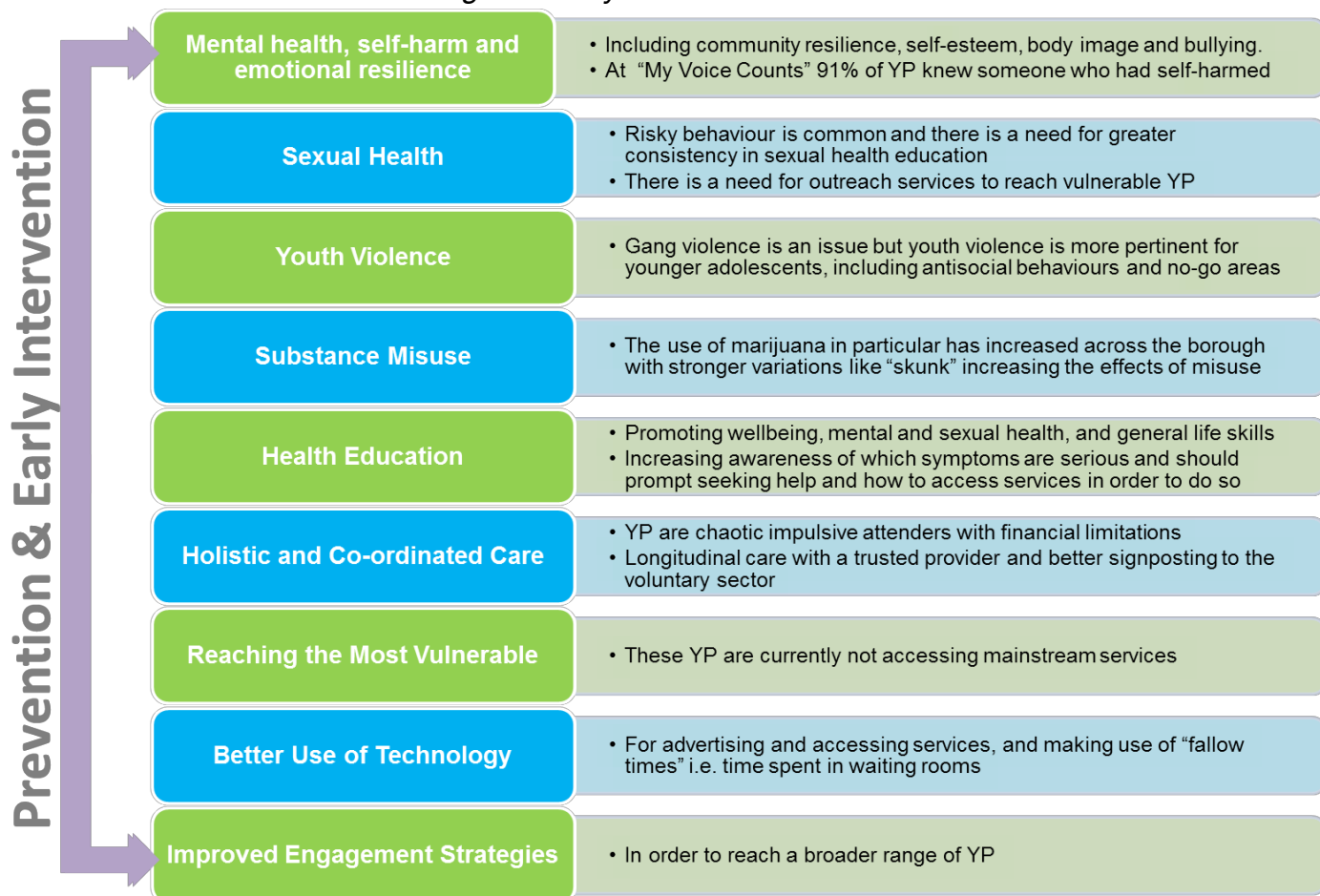
Lifeline Southwark provides drug and alcohol services for those over the age of 18 living in Southwark. They are based at Cambridge House (just off Camberwell Road), work at other satellite locations, and will see people at other places where they feel comfortable and safe.

A tobacco strategy is under development, no specific YP smoking cessation service was found on service mapping.

Key areas of need

Themes from semi-structured interviews with 16 professionals were analysed using thematic analysis. Details can be found in Appendix D. A focus group was held with 6 YP from the Standup Southwark service, and a workshop event “My Voice Counts” attended by 23 YP and between 16 and 20 years. Minutes from the focus group and workshop event were analysed and can be found in Appendix E and G. Engagement work from published data was also reviewed. Key areas of need identified are listed in Figure 5. Overarching all of these needs is a need for prevention and early intervention.

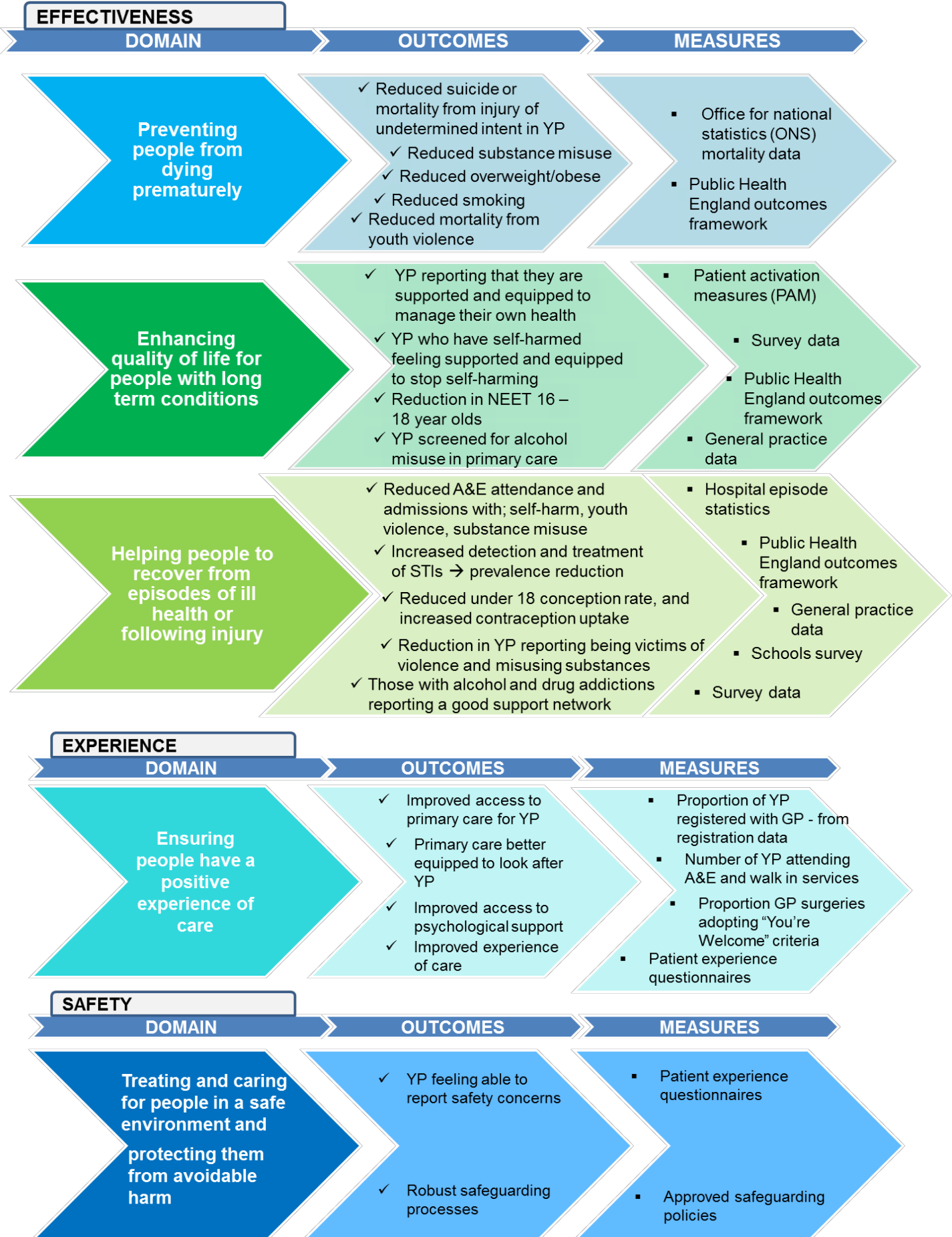
Figure 5: Key Areas of Need



Service Outcome-Evaluation Model

Outcomes are mapped to the quality and safety criteria from the NHS outcomes framework [15] in a proposed service outcome-evaluation model in Figure 6. This gives an idea of how services could be evaluated against these criteria. Existing measures are used where possible. However consideration could be given as to how to co-design outcomes that are important to YP and how best to measure these. Further consultation with stakeholders and YP would be needed in order to finalise outcomes.

Figure 6: Outcomes for YP mapped to NHS outcomes framework [15].



Return on Investment

A New Economics Foundation Report estimates a return of investment of £5.65 for every £1 spent on increased 1:1 support for YP with complex needs and better co-ordination of services [16].

Interventions that reduce risk factors for adult disease such as smoking, unsafe sex and alcohol use will lead to downstream savings.

There is evidence that

- Every £1 spent on preventing teenage pregnancy (increasing contraceptive uptake, particularly long acting reversible contraception) saves £11 in healthcare costs
- Every £1 spent on motivational interviewing and developing supportive networks for people with alcohol and drug addiction returns £5 to public sector in reduced health and social care and criminal justice costs
- Every £1 spent on screening and brief advice for alcohol misuse in primary care returns £12 [4].

Service strengths and gaps

There are many services for YP across the borough, catering to a wide variety of needs, as can be seen from the results of service mapping. However reviewing the service mapping, key areas of need, service outcome evaluation model and considering borough demographics and service locations there are areas that would benefit from further investment. These are summarised and mapped to key areas of need in Figure 7.

Figure 7: Summary of service strengths and gaps mapped to key areas of need.

Service Strengths	Key Areas of Need	Service Gaps
CAMHS transformation money being spent on: youth worker in A&E for self-harm, workforce for early help and training about body image, resilience and prevention in schools	Mental health, self-harm and emotional resilience	Clear and widely known pathways for YP who need psychological support who do not meet the CAMHS referral thresholds and to help those on CAMHS waiting lists
Multiple options for sexual health services. SH:24 offering an innovative service	Sexual Health	Improved transition between child and adult mental health services
Youth Violence Intervention Programme in A&Es	Youth Violence	Sexual health outreach to vulnerable groups, such as those in hostels and the youth offending service
Insight Southwark provide diverse access options, and a broad range of help and advice	Substance Misuse	Consistent sexual health education, particularly in school based settings, and surrounding healthy relationships
Transformation funding to build capacity and workforce in schools bring education and CYP mental health services together	Health Education	Consistent education in schools around: general and mental health, substance misuse, emotional resilience, self-harm and life skills, using peer support and health professionals
GPs seen as doing a good job overall	Holistic and Co-ordinated Care	There is scope for greater care co-ordination and integration, breaking down siloes and improving communication between agencies
Practice becoming "YP Friendly"	Reaching the Most Vulnerable	Greater proportion of "YP Friendly" General Practices
YP can attend The Well Centre one-stop shop	Better Use of Technology	Dedicated YP service with a view to reaching the most vulnerable-
Pop-up GP clinics at LESOCO	Improved Engagement Strategies	Development of YP website to include more online resources, and/or an App
CAMHS provide workers at the youth offending service and training for foster carers		Engagement strategies to reach the most vulnerable, making use of existing networks
Website: whtvr.org for YP in Southwark		
Previous extensive engagement with YP		

6. Service Future State Design

Evidence and examples of different service models

Evidence for different service models and examples of services that address the key areas of need mapped to the service gaps identified were reviewed.

