HEALTHSPOT: Implementing an innovative GP service for young people at Spotlight youth service in Tower Hamlets

FINAL REPORT

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Executive Summary

**Background:** Healthspot is an innovative primary care service for young people, established within an existing youth work service for young people in Tower Hamlets. It represents a partnership between the Tower Hamlets GP Care Group and Spotlight, a multimillion pound, codesigned creative youth service. The Healthspot service is currently delivered by three GPs and two youth workers, in collaboration with an integrated team of local partners. Work to develop the service began in 2017 and the first clinics were delivered in April 2020. The launch of the service coincided with the start of the Covid-19 pandemic and the first national lockdown in England.

**Methods:** The Association for Young People’s Health (AYPH) was commissioned by North East London Integrated Care System/Sustainability and Transformation Partnership to undertake a preliminary process evaluation to capture the Healthspot story over the first year of implementation. Mixed methods were used including analysis of existing documentation and datasets, interviews with key staff, and initial indications of outcomes as reported by young people and stakeholders.

**Results:** The service started as planned and delivered a fully functioning, integrated primary care and youth work service to 51 young people (many attending several times) across the first 10 months. The infrastructure, relationship building and partnership working necessary for delivery were successfully achieved. The young people attending reflected the needs and demographics of the target group. Initial measures of outcome from both the young people and service providers were very positive. The aim of delivering a holistic and youth centred service was clearly met. The challenges faced have been essentially organisational and practical and are common to these kinds of innovative new services.

**Conclusion:** Healthspot has had an eventful, challenging and successful first year. A lot has been learned and the underlying model of the interface and joint working of primary care and youth work has been shown to be critical. The next year will undoubtedly be one of consolidation, particularly as the service will now have to partly reinvent itself to work in post-pandemic conditions. The next steps include meeting some of the challenges outlined and developing accessible outputs and ways of communicating about the service.
1 Background

The London Borough of Tower Hamlets has the fourth youngest population in the UK, and the 16th most ethnically diverse population of all local authorities in England. A total of 20% of the population is aged 10-24 (approximately 64,000). There is a higher rate (17%) of under 25s in the borough with special education needs compared to the England average, and higher rates of children aged 10-16 who are in the youth justice system (Tower Hamlets, 2018). The borough has one of the highest levels of child poverty in the country, and a significant proportion of children are eligible for free school meals (Tower Hamlets, 2017). The local authority and other statutory agencies in the area are explicitly committed to achieving the best possible outcomes for its population of young people (Tower Hamlets, 2017). Addressing their health needs is a key part of this.

Spotlight is a youth work provision set within a £7 million creative space in East London, opened in 2014. With a rapidly increasing youth population it had been recognised that existing youth facilities in Tower Hamlets could be improved. Poplar HARCA, a housing association in East London, led a partnership of local stakeholders including young people to look at making a lasting difference to the area. Spotlight has state of the art studios, film, design and broadcast facilities with performance, dance, boxing, fashion spaces with a cafe, offices and meeting/one to one room. The ethos clearly encourages partnerships with local community organisations, businesses and other services.

Once the centre was up and running, youth work highlighted issues of unmet health needs among the young people attending. Working with the youth workers, in 2017 Dr Helen Jones, a local NHS GP affiliated to the Tower Hamlets GP Care Group, began to develop a new ‘drop in’ GP clinic for young people within the Spotlight framework, inspired by an existing GP service for young people at the Well Centre in Streatham (Hagell and Lamb, 2016). The aim was to use the Spotlight model to help address health inequalities for this age group in the Newham/Tower Hamlets area. This drop in clinic, later named ‘Healthspot’ by the young people themselves, formed part of the of the offer of the local extended access primary care hub service.

The service was preparing to start delivery, and this evaluation was funded, just as the first coronavirus pandemic lockdown was initiated in March 2020. The decision had already been made that, given the innovation this service represented, and the potential for further roll-out if it was successful, it was important to document the process and assess initial outcomes. The evaluation was funded by North East London Integrated Care...
Young people, health inequalities and primary care

The key focus of the Healthspot intervention is on reducing young people’s health inequalities. Although health is clearly influenced by genetics and health care, the wider social determinants of health, such as poverty, play a huge part. Estimates of the relative contribution of different factors to health outcomes suggest that the proportion determined by social factors is the largest, accounting for approximately half of the variation (Buck and Maguire, 2015). Low income is the most salient social disadvantage. We know, for example, that childhood poverty leads to premature mortality and poor health outcomes for adults (Marmot, 2010).