Mental health, self-harm and emotional resilience

There is strong evidence that intervening early in mental health problems improves outcomes, and therefore interventions that provide support for those not meeting the CAMHS referral thresholds and on CAMHS waiting lists are likely to reduce down-stream mental health burden [4]. There is also evidence that GPs and teachers do not feel that they are equipped to deal with adolescent emotional distress [17]. Training could be given to equip the workforce, for example Harm-Ed was commissioned by NHS East Lancashire CCG with NHS Blackburn and Darwen CCG to provide training to the workforce with the aim of reducing the risk of suicide and self-harm in CYP [18]. Having clear and widely known pathways for those YP who need psychological support but do not meet the CAMHS referral thresholds, or who are on waiting lists would equip GPs and other professionals to signpost YP

Case study 1: Providing seamless voluntary sector counselling referrals from the GP – Sheffield

A GP Surgery in Sheffield and a voluntary sector organisation called Interchange Sheffield, designed a pathway whereby GPs could refer directly to Interchange from the consulting room. The youth counsellors would text the YP and keep in touch with them until an appointment was available. The GPs noted positive outcomes in the lives of those YP who had accessed the service who otherwise would not have met the referral thresholds for CAMHS. [3]

to appropriate support services. There are support services available both online and in the voluntary sector, and there is scope for closer both working between sectors and training to raise awareness of available options amongst health and social care providers.

There are many online options available including “MindEd” a free online resource aimed at educating parents, carers and health professionals, in order to help them support YP and identify early issues [19]. Another example of a useful online tool is an App called “MindShift” developed by AnxietyBC, and British Columbia Children’s Hospital to give YP tools to deal with anxiety [20].

There is also a need for support for YP transitioning between child and adult mental health services, and improving awareness of broader resources available could be useful for this purpose also.

Case study 2: The House Project – Stoke on Trent

Stoke on Trent Council has received funding from the Department for Education’s innovation fund to develop ‘the house project’. This is led by young care leavers and plans to develop a housing co-operative using homes owned by the council. The pilot will aim to reach 10 YP, and aim to provide them with the skills to manage their own home, develop confidence and resilience and reduce long term homelessness and unemployment. Evaluation will be done by York University. [21]

Sexual Health

Contraceptive counselling by community workers has been shown to increase uptake of long acting reversible contraception (LARC), although most studies have been done in developing country settings [22]. There is evidence that providing contraceptive services and sexual health education in schools can reduce teenage pregnancy rates [23]. A systematic review of outreach programmes for sexual health screening, targeting vulnerable groups such as homeless shelters, showed that while they reached a relatively small number of people, they detected a high rate of infection. They also found that going to an existing venue was more effective than to public areas [24]. In Southwark, WUSH has been successful in providing this approach, but has not had the capacity to meet the full need of the population, and its impact on health outcomes is not known [4]. While there is a service for CSE in the borough, awareness of this is not high and it is at capacity. There is scope for greater investment in sexual health and holistic wellbeing outreach services to vulnerable YP including LAC, homeless and learning disabled YP and those in YOS and supported accommodation etc. This could make use of existing services coming together to co-ordinate new approaches, promoting joined-up working and greater collaboration between services.

Case study 3: A Young People's Sexual Health Network – Camden

A young people's sexual health network has been commissioned in Camden and Islington. This consists of three clinics, each with a different specialism, and a network manager co-ordinating the network and outcomes. PULSE provides clinical outreach, Brook provides targeted outreach with four youth workers (one to one, group sessions, peer education), and The Brandon Centre coordinates the condom card scheme and training. This is an example of different services coming together to produce a joined-up and co-ordinated offer.

Case study 4: Multi-Agency Service to Meet the Needs of Adolescents at risk of CSE – Sefton Council

Sefton Council has received funding from the Department for Education's innovation fund to create an integrated multi-agency service to meet the needs of adolescents at risk of CSE, who come into care, have open Child in Need or Child Protection plans, children missing from home, school or care, and those presenting risk factors related to offending and anti-social behaviour [21].

Case study 5: Safe Talk - Haringey

Safe Talk are school nurses who provide a free, confidential and friendly sexual health service for YP who are under 19 years old who live or study in Haringey. YP can contact them on one of two phone numbers or via e-mail. [25]

Health Education

For YP to seek medical help, they first need to recognise that there is a problem that requires action, promoting health literacy in order to enable them to do this has traditionally taken place in schools. There is strong evidence for a “whole schools approach” for health promotion. Positive effects have been seen in terms of; reducing drinking, improving drug-refusal skills, reducing smoking and risky sexual behaviours, improving mental health awareness, reducing suicide attempts, and reducing stigma associated with mental health problems. Peer based interventions have also been shown to have an impact on health behaviours, including reducing smoking and improving physical activity levels and condom use [4]. This indicates that looking at how we can improve consistency and quality of health education in schools, and make use of peer based interventions where possible would be effective in reducing risky behaviours and improving outcomes.

Case study 5: Right Here – Brighton and Hove

Right Here is run by the YMCA in Brighton and Hove, and aims to provide “A voice and a choice for our mental health”. They offer peer-led workshops in schools talking about wellbeing for YP. Currently there are two workshops available; “Coping Better with Exam Stress”, and “The Five Ways to Wellbeing”.

Right Here also offer free resilience-building activities to people aged 18 – 25 years in Brighton and Hove. These include; creative arts for building confidence, anger management groups and “Dog Walk and Talk” a counselling and group walk for YP experiencing anxiety. They have produced a support guide about self-harm that can be accessed from their website, which has lots of other useful information and resources. [26]

Case study 6: Headspace School Support Australia

Headspace school support is funded by the Australian Federal Government and provides support for school communities to prevent and deal with suicide. This includes the provision of education and training for staff, students and parents. [27]

Case study 7: Coram Life Education – UK

Coram life education works with schools in the UK teaching children to make positive health and lifestyle choices. They cater primarily to primary school aged children, but also provide a drug and alcohol education programme for 11-13 year olds, and resources for PHSE for students with special educational needs aged 3 – 18 years. In London they have two mobile classrooms and two educators and list Southwark as a borough where they provide services. [28]

Care Co-ordination and Integration

Lack of co-ordination results in overlap, delays, frustration and inefficiency, and the New Economics Foundation estimate a significant return on investment for more integrated services [16]. However evidence of impact on outcomes is not yet clear [4]. The Youth Support Service in Surrey (Case study 8) is one example of how this can be successful.

Case study 8: Youth Support Service – Surrey

The Youth Support service uses a case management approach to support vulnerable YP who are; 16-19 years old and not in education, employment or training (NEET), 10-17 years old and are in the youth justice system, or display risk factors linked to becoming NEET [29]. Surrey County Council and Surrey CCGs have brought services together including; child in need, youth justice, the youth offending service and CAMHS. They are able to operate a single point of access and so there is “no wrong door” for YP and referrers. On visiting them they reported that they had saved 30% of their budget by bringing services together. As a team they benefit from a diverse skills mix, strong leadership vision and shared motivation. They have also seen a 60% reduction in the NEET population [30].

Young People Friendly Practices

The Department of Health has developed a set of health quality criteria for criteria for young people friendly health services. These are “based on examples of effective local practice working with young people aged under 20”. They include topics such as accessibility, publicity and joined up working, and are being implemented by providers across the UK [31]. There is evidence from two randomised controlled trials that appropriate professional training can improve performance in addressing YPs health issues [32][33]. In the focus groups and workshops YP were clear that they wanted longitudinal care from a GP that they know, and suggested that practice websites could have more information about the GPs and that GPs could be more involved in the community to get to know YP. There is some evidence that youth friendly primary care services improve access, but not much evidence that this impacts outcomes. There is also some evidence for brief interventions in primary care targeting smoking, drinking and substance misuse (both brief advice and motivational interviewing [4]).

Case study 9: Training GPs to Improve YP Health – Washington, Tyne and Wear

In Washington, Tyne and Wear, two charities (Washington Mind and Encompass Health Care) developed a training programme to improve GP’s understanding of YP’s needs and feelings. This was delivered to over 200 GPs at a CCG protected learning time event. YP from the project subsequently ran two workshops at the RCGP, and filmed an YP interviewing a GP about the consultation to breakdown myths. [3]

Dedicated YP services with a view to reaching the most vulnerable

Outreach has been shown to be effective in increasing access for ‘hard to reach’ YP, and the evaluation of the Well Centre indicates that the ‘one stop shop’ holistic hub model has made progress in providing an effective service for vulnerable YP. However, while ‘One stop shop’ models show high satisfaction rates, there is a lack of data on impact on outcomes and cost-effectiveness. There is strong evidence that targeted parenting and family interventions are useful in health promotion for vulnerable YP, and that the therapeutic relationship is particularly important for this group. [4]. Case Studies 10 and 11 give examples of one-stop-shop models, while Case Studies 12 and 13 give examples of outreach models, and Case Study 14 compares the two.

Case study 10: The Well Centre - Streatham

The Well Centre was founded in 2011, and is a youth health centre for 13 – 20 year olds. YP can drop-in between 3:30pm and 6:30pm to see a youth worker, counsellor or doctor. Herne Hill Group Practice, and a local youth work charity Redthread run the centre. [34]

Evaluation showed that significant numbers of service users were referred through multi-agency teams for children and young people, and were in care or NEET. The Well Centre has a higher documented rate of common mental health problems and substance misuse than the general practice population in London. However impact on health outcomes and cost-effectiveness is not yet determined [4].

Case study 11: Headspace - Australia

Headspace is the National Youth Mental Health Foundation in Australia. They provide early intervention mental health services to 12 – 25 year olds. They have designed a service to make it as easy as possible for YP and their families to get help with mental and physical health, work and study support and drug and alcohol services. Headspace centres are located across Australia, built and designed with input from YP. They are multidisciplinary hubs where YP can access GPs, psychologists, social workers, alcohol and drug workers, counsellors, vocational workers or youth workers. Some centres run drop-ins as well as booked appointments. They also provide online and telephone support seven days a week. [35].

A national evaluation of the service showed high satisfaction rates, and that YP felt it had improved their ability to be in education, work or training. However there was no data on outcomes or cost-effectiveness. [4]

Case study 12: A one-stop-shop in a youth setting – Liverpool

A GP practice and the Young People’s Advisory Service (YPAS) in Liverpool secured funding from the CCG to run a weekly drop-in service at YPAS, with GPs, nurse, counsellors, outreach workers and staff from other statutory services. This was available to all YP living in the city centre regardless of whether they were registered with a GP. There was low uptake initially, but once YP began to know at trust the service it became well used and liked, and Liverpool CCG have agreed to fund the project until 2017. [3]

Case study 13: A pop-up GP service in a further education college – South London

The South London GP Champions partners, Redthread and Queens Road Partnership worked with Lewisham/Southwark Further Education College (LeSoCo) to run two-hour weekly drop in GP sessions, with a youth work component, at all three university campuses, funded by the college. They find that they are seeing YP with complex and multiple needs. [3]

Case study 14: Teenage Health Demonstration Site Programme - UK

The Teenage Health Demonstration Site Programme took place in 2006-8 in 4 UK Pilot sites (Bolton, Hackney, Northumberland and Portsmouth). These different sites showed different approaches to enhancing services for YP, including the ‘one stop shop’, youth friendly mainstream services, and health provision in non-health settings. Evaluation showed that the ‘one stop shop’ was an efficient way of providing multidisciplinary care, but required YP to travel. Neighbourhood based services could be located in accessible places for deprived populations but did not deliver such a flexible holistic service. They did not assess impact on health outcomes. [4]

Better use of Technology

For YP the internet and mobile phones are an important source of health information, with one study showing that 42% of YP use the internet for this purpose, with no difference between socioeconomic and ethnic groups [36]. However there is as yet little evidence about how this can be used to improve outcomes [4]. There is a use for Apps and videos in fallow times i.e. when YP are sitting in waiting rooms.