As well as health inequalities that are directly associated with deprivation, some groups of young people experience health inequalities as a result of other social circumstances and the environment in which they live. This includes children who are in the care of the Local Authority, young carers, LGBTQ young people, and young people in some black and minority ethnic groups. Existing data have demonstrated that these inequalities are associated with young people’s rates of obesity, smoking, asthma, under 18 conception rates and poor mental health (Hagell and Shah, 2019). There are also data demonstrating that adverse childhood experiences (ACEs) may contribute to later health outcomes (Bellis et al, 2014; Hughes et al, 2017). These include childhood physical abuse, household substance abuse, childhood sexual abuse, household mental illness, and exposure to domestic violence. Individuals with at least four ACEs in childhood have been shown to be at particular risk of later sexual risk taking, mental ill health, problematic alcohol use and suicide (Hughes et al, 2017).

In addition, concerns about young people and health inequalities have been exacerbated by our learning from the pandemic. Emerging evidence from studies started during the pandemic are showing that while young people may have been less directly impacted by the Covid-19 disease itself, they may be disproportionately affected by the lockdown and its educational, economic and social consequences (Barnardos, 2020; The Children’s Society, 2020; YouthLink 2021; National Youth Agency, 2020; Hagell, 2021).
Primary care is central in addressing health inequalities (Norbury et al, 2011). Equal access to resources and support is critical for improving young people’s outcomes (Viner et al 2012) and primary care is the gateway. Young people visit their GPs regularly for a wide range of health issues. In their teens, this averages out at approximately twice a year for young men and more than four times for young women, although we are woefully short of up to date data on this. Overall, four out of five of 11-15 year olds report they have been to the GP in the last year (Brooks et al, 2015). Surveys show that while the majority of young people feel happy with their GP visits, there are more negative comments on practicalities and the convenience of visiting, and only half report they are able to talk about personal issues (Brooks et al, 2015). Their reported satisfaction with services is often lower than for adults (Hargreaves and Viner, 2012; Sizmur et al, 2015).

Youth health services: taking a holistic approach

The importance of reaching young people and identifying the barriers to their use and positive experience of primary healthcare have led to attempts to promote youth friendly health services. The World Health Organisation has provided strategic leadership on this, with variable uptake at the country level (WHO, 2012). Many of the royal colleges in the UK, including the Royal College of GPs, have adolescent health special interest groups. Although the Department of Health and Social Care has provided some guidance (the You’re Welcome quality criteria, for example), good examples on the ground are few and far between.

Yet research evidence suggests that ‘holistic’ youth services, co-located with other youth-friendly health promotion activities, may improve young peoples’ perception of and engagement with health services (Whitehead et al, 2018). There is less evidence to date of effects on health outcomes, but this is largely because of a lack of data rather than data showing no effect. Practical manifestations of ‘youth friendly’ have included being “informal”, having wi-fi access, spaces being decorated or designed by young people, being safe and welcoming, having youth engagement activities available, and having a youth friendly layout and furniture. Also important are staff who are trained in adolescent development, and who understand best practice around consent and patient confidentiality for young people under 18.

An international review of youth friendly services showed that many have youth participation in decision making and leadership, and are co-located in youth support services, but also that no single example yet constitutes best practice (Hetrick et al, 2017).
Research questions

As the Healthspot intervention was at an initial feasibility and piloting stage when the evaluation was commissioned, a process evaluation was undertaken. This centred on whether the intervention fulfilled its intended objectives during the implementation phase. Our questions included:

- **Implementation of the intervention**: Was Healthspot set up as planned? How many young people used the services in the first year, how were they referred, and were the issues they brought as expected? What were the patterns of service use?

- **Evidence concerning initial impact** – Given the underlying model for the intervention, did it have the intended impact? What were the experiences of patients and stakeholders? To what extent was it able to address health inequalities by engaging young people not usually in touch with primary care?

- **Impact of context and lessons for sustainability**: What were the barriers and enabling factors to setting up the services? What were the critical elements that contributed to success? How did it fit within the overall local offer, and what were the lessons for further roll out both locally and in other areas?
2 Methods

Overview

In order to capture the story of Healthspot over the first year of implementation a mixed methods process evaluation was undertaken, including initial indications of outcomes as reported by young people and stakeholders.

Data sources

The methods and data sources for this process evaluation included:

- Analysis of existing documentation, meeting minutes, “learnings and musings” notes, and reports from other groups/organisations (Joint Strategic Needs Assessment, Healthwatch etc). A large amount of background information about the development of the project had been accumulated by the team during the process of implementation. This included preliminary work to establish levels of need in the local community of young people.
- Analysis of data collection by the GP team, including patient referral information, reasons for presentation, actions taken
- Analysis of data from the youth service, including additional referral information and measures of patient experience from pre and post-consultation questionnaires
- Additional interviews with staff and stakeholders
- Case studies recorded by GPs and youth workers
- AH attendance at Healthspot monitoring monthly staff meetings throughout the project. ¹

Participants

Additional formal interviews were undertaken with the two lead GPs, two lead youth work staff, and a representative from the Clinical Commissioning Group in order to complement the existing documentation.