Case study 15: Innovation Labs – Mental Health Apps and Websites for Young People

The Innovation Labs have produced Seven Apps and Websites to support YP with mental health issues, including “Doc Ready,” which helps YP prepare for appointments with their GPs, and “Madly in Love,” which provides relationship and mental health advice for YP and their partners. These resources are freely available online. [37]

Case study 16: Use of Facebook and a video to improve access – Cornwall

YP in Cornwall worked with a GP practice to devise and pilot a “Dr Grace” Facebook page, offering generic health information regarding GPs from Dr Grace. They also made a film to be used in training GPs on YP’s needs around mental health and wellbeing, and informing YP about misunderstanding they may have about GPs, including an interview with Dr Grace. They aim to empower YP to take charge of their health, understand the GP role and make appropriate use of their GPs. [3]

Case study 17: The 4:01 Show

The 4:01 Show is a YouTube support group for teenagers with nearly 25,000 subscribers. They chat to YP and celebrities about issues such as; sex and relationships, body confidence, bullying, drugs, smoking and drinking. A video was posted every Wednesday at 4:01 until one year ago, when the last video posted got 76, 000 views. [38]

Case study 18: young + healthy Haringey - App

This is an App designed for 13 – 19 year olds giving them information about local events, quick polls and surveys, games and quizzes, getting them to think about relationships and offering to get them free and confidential advice. Haringey council commissioned a company called “exposure” to design a folded card and packaging to promote the app. No evaluation data showing usage was found.

Engaging with Vulnerable YP

In order to understand the needs of vulnerable YP (e.g. looked after children, care leavers, children in need) and co-design services around their needs it is important to engage with them. Stakeholders reported that the YP who attend engagement events tend to be the same “professional engagers” and suggested engaging with a wider variety of YP by making use of existing networks, particularly in the voluntary sector and education. Two examples of how this can be done are shown in case studies 19 and 20.

Case study 19: Addressing the needs of homeless YP - Southampton

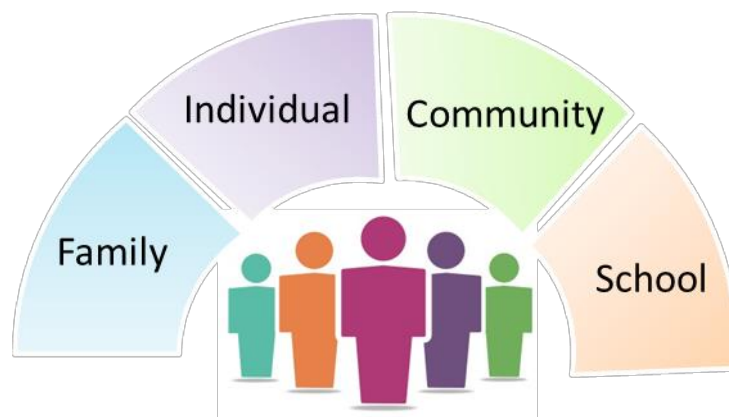
The GP Champions project found as high as 10% of young people not registered with a GP. This is particularly the case for YP leaving care, the criminal justice system or who are homeless as they may not have the formal documentation needed. A GP surgery in Southampton partnered with No Limits to survey young homeless people in order to identify the issues they were facing and gather evidence to support service improvement. [3]

Case study 20: Right Here: Using YP to consult with YP – Brighton and Hove

Right Here work with volunteers aged 16-25 years to consult with YP about their views and experiences, and create youth-led multimedia campaigns to raise awareness of issues such as mental health, self-harm and relationships. [26]

Prevention of Risky Behaviours

Overarching the question of how best to provide wellbeing services for YP is the question of how we can maximise the role of all these services in wellbeing promotion, including prevention and early intervention. Risky behaviours are affected by individual, school, family and community factors, and prevention and promotion programmes should consider how to increase protective factors and reduce risk factors across these domains. A focus on prevention takes an “invest to save approach”, and fits with the move to commission services across the whole system, allowing decisions to be made in a more holistic manner. The benefits of savings from prevention are likely to be seen across the board, for example, one study showed that more a quarter of total costs for mental health services among adolescents were incurred in the education and youth offending systems [39]. The life course model tells us that reducing risky behaviour starts even before someone is born, and there is some evidence that intervening in early and mid-childhood can have an impact on later risk [40]. Taking this approach is crucial as it will lead to healthier more resilient communities in the future.



Prevention and promotion programmes need to be tailored in order to have maximum impact for resource allocated. Design needs to consider the impact of factors affecting particular risky behaviours. Gender is one such factor; anti-social and criminal behaviours, cannabis use, unsafe sex and vehicle related risk behaviours have been shown to be more prevalent amongst boys, and tobacco smoking, self-harm and physical inactivity more prevalent among girls [41][42].

Various other socio-demographic factors have also been shown to have an effect on risk behaviours. For example, in one study being good in school was shown to be associated with increased drinking, but reduced unsafe sex [43]. Personality traits, such as impulsiveness and social anxiety have also been shown to impact risk taking behaviour [44]. There is evidence that early aggression and poor academic performance are risk factors for substance misuse [45], and that school based emotional and social learning programmes can reduce risk of aggressive behaviour problems [46]. It is also important to consider the effect of peers, as their influence on an individual’s risk behaviour becomes more important with increasing age [45].

Transition points, for example from primary school to secondary school, have been shown to be a time of increased vulnerability and to have an impact on later risky behaviour. Predictors of successful transitions include; social mobility, personal competence and resilience, education, gender, local deprivation and family support [40]. Targeting these key transition points allows universal provision of prevention programmes, including those at high risk, without labelling or stigmatising them [45].

Risk behaviours also tend to cluster, although there is a paucity of evidence for impact of programmes targeting multiple risk behaviours [40]. However the evidence does suggest that interventions with individual, school, family and community elements have the greatest impact [40]. It is also important to provide consistent messages across these multiple settings [45].

Health Promoting Schools adopt this approach to an extent, as the interventions consist of three elements: input to the curriculum, changes to the school ethos or environment or both, and engagement with families or communities or both. The nature and amount of family and community involvement varies from school to school. A Cochrane review found evidence that interventions following this framework are effective at improving BMI, physical activity, physical fitness, fruit and vegetable intake, tobacco use and being bullied. There is more evidence required regarding any impact on sexual health, mental health, violence and educational attainment [47]. What is asked of schools needs to be balanced against the time they have to deliver interventions.

There is evidence that motivational interviewing can be effective in reducing risk behaviours in older needs, recognising the need to acknowledge adolescents' role in decision-making about their behaviours [48]. The Canadian Paediatric Society recommends that adolescents be screened for potentially risky behaviours at regular health care visits, provided with messages encouraging delay of risky behaviour and promoting risk reduction strategies for those engaging in those behaviours, and use motivational intervening principles in assessing and discussing risky behaviours with adolescents. They also emphasise the importance of health care professionals being familiar with local resources [48].

Case study 21: A Selective, Personality-Targeted Prevention Program for Adolescent Alcohol Use and Misuse

A cluster randomised controlled trial was undertaken in 21 secondary schools in London. Four teachers from each school were trained to deliver brief personality- targeted interventions to YP defined as high risk (HR) on the basis of the Substance Use Risk Profile Scale. The intervention consisted of two 90 minute group sessions targeting one of the 4 personality risk factors. HR YP in the intervention schools showed 29% reduced odds of drinking and 43% reduced odds of binge drinking, and 29% reduced odds of problem drinking at 24 month follow up. The trial also showed some "herd effect" on the low risk YP. The mean age of YP taking part was 13.7 with a standard deviation of 0.33 years. [49]

Funding available

TBC

Service enhancement opportunities

Service enhancement opportunities are presented in terms of the service gaps mapped to the key areas of need as identified above.

Mental health, self-harm and emotional resilience

- Develop clear, straightforward and widely known pathways for those YP who need psychological support but do not meet the CAMHS referral thresholds or who are on waiting lists
- Improve support for YP transitioning between child and adult mental health services.
 - ✓ Training of the health and social care workforce in supporting adolescents with emotional distress and in directing them appropriately to available services, both face-to-face, online and apps.
 - ✓ Production of clear information on options for YP that can be given to them in leaflet form and online
 - ✓ Investigate the possibility of providing referrals from GP Surgeries into voluntary sector counselling and other voluntary sector services (see Case Study 1)
 - ✓ Training the workforce on the subject of children and young people who self-harm, with a view to reducing stigma and encouraging frank and open conversations in both educational and healthcare settings. Professionals need to feel able to ask YP about self-harm and know what to do when it is identified.

Sexual Health

- Sexual health outreach to vulnerable groups, such as those in hostels and the youth offending service
 - ✓ Consider commissioning sexual health outreach services to hostels, homeless shelters, the youth offending service and other vulnerable groups – developing existing services to co-ordinate this approach if possible (see Case Study 3)
 - ✓ Assess viability of providing sexual health and contraception services in schools
 - ✓ Consider using school nurses to provide sexual health advice using a telephone service (see Case Study 5)

Health Education

- Consistent sexual health education, particularly in school based settings, and surrounding healthy relationships
- Education in schools around: general and mental health, substance misuse, emotional resilience, and life skills, using peer support and health professionals
 - ✓ Investigate whether the community and family engagement component of Health Promoting Schools programme could be strengthened, and look at delivering health promotion messages consistently across school, family and community components.
 - ✓ As part of this, consider commissioning voluntary sector organisations working with YP, in partnership with healthcare professionals (e.g. a local GP Surgery), to assist in providing health education in schools, making use of peer support. Ideally, part of this service would include up-skilling staff and providing education for parents (See Case Studies 5 and 6). This might be particularly valuable at transition points.

Care Co-ordination and Integration

- Greater care co-ordination and integration, breaking down siloes and improving communication between agencies
- ✓ Consider whether services for vulnerable YP (child in need, youth offending system, CAMHS etc.) could be brought together, or have a single point of access so there is “no wrong door” for vulnerable YP or referrers (see Case Study 8).
- ✓ Training the workforce regarding services available and how to access them.

Young People Friendly General Practice

- Greater proportion of “YP Friendly” General Practices
- ✓ Engage with General Practice to discover enabling factors and barriers to them becoming “YP Friendly”, and develop a plan to promote this approach
- ✓ Consider introduction of a “Teen Health Check” template, possibly linked to a Key Performance Indicator (KPI) in order to encourage GPs to ask about issues such as sexual health, smoking, substance misuse, youth violence, physical activity, health eating and self-harm, and give an opportunity for brief advice and motivational interviewing.
- ✓ Training and education for GPs to improve understanding of YP’s needs and feelings. This could be done in partnership with the voluntary sector and co-produced with YP (see Case Study 9)

Reaching the most Vulnerable

- Dedicated YP service with a view to reaching the most vulnerable
- Engagement strategies to reach the most vulnerable, making use of existing networks

- ✓ Work in partnership with schools and voluntary sector organisations to engage with vulnerable YP through existing networks, using surveys, workshops and focus groups (see Case Study 19)
- ✓ This work could be used to co-produce multi-media health promotion campaigns with YP (see Case Study 20)
- ✓ Use this work to gauge demand for a holistic “one-stop-shop” youth hub for health, or an outreach approach with pop-up clinics in places YP already go. There is evidence that both these approaches are valuable in reaching vulnerable YP, but each has advantages and disadvantages (see Case Studies 10 – 14)
- ✓ Investigate commissioning either a “one-stop-shop” youth hub, pop-up multidisciplinary YP clinics or both – this will need to follow a detailed analysis and comparison of costs for both options and funding streams available.
- ✓ Strengthening existing services for child sexual exploitation (CSE) and raising awareness of referral pathways

Better Use of Technology

- Development of website to include more online resources, and/or and App
- ✓ Training of the workforce to promote online resources that are already developed and free to use (see Case Studies 15 and 17)
- ✓ Further development and promotion of the Southwark YP website
- ✓ Consider producing a Southwark YP App with resources covering self-harm, mental health, sexual health, youth violence, substance misuse etc., ways to access confidential advice, and quick polls and surveys so YP can have a say in services.

Research and Evaluation

It has been apparent from the case studies that, while there are a lot of innovative services for YP there is a paucity of information on cost-effectiveness and their effect on outcomes. It would be prudent to ensure that new initiatives were used as a basis for research and evaluation to establish these things. However it should be borne in mind that the true benefits for YP from these services will likely be seen in the long term rather than the short term and evaluation would need to take this into account.

Challenges

- True extent of impact on outcomes will not be seen for many years and is difficult to measure. Therefore it is more difficult to demonstrate cost-effectiveness in the short term
- Achieving buy-in and investment across a wide range of stakeholders across education, health and social care.

7. Conclusion and Recommendations

Young people (aged 10-25 years) make up 21% of the population of Southwark [1]. They are an important group for early intervention and prevention as if the ten major risk factors for adult disease, five are heavily shaped in adolescence, with 75% of lifetime mental health disorders (excluding dementia) starting before the age of 24 years [4]. Risk behaviours that were identified as being important in Southwark by the JSNA and local stakeholders are: self-harm, substance misuse, gang violence, and sexual health. . When considering risky behaviour in this cohort it is also important to consider smoking, obesity and lack of physical activity as these are significant risk factors for adult disease.

There has been a move in both national and local policy to commission for population groups rather than on the basis of providers, and YP have been selected as one of the population groups in Southwark that would benefit from this approach [10][12]. The Southwark Children and Young People’s Wellbeing Strategic Framework is therefore being developed as a joint framework for commissioning local CYP services by NHS Southwark CCG and Southwark Council for 2016-2021. One of the works-streams for this framework is: Young People’s Health, 10-25 years, including sexual health, drugs misuse, self-harm and youth violence. This report has reviewed the existing service provision for this population, in terms of these issues, and identified service enhancement opportunities in order to inform this work-stream. Mapping of existing services and engagement with stakeholders and local YP was undertaken to identify key areas of need and service strengths and gaps, as shown in Figure 7. Overarching all of these needs is the importance of investing in prevention.

Figure 7: Summary of service strengths and gaps mapped to key areas of need.

Service Strengths	Key Areas of Need	Service Gaps
CAMHS transformation money being spent on: youth worker in A&E for self-harm, workforce for early help and training about body image, resilience and prevention in schools	Mental health, self-harm and emotional resilience	Clear and widely known pathways for YP who need psychological support who do not meet the CAMHS referral thresholds and to help those on CAMHS waiting lists
Multiple options for sexual health services. SH:24 offering an innovative service	Sexual Health	Improved transition between child and adult mental health services
Youth Violence Intervention Programme in A&Es	Youth Violence	Sexual health outreach to vulnerable groups, such as those in hostels and the youth offending service
Insight Southwark provide diverse access options, and a broad range of help and advice	Substance Misuse	Consistent sexual health education, particularly in school based settings, and surrounding healthy relationships
Transformation funding to build capacity and workforce in schools bring education and CYP mental health services together	Health Education	Consistent education in schools around: general and mental health, substance misuse, emotional resilience, self-harm and life skills, using peer support and health professionals
GPs seen as doing a good job overall	Holistic and Co-ordinated Care	There is scope for greater care co-ordination and integration, breaking down siloes and improving communication between agencies
Practice becoming “YP Friendly”	Reaching the Most Vulnerable	Greater proportion of “YP Friendly” General Practices
YP can attend The Well Centre one-stop shop	Better Use of Technology	Dedicated YP service with a view to reaching the most vulnerable- Development of YP website to include more online resources, and/or an App
Pop-up GP clinics at LESOCO	Improved Engagement Strategies	Engagement strategies to reach the most vulnerable, making use of existing networks
CAMHS provide workers at the youth offending service and training for foster carers		
Website: whtvr.org for YP in Southwark		
Previous extensive engagement with YP		

A review of evidence and different service models was undertaken and a list of service enhancement opportunities was identified. These are now framed as a list of recommendations for consideration by the CYP CDG.

Recommendations:

1. Maximise Prevention and Early Intervention

- ✓ Work with public health colleagues to implement effective interventions for this cohort
- ✓ Implementation of the Healthy Child Pathway (0-19) as this will build protective factors against risky behaviours and their harms, by strengthening individual, community, family and school factors.
- ✓ Investigate whether the community and family engagement component of Health Promoting Schools programme could be strengthened, and look at delivering health promotion messages consistently across school, family and community components.
- ✓ As part of this, consider commissioning voluntary sector organisations working with YP, in partnership with healthcare professionals (e.g. a local GP Surgery), to assist in providing health education in schools, making use of peer support. Ideally, part of this service would include up-skilling staff and providing education for parents. Interventions could be targeted by gender, and at transition points. A similar service could also be commissioned in colleges, universities and job centres in order to reach the 18-25yrs age group
- ✓ Training of the health and social care workforce (e.g. GPs, Practice Nurses etc.) in brief advice or motivational interviewing on risk behaviours (including smoking, substance misuse, sexual health, self-harm, youth violence, diet and physical activity)
- ✓ Consider introduction of a “Teen Health Check” template, possibly linked to a Key Performance Indicator (KPI) in order to encourage GPs to ask about issues such as sexual health, substance misuse, smoking, youth violence, physical activity and self-harm, and give an opportunity for brief advice or motivational interviewing. CYPHP have developed a template which could be used for this purpose.

2. Provide Appropriate and Accessible Health Services for YP

i. Strengthening Existing Services and Pathways

- ✓ Clear, straightforward, and widely known pathways for YP not meeting the CAMHS referral thresholds and on waiting lists, and communication of these pathways to care workers and YP. This should include improving the pathway for transition between child and adult mental health services
- ✓ Investigate the possibility of providing referrals from GP Surgeries into voluntary sector counselling and other voluntary sector services
- ✓ Consider whether services for vulnerable YP (child in need, youth offending system, CAMHS etc.) could be brought together, or have a single point of access so there is “no wrong door” for vulnerable YP or referrers
- ✓ Engage with General Practice to discover enabling factors and barriers to them becoming “YP Friendly”, and develop a plan to promote this approach. There is an opportunity to collaborate with the CYPHP in their work on this.
- ✓ Strengthening existing services for CSE and raising awareness of referral pathways

ii. Workforce development

- ✓ Training of the health, education and social care workforce in supporting adolescents with emotional distress, and enabling them to direct YP appropriately to available services, both face-to-face, online and apps.
- ✓ Training of the workforce to identify those at risk of CSE
- ✓ Training and education for GPs to improve understanding of YP's needs and feelings. This could be done in partnership with the voluntary sector and co-produced with YP
- ✓ Training the workforce on the subject of children and young people who self-harm

iii. Improved Resources

- ✓ Production of clear information on service options for YP that can be given to them in leaflet form and online
- ✓ Further development and promotion of the Southwark YP website: whtvr.org
- ✓ Consider producing a Southwark YP App with resources covering self-harm, mental health, sexual health, youth violence, substance misuse, smoking etc., ways to access confidential advice, and quick polls and surveys so YP can have a say in services. There is an opportunity to collaborate with CYPHP who have produced an App, rather than developing something de novo.
- ✓ Explore other methods of information dissemination, technologies and tools

iv. Consideration of New Services

- ✓ Consider commissioning a targeted health outreach service to vulnerable young people, which could also address their sexual health, and other holistic health and wellbeing needs. This could include looked after children (LAC), homeless and learning disabled YP and those in the youth offending service (YOS) and supported accommodation. CYPHP are piloting the use of a LAC nurse to work with hard to reach and out of borough LAC. This service should be reviewed with the intent of assessing it's suitability for commissioning in 2018/19
- ✓ Further engagement work to assess viability of providing sexual health and contraception services in schools. Engagement results thus far on this subject have been mixed.
- ✓ Consider using school nurses to provide sexual health advice using a telephone service. CYPHP are piloting this service and so a review could be undertaken to assess suitability for commissioning in 2018/19.
- ✓ Investigate commissioning voluntary sector organisations working with YP, in partnership with healthcare professionals (e.g. a local GP Surgery), to provide health education in schools, making use of peer support. Ideally, part of this service would include up-skilling school staff and providing education for parents. A similar service could also be commissioned in colleges, universities and job centres in order to reach the 18-25yrs age group.
- ✓ Consider commissioning either a holistic "one-stop-shop" youth hub for health, or an outreach approach with pop-up clinics in places YP already go (schools, colleges, job centres, youth groups, youth offending service etc.) There is evidence that both these

approaches are valuable in reaching vulnerable YP, but each has advantages and disadvantages. The most effective model is likely to be a “hub and spokes” model, with a central youth hub and outreach services stemming from that. However there is a paucity of data on cost effectiveness for a “one-stop-shop” youth hub, and in the absence of this it is difficult to justify the expenditure that would be required, particularly given the current financial climate. Pop-up clinics in places YP already go provide a way to offer a holistic youth-specific service without the cost of real estate that would be required for a hub. Evaluation of cost-effectiveness of this model could then be used to justify the cost of a hub further down the line. NHS Southwark CCGs local plans for primary care to be delivered at scale also offers an option for providing YP specific services for a larger practice population, and this would contribute to research and evaluation of service models. Discussions could be had with the federations regarding providing a clinic for YP alongside the existing extended access services, perhaps with a mixture of walk-in and pre-booked slots, and making use of a GP and youth worker. This would offer an opportunity to provide brief interventions on risk behaviours and promote healthy lifestyles.

- ✓ With the advent of Multi-Speciality Community Providers there is an opportunity to consider how this cohort could benefit from an integrated community multi-disciplinary team.

v. Further Understanding the Needs or YP – Engaging with Vulnerable YP

- ✓ Work in partnership with schools and voluntary sector organisations to engage with vulnerable YP through existing networks, using surveys, workshops and focus groups
- ✓ This work could be used to co-produce multi-media health promotion campaigns with YP, and to gauge demand for dedicated YP services.

Suggested Next Steps

1. Form a multidisciplinary steering group
2. Develop logic models to assess how services map to improving outcomes
3. Engagement with stakeholders, schools, voluntary sector organisations and the health and social care workforce in order to test and refine recommendations
4. Undertake a detailed analysis of costs, including affordability and market capability in order to prioritise recommendations

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Appendix A: List of Documents Reviewed

Key high-level documents were identified by looking at reports commissioned by the Department of Health, the Chief Medical Officers Report, reports released by Southwark CCG and Local Authority regarding Young People's Health and Wellbeing, and those recommended by stakeholders. Information in these documents was used to inform meetings with stakeholders, and to contribute to the identification of key areas of need

Local

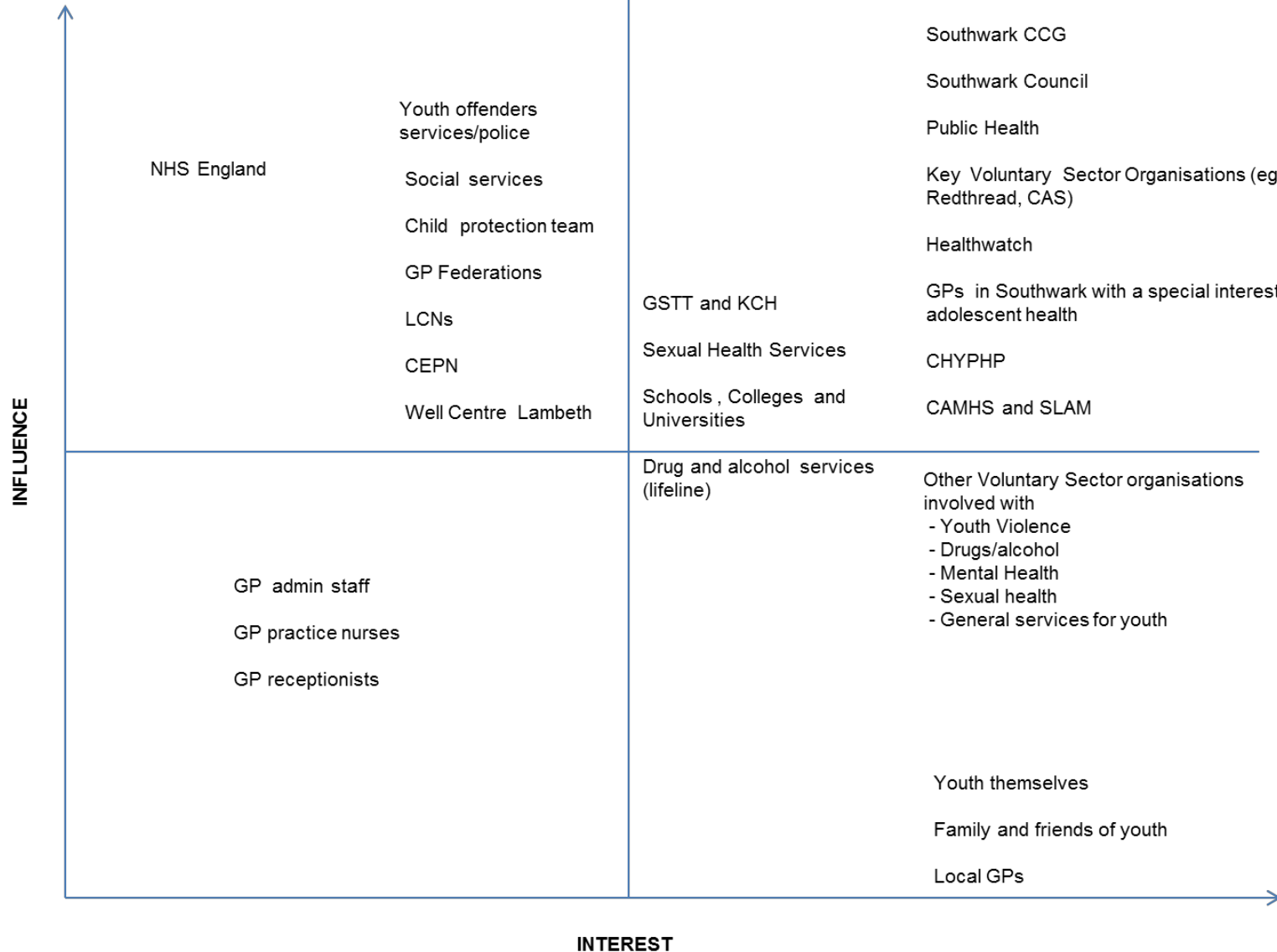
- Southwark Children and Young Peoples' Health and Care Strategic framework 2016-2021
- Southwark Council Transformation Plan
- Public Health/CYPHP Joint Strategic Needs Assessment
- Southwark Report: Wellbeing and Mental Health for Young People (14-25) 2014
- Southwark's 1000 Lives Exercise Stories
- 1000 Journeys
- Children and Young People's Partnership Youth Panel Report, October 2015
- Schools survey Southwark

National

- NHS 5 Year Forward View
- Children and Young Peoples' Health Outcomes Forum Report
- You're Welcome – Quality Criteria for young people friendly health services
- Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays
- Future in Mind
- What about youth
- Association of Young People's Health needs and gap analysis

Appendix B: Stakeholder Map

STAKEHOLDER MAPPING – YOUNG PEOPLES’ HEALTH



Appendix C: Engagement Log

Organisation	External Attendees	Date
Public Health	Abdu Mohiddin	16.12.15
Local GP with Special Interest in YP health	Nicola Hanson	18.1.16
CYPHP	Janet Lailey	4.2.16
Cambridge House	Karin Woodley, Charlotte Gilsenan, Jo Hrabí, Joe Schwartz	11.2.16
Southwark CCG	Linda Drake	10.3.16
Redthread/Well Centre	John Poyton	12.2.16
Southwark Council	Lee Souter	17.3.16
Well Centre	Stephanie Lamb	17.3.16
Sexual health	Jennifer Reiter	3.3.16
CAMHS commissioner	Carol-Ann Murray	22.2.16
KCH (SLAM)	Virginia Davies	24.3.16
KCH (Paeds)	Omowunmi Akindolie	24.3.15
Surrey Youth Support Service	Ben Byrne	11.4.16
KCH (management)	Megan Beardsmore-Rust	21.4.16
Public Health (NB semi-structured interview not done)	Kirsten Watters	26.5.16

Appendix D: Interview Details

Interview details are shown in the form of thematic analysis. Table 1 shows thematic analysis of key areas of need. Table 2 shows thematic analysis regarding service gaps.

Table 1: Thematic analysis of stakeholder interviews – key areas of need

Themes	
<p>i. Reaching the most vulnerable</p>	<p><i>“need to provide services for those who are vulnerable or on the edge of vulnerability”</i></p> <p><i>“Vulnerable young people are not accessing mainstream services and there is a need to address their wellbeing in a holistic way”</i></p> <p><i>“The system is not geared to vulnerable groups”</i></p>
<p>ii. Mental Health, self-harm and emotional resilience</p>	<p><i>“Mental health, social media, cyber-bullying and self-harm are important”</i></p> <p><i>“The Head Teachers’ Executive feel there is a declining picture in terms of emotional wellbeing and mental health”</i></p> <p><i>“Self-harm is a massive issue- most of it is hidden, prevention and early intervention are key”</i></p> <p><i>“emotional resilience related to neglect, need to strengthen family structures”</i></p> <p><i>“need work around mental health, emotional wellbeing including resilience, social and moral development, identity and sense of belonging and all aspect so self-esteem and sense of self”</i></p>
<p>iii. Holistic care</p>	<p><i>“GPs and community workers need to think more about the whole person, and understand better the dynamics of family life”</i></p> <p><i>“YP need access to gyms, healthy living programmes and basic training in how to</i></p>

	<i>look after themselves, for example cooking, cleaning, shopping well”</i>
iv. Sexual Health	<p><i>“We have the highest rates of STIs in London”</i></p> <p><i>“Need ongoing engagement and support with youth offenders regarding attitudes to women and sex”</i></p> <p><i>“There is a need for healthy relationships education, and to explore understandings of cultural issues around sex and relationships”</i></p>
v. Youth violence	<p><i>“Gang violence is not such a problem for young people, this actually tends to affect the older age groups. There is more an issue with antisocial behaviour and youth violence. There are still no-go areas for different youths but this isn’t related to gangs in the traditional sense of the word”</i></p> <p><i>“There is an issue with violence against women and girls”</i></p>
vi. Health education in schools	<p><i>“We need to get information and education to children in a standardised way when there are issues with getting in to schools. At the moment schools that are already good at this are more likely to let you in so this leads to greater inequality”</i></p> <p><i>“we need to develop healthy working relationships with schools that allow us to engage and support”</i></p>
vii. Better use of Technology	<i>“We need to speak their language and utilise technology better, for example using mobile phones and face time for consultations”</i>
viii. Improved Engagement strategies	<p><i>“We need to ask young people what they need”</i></p> <p><i>“We need to engage with a broader</i></p>

	<p><i>range of youth including those who are disabled and those in the Youth offending System. We need to go where they are. I am concerned that engagement work is being done with the same group of people every time who have become ‘professionals’</i></p> <p><i>“Engagement work needs to change commissioning”</i></p> <p><i>“We need measurable outcomes, that are designed by YP that are fit for purpose”</i></p> <p><i>“There is a need for reseatch from places such as Cambridge House that already have good relationships with young people who are not engaging”</i></p> <p><i>“We need co-created healthcare in consultation with young people”</i></p>
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Table 2: Thematic analysis of stakeholder interviews – service gaps

Themes	
i. Joined up resources	<p><i>“There are communication issues with voluntary sector organisations”</i></p> <p><i>“services are scattergun with lots of different people providing similar or the same services”</i></p> <p><i>“There are lots of different focussed areas of work, but perhaps not understanding the real needs, and there is an understanding or where we are not reaching but this is not translating into a policy drive”</i></p>

	<p><i>“There is lots of siloed working rather than a joined up offer, especially with respect to vulnerable young people”</i></p> <p><i>“The offer is not consistent across all services an often the right individuals don’t access services”</i></p> <p><i>“There needs to be more transitions across specialisms, commissioned siloes and different age ranges, leading to better joined up services”</i></p> <p><i>“We need more resources joined up more effectively, better care co-ordination, good signposting and advocates”</i></p> <p><i>“There needs to be greater consistency, being smarter with investment and communicating with all individuals that it is everyone’s business, with a drive to a multi-agency approach and key individuals coming together and sharing”</i></p> <p><i>“We need to be sell siloed and less hidebound by where budgets end”</i></p> <p><i>“We need to put things together better, and probably wouldn’t need more money if this was done well”</i></p>
<p>ii. CAMHS waiting lists and referral thresholds</p>	<p><i>“There are problems with CAMHS waiting lists and referral thresholds”</i></p> <p><i>“CAMHS waiting times are a service gap”</i></p> <p><i>“CAMHS and social services thresholds are high”</i></p>

	<p><i>“We need better early intervention mental health work”</i></p>
<p>iii. Lack of a dedicated YP service, especially for the most vulnerable</p>	<p><i>“There is no base for youth work.....we need access to either pop ups in GP surgeries or drop in services”</i></p> <p><i>“YP in general are a neglected group”</i></p> <p><i>“There is a group of vulnerable young people, and those on the edger of vulnerability, who are not good at accessing primary care, who we are not doing anything for”</i></p> <p><i>“There is difficulty in meeting the expressed needs of young people, i.e. a stand-alone service near where they live that can be accessed when they need it, in the context of health economics”</i></p> <p><i>“We need to strengthen the universal offer for young people and provide something more for those who need it, working in partnership using existing knowledge from the needs assessment. An adolescent template would be helpful”</i></p> <p><i>“ We need to do something for vulnerable youth and those at the edge – this will need to be co-ordinated, approachable and accessible, and it will take time to build up trust”</i></p> <p><i>“We need a hub and spokes model. A youth hub like the Well Centre is seen as being best practice”</i></p> <p><i>“We need a dedicated offer for vulnerable young people who aren’t</i></p>

	<p><i>accessing mainstream services, a combination of joined-up working and targeted outreach workers”</i></p> <p><i>“ideally we would have a one stop shop for young people”</i></p> <p><i>“We need people to fight for Youth”</i></p> <p><i>“Adolescents are unpredictable, impulsive attenders, they need a service where if they think ‘I need it now’ they can access is. A clean space”</i></p>
<p>iv. Lack of consistent funding</p>	<p><i>“There have been cuts from the local authority in the last 6 years and a lack of funding for VSOs for young people who wouldn’t access statutory service provision”</i></p> <p><i>“There is a lot of short-termism, running things for a bit and then stopping. We need to look everywhere and see what is working elsewhere and do something big and ambitious. We need to DO something, and use the results of this for research “</i></p> <p><i>“We need to tackle the artificial nature of funding, looking at the whole system and thinking through the logical conclusions of actions as what may seem like a cost saving in the short term ends up being a cost later on”</i></p>
<p>v. YP friendly practices</p>	<p><i>“Practices in general are not especially YP friendly, we could consider a young person’s board in the waiting rooms, STI testing in the toilets and young person friendly reception staff”</i></p> <p><i>“We need a young person’s template or teen health check to be used in general practice and to make practices more</i></p>

	<p><i>young person friendly”</i></p> <p><i>“We need training for GPs in young people’s health”</i></p> <p><i>“We should apply young people friendly standards in practices”</i></p>
vi. Services for transition	<p><i>“There is a problem with services for the 16-17yrs age bracket and services for the transition period between childhood and adulthood; some services treat this age group as adults, some as children”</i></p> <p><i>“We need better transition points”</i></p>
vii. Service for those at risk of CSE	<p><i>“There is no dedicated service for those who are at risk of CSE”</i></p> <p><i>“We need targeted one:one service based on estimates for CSE”</i></p>
viii. Outreach work	<p><i>“There are no outreach workers in hostels or supported accommodation, and no-one in the YOS is asking about sexual health”</i></p> <p><i>“There should be outreach work using existing networks, and using focus groups. If we base the strategy on the most excluded this will benefit everyone else too”</i></p> <p><i>“Maybe we could embed GPs in A&E”</i></p> <p><i>“We should expand the A&E work from gang violence to other things such as self-harm and sexual health”</i></p>
ix. Local healthy environment	<p><i>“We need to make sure that there is a healthy local environment for healthy eating and exercise, for example should there be Burger Kings or Costas in</i></p>

	<i>hospitals?”</i>
x. Use of technology and online resources	<p><i>“The young person’s website doesn’t have much information”</i></p> <p><i>“enhanced use of new technology, like something similar to SH:24”</i></p> <p><i>“it would be good to have an information portal or website”</i></p> <p><i>“We need a well maintained website with reliable information. Could use online resources such as MindEd or ZenZone”</i></p> <p><i>“ We need to use the fallow times better, options other than putting an x-box in a waiting room”</i></p>
xi. Consistent health education in schools	<p><i>“Unless education regarding substance misuse, knife crime and sexual health is on the radar for academies to teach then it may not be in the curriculum”</i></p> <p><i>“We also need to look at the independent sector as there is risky behaviour there too, especially self-harm”</i></p> <p><i>“There should be more crossover between education and health – more time for health in the curriculum, listening more to what teachers are saying, health professionals in schools, sharing of budgets”</i></p>

Appendix E: Report from focus group with StandUp Southwark

Summary of notes taken at engagement meeting with young people who have been involved in the Standup Southwark Service / Programme over the past few years

Date and time of meeting: 7th March 2016, 7-9pm

Location: Level 2, Cambridge House, 1 Addington Square, London SE5 0HF

Participants: Dr Sarah Teague, Matt Norman, Jo Hrabí, 6 YP from Standup Southwark.

Authors: Matt Norman, Sarah Teague, Jo Hrabí

Notes:

Health services in Southwark:

- Broad barriers that Young People (YP) face when thinking about making a GP appointment include:
 - The need to tell their parents in some cases (this is particularly difficult if the concern surrounds sexual or mental health);
 - The inconvenience of travelling (YP often do not have sufficient funds to take public transport);
 - The price of prescriptions has convinced at least one of the YP not to pick up the medication they were prescribed;
 - They did not know how to adequately express their depression or other MH needs;
 - Other YP can judge them for attending a sexual health clinic.
- The appointment-booking process was discussed, as it does not fit well into the YPs' lifestyles:
 - Appointments generally need to be made on the same day, very early in the morning. This is particularly difficult for YP with MH issues, who have a disturbed sleep routine;
 - It was suggested that home visiting doctors should be available for YP who find it difficult to function when depressed;
 - The YP often do not have credit on their phones to make the call in the first place;
 - One YP was satisfied with the process in her practice: the GP calls the patient back to have a brief discussion about the health issue, then offers an appointment at the patient's convenience. This kind of telephone appointment service is inconsistently delivered across the borough.
- The YP mentioned they are reticent to make appointments in the first place: "We are still discovering ourselves; you automatically think nothing is wrong, are you exaggerating, should you really be there [at the GP practice]?"
- Issues with Mental Health services reported by young people who have had interactions with these services (both historically and currently):
 - A lack of holistic support raised as an issue
 - One young person reported miscommunication meant missing initial screening appointment

- They have been asked the same questions at various appointments over time, by a number of professionals, and feel there was no overall record that all could refer to.
- A lack of confidence in health services and modern medicine was raised as a potential reason young people don't access certain services.
- The YP are extremely distrustful of the pharmaceutical industry; they expressed their strong belief that the companies were only interested in making money, and that many drugs create side effects that will then need to be treated with even more drugs. They mentioned that the companies sell 'a lie', and that they had been taught about the 'placebo effect' at school. They asked why GP's do not prescribe holistic medications and natural remedies rather than just pharmaceutical drugs.
- Prevention is the major area where health services can improve for young people:
 - Improve PSHE in schools – healthy eating, sexual education, substance misuse, finding out about yourself as a person, discussing emotions.
 - There is a need to provide young people with more general life skills through educational settings – i.e. paying rent, bills, etc.
 - Building relationships and increasing integration and connections in society was seen as important. Peer advocates from the community could be used to promote certain health focus areas – i.e. sexual health, depression – and as a bridge between YP and GPs – the YP in the session were willing to volunteer their services.
 - GPs and voluntary advocates (in particular peer support) should complete a lot more outreach work, in particular to schools and youth clubs, especially in deprived areas.
 - YP should be re-educated about mental illness – the term itself should be changed as there is a huge amount of stigma surrounding the word 'mental' – so that it becomes the 'norm'. A proposed name for the workshops in schools was 'emotional resilience'.
 - There would be value in General Practice delivering services in an educational setting, to increase trust and utilisation of services in young people. Particularly using a combination of GPs, peer advocates and youth workers in order to facilitate discussions about issues such as self-harm.
- One of the YP commented "I would like to have a GP I know", which inspired a discussion about 'humanising' GPs, providing them with experiences that will help them to identify more with the YP. Ideas discussed were:
 - GPs should consider connecting more with local services;
 - GPs should consider visiting youth clubs, schools etc, particularly in more deprived areas;
 - GPs should possibly have a small 'spiel' on their practice website, highlighting personal interests etc.
- GP's were praised as doing a great job overall, but are too busy to pick up on some issues with young people – particularly with regards to mental health problem
- It was discussed that there are no specific Youth Health Services, with the exception of CAMHS and CMHT.

Young person’s health in Southwark:

- Mental Health is a major issue for young people: self-esteem, body image, bullying – technology and modern advertising creates the idea that you should be perfect which can create insecurities.
- Sexual Health is major issue for young people: risky behaviour is very common. Sex is being normalised through technology – i.e. internet, social media. There is an apparent lack of understanding about STI’s, their symptoms, and the long term effects.
- Substance misuse, particularly with smoking marijuana has increased in young people in the borough. Stronger drugs are increasing the effects of misuse.
- Social Media plays a big part in the YP’s lives – they discussed how it has created a ‘disconnect’, with few real conversations taking place, particularly about health concerns: “Everything is meant to be perfect [in reference to the way life is portrayed on social media], so you feel resentful that you need to go [to the doctor]”. (This was particularly true for Mental Health concerns). There was a feeling that social media leads to disconnection in communities which contributes to lack of resilience

“You don’t know yourself and so you doubt that something is wrong”

“It’s all about relationships”

“We are taught in school that the placebo effect is a thing”

“You need to build self-esteem, confidence and resilience so when you reach barriers you can deal”

“It is important to have people that identify with the person they are trying to reach”

“You are not given the holistic support that you need”

Appendix F: Personas

Shahida

A teenager with sexual health concerns

Age: 15
Ethnicity: British-Asian
Occupation: Student
Housing: 4 bedroom semi-detached house, privately owned
Education: At secondary school, enjoying it and doing well
Languages spoken: English, Urdu



Background

- Shahida's family is very important to her and she enjoys spending time with her friends and boyfriend.
- She wants to do well at school so she can go to university. She loves "One Born Every Minute" and would like to be a midwife.
- Shahida lives with her mum, who has arthritis, her 7yr old sister and her dad who works for an investment bank in the city

Well-being

- Shahida has just started having sex with her 17yr old boyfriend but he won't use a condom. She knows he has had sex with other people and is worried about the risks of infection and pregnancy
- One of her friends had to have an abortion recently and she doesn't want the same to happen to her
- She has had asthma since she was a child, but doesn't tend to get symptoms very often.

Day to day life

- Shahida is doing well at school, enjoys lessons and seeing friends
- School is an hour away and she needs to help with cooking and shopping at home as her mum has arthritis. This means she can't go out with friends after school but she talks to them all the time on WhatsApp
- Shadida is not sure that her current boyfriend is "the one" and has not told her parents about him. She felt ready to have sex with him but feels guilty as she knows her parents won't approve.

Well-being attitudes

- Shahida's health is important to her, she views this as eating healthily, staying thin and having well controlled asthma
- A Pharmacist provided Shahida with morning after pill after her first time having sex, but the encounter felt awkward so she doesn't want to go back
- Shahida is scared to see GP for contraception as worried they will be judgemental and might tell her mum. She finds it difficult to get an appointment anyway because of school and helping her mum.
- She doesn't want to attend the sexual health clinic as she is concerned that someone will see her going in
- Shadida goes to A&E 3 or 4 times every winter with her asthma, but has never needed to stay in overnight, she is always sent home with steroids and antibiotics.

Tyrone

Joined a gang to help his family and gain respect

Background

- The most important things to Tyrone are respect and money
- Tyrone's dad left shortly after his younger brother was born. He lives with his mum and his 8yr old brother.
- He cares about his mum and his brothers and feels responsible for looking after them while his older brother is in prison

Well-being

- Tyrone is rarely unwell
- He was cut with a knife to his face going into elephant and castle tube station a year ago. Probably by a rival gang member. The scar makes him feel manly.

Age: 13yrs

Ethnicity: Black-British

Occupation: Student

Housing: 2 bedroom council flat in Camberwell

Education: At secondary school, missing lots of lessons

Languages spoken: English



Money and respect... that's what matters

Day to day life

- Tyrone has been working as a runner for a gang for the past year, earning some money for taking packages from place to place. This helps to earn extra money for the family as his younger brother has sickle cell disease, and his mum is struggling to both care for him and work enough to make ends meet.
- Tyrone has been skipping school because it doesn't seem relevant; he is making lots of money working for the gang and he wants to move up the hierarchy as then he will be able to make more money. School won't help him do this.
- His older brother is higher up in the gang but is currently in prison. He used to help with family finances and had fancy trainers and an x-box.

Well-being attitudes

- Tyrone doesn't think much about his health, but he does want to be muscular so he is using his older brother's weights and is drinking protein shakes to bulk up
- Tyrone wouldn't go to see a doctor unless he was really sick, like if he had been stabbed or thought he was going to die
- He wouldn't see his GP as they can't offer him an appointment when he needs one. He doesn't want to wait to see a doctor so he would go to A&E.

Mark

A young gay man struggling with self-harm and drugs

Background

- Mark grew up in Wigan and was looked after by his grandmother since he was 7yrs old because of abuse. He moved to London for university and is finding adjusting to London life difficult, struggling to make friends and feeling isolated
- He would like to lose weight and get fit
- Mark came out as gay last year. He would really like a boyfriend and started using Grindr to meet people.
- Mark would like to do well at university and own his own graphic design business one day

Well-being

- Mark takes GHB and binge drinks at parties. He has smoked cigarettes since he was 12yrs old, and has just started smoking skunk.
- He has had anxiety and depression for many years now, and he intermittently self-harms to release pent up emotions. He cut himself last week with a razor on his thigh. He is feeling low and having thoughts of being better off dead.
- He is overweight and this has contributed to poor self-esteem

Age: 18yrs

Ethnicity: White-British

Occupation: Student

Housing: University Halls in Bermondsey

Education: Studying Graphic design at London South Bank University

Languages spoken: English



Day to day life

- Mark would like to be accepted by people at university and have a stable group of friends. He has been on a couple of dates with guys from Grindr, but feels that most of the men on there are only interested in having random sex and not in relationships.
- He was offered GHB at a sex party he went to with a guy he met on Grindr and he found that this made him feel less self-conscious about his body and he enjoyed the party more. There are bits of some parties that he doesn't remember which worries him, as he isn't sure condoms were always used.
- Mark has been feeling more low in mood when he is sober and has started feeling anxious about his studies as he is missing lectures and finding it difficult to concentrate when he does attend. He has been having thoughts of being better off dead but does not think he would act on these.

Well-being attitudes

- Mark has had various counsellors over the years with varying success. He had just started to form a good relationship with one in Wigan when he left for university
- He has called the Samaritans twice since he started university to talk through his negative thoughts.
- He has considered seeing a university counsellor but is worried about explaining everything to someone new, particularly concerning his drug use.
- Mark is not registered with a GP. He has had good and bad experiences with them in the past, some being supportive and some not seeming to care about him much.

Maria

Starting to feel anxious about everything

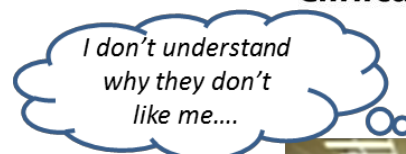
Age: 13yrs

Ethnicity: Latin American

Housing: Lives with Mum in 2 bed rented flat in Elephant and Castle

Education: At Notre Dame School

Languages spoken: English, Spanish



Background

- Maria and her mum moved to London from Colombia when Maria was 3yrs old
- She and her mum have a close relationship and her mum is working as a receptionist at a local company
- Maria enjoys reading books, going to the cinema and visiting relatives in Colombia

Well-being

- Maria has been feeling worried about lots of things recently, and she has been feeling quite sad about life in general.
- She is finding that other girls at school make nasty comments about her. She doesn't think the teacher notices as it is often in a jokey way like banter, or messages sent on social media. She is naturally quite shy and this is making it worse
- Some of the comments are about her appearance and so she is worrying about people thinking she looks bad or doesn't dress right.

Day to day life

- Maria enjoys her lessons at school, and is doing well. She has two friends but they are not in the same year group as her and so they are not in any of her lessons. She knows them because they are also from Latin America, and they can speak Spanish together
- She has struggled to make other friends in her year group. She is shy and finds it difficult to join in with the other girls. She will often freeze and not know what to say when they ask her questions.
- Maria spends a lot of time on her own reading books, which helps her escape from it all.

Well-being attitudes

- Maria really wants to be one of the happy, chatty, trendy girls she sees at school but doesn't see how she can ever be like that.
- She doesn't know what to do about the fact that she has started to feel worried about her appearance, and going to school and seeing the other girls, or how sad she is about being lonely.
- She is scared about talking to her teacher about how they treat her, and doesn't feel that the teacher will think it is serious anyway.
- Her mum tells her to keep trying but she doesn't think anything will ever change.

Caleb

Not sure what to do to help his friend

Age: 16yrs

Ethnicity: White-British

Housing: Lives with Mum, Dad and sister in Peckham

Education: At School

Languages spoken: English,

I'm not sure how to help....



Background

- Caleb was born in Peckham and has grown up in the area
- His dad is a plumber and he helps him out at weekends sometimes He thinks he will go into a similar job himself

Well-being

- Caleb is generally happy with his life, he enjoys playing football in the school team, and supports Crystal Palace.
- His only real worry is about his friend Tom, who has started hanging out with members of a local gang. He wants to help him but is a bit scared about getting involved.

Day to day life

- Caleb goes to school during the week, and spends weekends watching or playing football.
- He has a group of friends he has known since primary school and they go out at the weekends too
- He has just started going out with a girl from school and is that is getting more serious which he is happy about

Well-being attitudes

- Caleb likes being fit enough to play football well and has started doing some extra running and weights in his own time to try and stay in shape
- He can eat what he wants without gaining weight so isn't really bothered about the fact he eats a lot of fast food
- He thinks that gangs are dangerous and doesn't want to get sucked into that world. He doesn't know who to ask for help for Tom, or what he can do to help.

Appendix G: “My Voice Counts” Workshop Report

My Voice Counts: Event Report

**Joint event for young people with Healthwatch Southwark and
NHS Southwark Clinical Commissioning Group**



Date: Tuesday 12 April 2016, 4pm-7pm
Venue: The Bussey Building, Peckham Rye
Attendees: 23 young people, aged between 16 and 20

Purpose of the My Voice Counts!

Healthwatch Southwark (HWS) and NHS Southwark Clinical Commissioning Group (CCG) worked together to deliver a joint public event aimed at young people.

The CCG's main purpose for the event was to engage with young people from Southwark to discuss some of the health issues they face and work with them to discuss potential solutions. The information captured at this event will help inform the CCG priorities for the commissioning of health services in the future.

HWS's main purpose was to continue talking with young people about their experience of using sexual health and mental health services in Southwark.

Together we recruited participants for this event by working with the Youth Council, Community Southwark's membership of voluntary organisations that work with young people, promoting the event to secondary head teachers, creating online interest through Twitter and Facebook, connected with youth providers to encourage them to promote this event to and through their networks. We also printed and distributed posters which were displayed in community and public spaces, leaflets were handed out to young people leading up to the event and on the day of the event in Peckham.

Do you agree or disagree?

We ran an interactive text poll at the beginning of the event to see if the group agreed or disagreed with some statements about mental health and sexual health in young people. Texting responses were free and anonymous, participants were able to see how people were voting in real time which gave a buzz in the room. Below are the results:

Statement	Agree	Disagree	Unsure
Health services are easy for me to use	33%	22%	44%
Information is explained to me in a way I can understand	80%	20%	-
The way a service looks inside and outside affects the way I use them	80%	10%	10%
I know someone who has hurt themselves on purpose	91%	9%	-
I know where to get sexual health information and advice	50%	40%	10%
The internet and TV affects the way I behave sexually	36%	55%	9%
If I got a sexually transmitted infection I would know what to do	45%	18%	36%

Abortions are a form of contraception	20%	60%	20%
I know where to get free condoms from	73%	27%	-

Theatre performance

We worked with London Bubble Theatre Company to create a performance for My Voice Counts!

The performance focussed on three fictional characters that were developed with input from clinicians and voluntary organisations. Each had a unique set of health issues consistent with findings from the recent Joint Strategy Needs Assessment for the children and young people of Southwark.

The purpose of using theatre was to engage with participants in a creative way. The characters allowed the audience to be focussed on some of the key health issues facing their demographic in a fun way and interactive way. This helped fuel discussions in the breakout sessions which followed and allowed people to connect with the characters.

Sexual health

Meet Shannon...

- Shannon is 16 years old and attends college.
- She is from a Catholic family who have strong views on sex before marriage, and Shannon marrying someone of the same religion.
- Shannon has had a boyfriend for a few years, which she hides from her family.
- She loves her boyfriend, although he does not like using protection and therefore they have unprotected sex. This is often more likely when she has been drinking.
- Shannon's friends tease her about this, and joke that she could have a sexually transmitted Infection (STI)
- Shannon did try and go to a sexual health clinic but the receptionist asked her lots of questions about why she was there, and she was afraid someone would see her as the clinic is right by the bus stop at Nandos.
- Shannon suspects she is pregnant and doesn't know what to do. She tried to talk to her teacher about it, but she wasn't very helpful.



A small group of young people spoke about Shannon's situation. These were some of the comments that were made:

Information given at schools

- We're meant to learn about this at school but we don't – in Year 7 PSHE, we were just told to stay away from sex.
- Schools need to do more but avoid it due to the cost of bringing someone in to talk to us. But they don't need to bring people in - teachers could do it.
- Teachers need to know the "A-Z of sexual health & matters" – they should be trained so that they're ready. Teachers need to have the right manner, make you feel comfortable. Some teachers already have it but others don't. It's not just about telling students where to go for help.
- Schools could do more to run projects on mental health and sexual health – our school did one on LGBT issues during a week and it gave us more awareness of the impact we have on others, particularly the power of language.
- Shannon is more vulnerable when she's drunk – schools could do more about educating young people about the issues of getting drunk and then having unprotected sex.

Peer pressure / stigma

- With sexual health it's hard to get it right – you're either called a slut or a virgin.
- Peer pressure in school can really harm mental wellbeing. It starts off with small things like name-calling but little things quickly develop. Your flaws get highlighted and then you are aware of them, they become internalised.

Sexual health clinics

- I think that if I was Shannon, I'd feel unsure about what to do or which services to use. I'd worry if my parents or someone I know saw me in a sexual health clinic.
- Sexual health clinics just for young people would make me feel uncomfortable and I don't think I'd go for a sexual health check-up there.
- Southwark is a small borough and people know each other – young people don't want to be seen at clinics and then be talked about.
- I think young people would prefer services to be anonymous and with less personal interaction – you're less likely to be judged or get bad vibes from a receptionist.
- They are always confidential though - unless you're really young or something. Perhaps not all young people know that?
- Young people could use clinics that are further away from home, or clinics could be integrated into wider services, so it isn't as obvious why you're there that day.

Relationships

- Shannon shouldn't let her boyfriend dictate their sexual relationship – she needs help recognising what a healthy relationship looks like – and what an unhealthy one looks like:– abusive, controlling, coercive, possessive and needy.
- All teenagers, not just girls, need education on this; schools, media and adverts could help.

Role of religion

- Shannon's religion makes her worried about getting help from services and she is worried about what her mum will say. (Everyone at the group agreed that they've got friends whose religion makes them worried about what advice to give or say about sexual health matters).

- Religious places like churches and mosques need a few community leaders within them to say – ‘you shouldn’t do this, but if you do, this is what you can do to get help and advice’. It’s difficult to do but communities need to recognise that this is what young people do - there is a need for a medium.
- Perhaps a way to get around this could be helped by a sort of anonymous and confidential online forum where people can get help.

Recommendations made by the group

- Complaints about attitudes of staff in sexual health clinics should be acted upon, so it doesn’t happen again and discourage young people from using them.
- Teachers should be trained so that they are better at talking about sexual health – not just offer information and signposting but talk about the emotional side too.
- There should be regular events/workshops in school so that people are aware of services and support available to them.
- People should be taught about ‘healthy’ relationships – important for males and females



Mental health

Meet Maria...

- Maria is 16 years old and attends college.
- She is overweight and is under pressure from her Mum to cut down on her food intake. Her mum makes her go to the GP to discuss her BMI and diet plans.
- Maria is self-conscious about the way she looks, and often wears baggy clothes and little make up.
- Maria has had difficulty making friends at school and is quite shy. Maria sometimes gets teased by her friends, quite often behind her back
- Maria wants help from her mum to deal with her weight issue
- Maria eats badly, eating takeaways several times per week
- Maria doesn’t exercise outside of walking to get places



A small group of young people spoke about Maria’s situation. These were some of the comments that were made:

Importance of exercise

- Before you get to your stop, come off two stops before and walk the rest of the way.
- Some people get too comfortable with themselves – realise that they’re unhealthy but can’t do anything about it.

- Physical exercise – lots of people try with gym but gave up.
- With regard to the free swim and gym - heard of it but not sure if it is worth it.
- If you own a bike, you'd cycle to school or work.

Where to get information about mental health

- You could use Google for information.
- You could speak to a counsellor in school.
- Friends and family would be the first port of call.
- Not as many people visit GP services.
- Not enough knowledge on services out there - adverts could be used to tell about services – social media, bus stops, school.
- School, although teachers and counsellors can be difficult to approach. Teachers could be better informed about mental health.
- Church – talking to a pastor - for those who are religious. They could have basic mental health training.

Physical health versus mental health

- Mental health is as important as physical health.
- Everyone knows more about physical health than mental health.
- It is easier to react to physical health problems - people don't know how to react to mental health issues.
- There is a lack of awareness around mental health services.

Recommendations made by the group

- More people need to know about the services on offer – better advertising – i.e. social media and school planners
- People need to know more about indicators of mental health – i.e. what is good mental health?
- Place of therapy needs to be away from a clinical setting – you want to forget that you have it.



Substance misuse

Meet Mark...

- Mark is 16 years old and attends college.
- Mark isn't very close to his parents – they often ignore him and he feels rejected. This might be because he is gay. This makes him fairly unhappy with his life.
- Mark likes to go out every weekend, and drinks a lot of alcohol and takes drugs.
- He often ends up in A&E because of drinking too much and taking drugs and he is known by the mental health team there, although he is not willing to accept help.
- Mark's friends are concerned about him but don't know how they can help him.



A small group of young people spoke about Mark's situation. These were some of the comments that were made:

Relationships with family

- Main contributors to issues are lack of family support for his sexual orientation.
- His lack of parental support – Mark and his family could be referred to a family support service in the community to help with his issues with his parents and how they behave.

Males accessing health services

- The consensus from the group was that the first point of call for most people their age experiencing health issues, particularly for males, was a Google search on the internet.
- The male members of group indicated that they would really only go to their GP if there was something presenting visible physical effects – i.e. something growing on their face. They indicated that they probably wouldn't access health services for issues that the health service would consider 'red flags', for example, a lump in their testicles.
- Hearing peoples' real experiences of mental health could help people educate people.

Where to go to for support

- LGBT communities / support groups to support with being gay.
- Referred to a family support service in the community to help with his issues with his parents and how they behave.
- The mental health nurse at A&E should be more probing about some of his mental health issues and should be speaking to Mark's parents about what is going on.

Recommendations made by the group

- Health professionals identifying underlying issues and signposting to appropriate services – LGBT groups, family support groups etc.
- Mutual support from existing networks – making people more socially aware of warning signs and how to support people.
- Hearing relatable, eye opening accounts from real people through arts e.g. drama, music etc.



Next steps

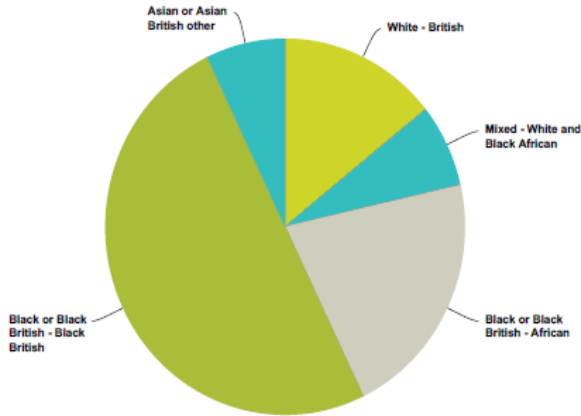
We plan to take this work forward at the CCG and HWS. The following actions are planned:

- To share this report on the CCG and HWS website to download
- The summary report will be presented at the CCG's Governing Body Members meeting
- The findings from the event will be incorporated into the Children and Young Person's Wellbeing Strategic Framework
- The findings and outcomes of the event will be communicated back to the event participants
- We will commence planning the next engagement activities, including:
 - A programme of work with 24 young people from The Challenge to look at further developing solutions and to raise awareness of local services
 - Engagement with schools in Southwark using film of the theatre production and spoken word artist to start developing solutions
 - Engagement with smaller, more focussed groups of children and young people and their families – for example CYP with special educational needs, youth offenders, etc
 - Working with the voluntary and community sectors to carry out further engagement with young people
- We will recruit and train young people to be youth champions to support with further engagement with young people
- We will engage parents and families around some of the emerging themes from our work with young people

Demographics of attendees

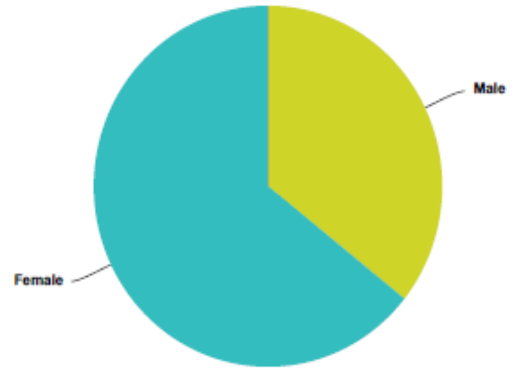
Q1 Ethnicity - Please select the category that best describes your ethnic group

Answered: 14 Skipped: 0



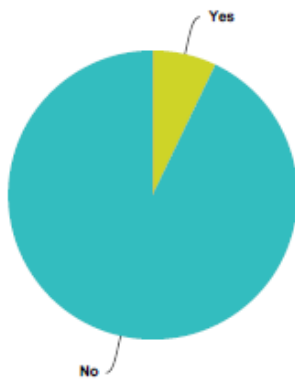
Q2 Sex - Please select the category that best describes you

Answered: 14 Skipped: 0



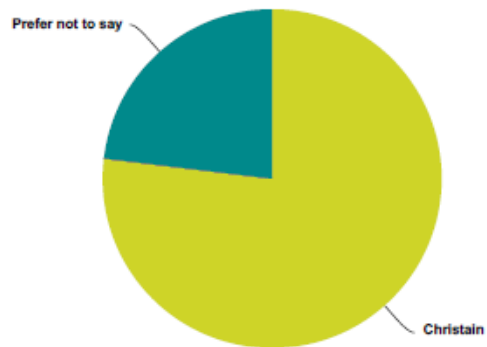
Q3 Gender Reassignment - Does your gender differ from your birth sex?

Answered: 14 Skipped: 0



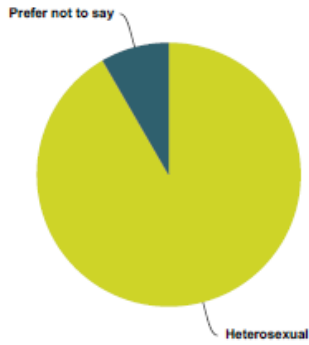
Q4 Religion or Belief - Please select the category as appropriate

Answered: 13 Skipped: 1



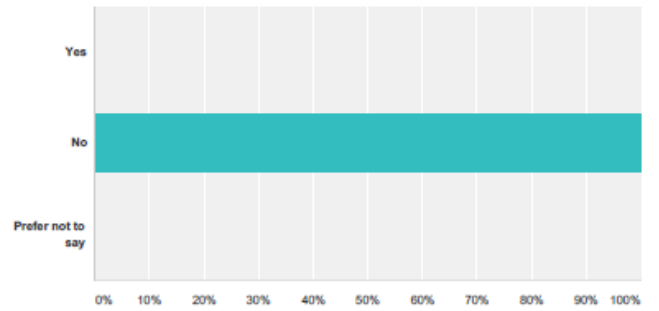
Q5 Sexual orientation - Please choose the answer that best describes you

Answered: 12 Skipped: 2



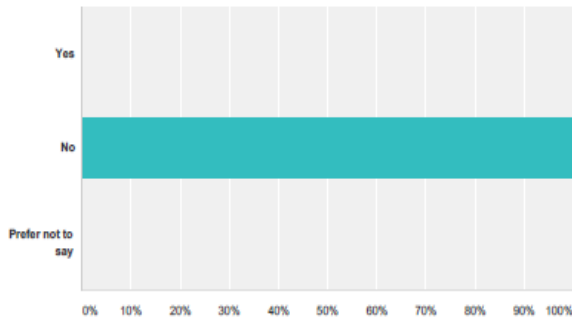
Q6 Pregnancy and Maternity - Are you pregnant?

Answered: 14 Skipped: 0



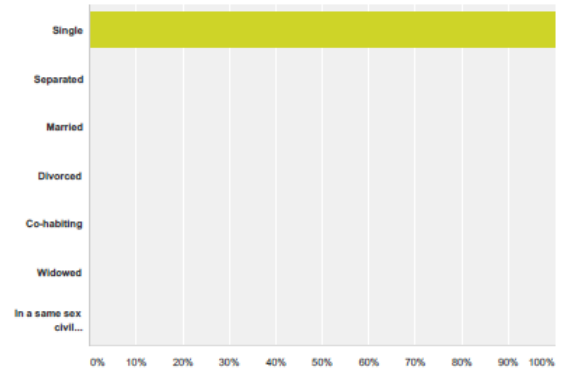
Q7 Pregnancy and Maternity - Have you had a baby in the last 12 months?

Answered: 14 Skipped: 0



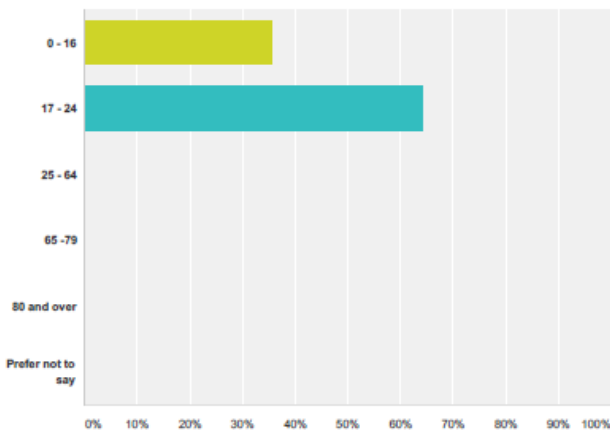
Q8 Marriage or Civil Partnership/Marriage - please select the answer which best describes you

Answered: 11 Skipped: 3



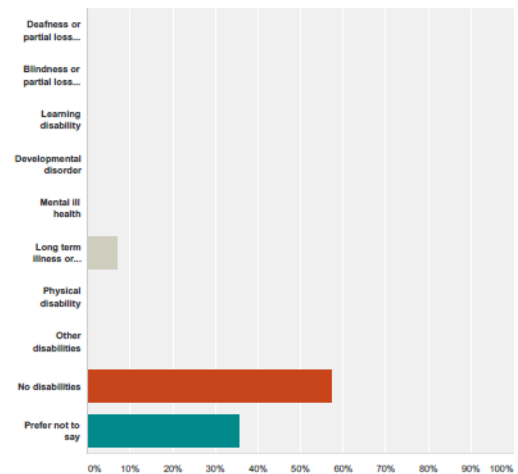
Q9 Your Age (years)

Answered: 14 Skipped: 0



Q10 Do you have any of the following conditions that have lasted or expected to last for at least 12 months?

Answered: 14 Skipped: 0



Appendix H – Appointment Data

An audit of my own last 20 booked appointment sessions as a GP was undertaken on 30/6/16. The data is presented in Table 1, and Graph 1.

Table 1: Look back over 20 GP booked sessions – Spring/Summer 2016

Look back over GP 20sessions - Spring/Summer 2016				
Age range	Number of appointments booked	Number of appointments not attended	% not attended	% of total appointments
0-4yrs	17	2	11.76	5.65
5-9yrs	9	0	0.00	2.99
10-14yrs	2	0	0.00	0.66
15-19yrs	12	4	33.33	3.99
20-24yrs	47	10	21.28	15.61
25-29yrs	29	7	24.14	9.63
30-34yrs	32	3	9.38	10.63
35-39yrs	35	8	22.86	11.63
40-44yrs	15	4	26.67	4.98
45-49yrs	25	6	24.00	8.31
50-54yrs	31	7	22.58	10.30
55-59yrs	22	0	0.00	7.31
60-64yrs	10	0	0.00	3.32
65-69yrs	2	0	0.00	0.66
70-74yrs	4	0	0.00	1.33
75-79yrs	3	0	0.00	1.00
80-84yrs	3	0	0.00	1.00
85-89yrs	3	0	0.00	1.00
Total	301	51	16.94	100.00
10-24yrs	61			20.27
55yrs +	47			15.61

Graph 1: Number of appointments booked by 5 year age bracket