¹ Julia has also suggested including additional mapping work, something by Rachel Parker and a Partnership survey? I’m not sure I have these or whether they are the same as some of those listed.
Quantitative data were collected by youth workers and GPs on 51 young people seen in 84 separate consultations between 7 April 2020 and 15 February 2021.

Of these, 31 young people completed a post-visit questionnaire after their first attendance.

**Analytic strategy**

Interviews were transcribed for analysis to complement the quantitative data and enable a deeper dive into the challenges presented by the pandemic and lockdown during the implementation period.

Quantitative, descriptive analysis of data was undertaken from Excel spreadsheets. The process of building a shared database was underway throughout this first year of the project, bringing together GP data (EMIS) and Spotlight youth service data (Lamplight) in relation to each individual referral.

**Ethics**

We confirmed through the NHS medical research service that the evaluation did not need formal NHS ethics approval as it did not qualify as 'research', falling instead under audit/evaluation. In terms of data protection, the young people receiving a service are subject to GP and Spotlight protocols and consent procedures. It was decided that the AYPH team did not need direct access to Emis (or the parallel Lamplight system at Spotlight) and would only receive the anonymised data collated in Excel spreadsheets. Individuals were assigned Healthspot ID numbers that could only be decoded by the clinical team, and the research team did not have access to the list that linked names with numbers.

AYPH also has its own data protection policies that are available for inspection if required. These specify how the data are stored securely at AYPH for the duration of the project, and when they will be deleted after the report is finished.
3 Establishing a baseline: Evidence of need and service logic model

Young people and primary care in Tower Hamlets

As well as a high level emphasis on the needs of young people in local strategic plans, a wide range of data are available that specifically illustrate the health care experiences and opinions of local young people. Some of this was undertaken separately to preparations for Healthspot and some was organised to inform the design of the service. Sources include a piece on young people and Primary Care Networks in the area undertaken by AYPH (Sachs and Rigby, 2020); two in-house surveys by Spotlight on the views of local grassroots workers and professional in the area, and the views of young people using Spotlight services (Spotlight 2019); a Healthwatch Tower Hamlets survey of 555 young people in the borough (Healthwatch Tower Hamlets, 2019); and a piece of work by Amplified, a programme led by YoungMinds and NEL Commissioning Support Unit, which focused on pupil insights around mental health and drew on young people in Tower Hamlets (Young Minds, 2018).

As one of the GPs summarised for us, all of these background pieces “echoed what was being collected nationally, the State of Child Health and Us [report], those reports and the youth forum response to the [NHS] long-term plan”. Drawing together these reports, the findings draw attention to:

- **The need for more health services specifically aimed at young people**, with a particular focus on provision of mental health services.

- **Logistical problems for young people accessing existing services**, with reports of delays in getting appointments, restricted locations and a lack of joined up provision

- **A lack of youth voice** in the current services that were available to them, and the need for more education and training for the community of staff, parents and young people that could reduce barriers and stigma in accessing services

- **A lack of knowledge** among local young people about what services and provision is available to them, and particularly a lack of awareness of those services that did exist that were most easy to access and free. A need to promote services better in a way that makes sense to young people
• **The importance of primary care** to young people as a first port of call, although this was much clearer for physical rather than mental health issues

• **The importance of having safe, confidential spaces** for young people to get the help they need, in trusted locations and with people they feel they can trust, such as youth centres

• **The need for more professional collaboration** between primary care and other services and between primary care and secondary care

In the Spotlight survey of 152 young people undertaken by youth workers as part of planning for the service, this group of mainly 11-19 year olds reported that the majority (59%) had been to their GP in the last year. Many said that their experience could have been better (improved appointment time, less waiting, better communication). When given a list of professionals who could potentially be available at Spotlight in the future, including mental health workers, careers advisors, sexual health workers, and substance use workers, from the nine options, the largest proportion chose having a GP (Spotlight 2019). The young people in this survey also demonstrated a lack of knowledge about their rights around confidentiality. For example, a third (32%) did not know that they had the right to see a GP without their parents.

Also in 2019, as part of planning for the implementation of primary care networks, AYPH worked with 45 young people in the borough aged between 10-24, drawn from youth groups including Step Forward, Step Out Group, Healthwatch Tower Hamlets, Spotlight Youth Centre and the Roya London Hospital’s Health Youth Forum. The results were informative for the development of Healthspot, in that the young people developed a priority list for primary care services including the importance of confidentiality, proactive, clear and supportive communications, options for digital interaction, community outreach and youth engagement (Sachs and Rigby, 2020).

These kinds of developments, as highlighted by the young people and professionals in Tower Hamlets, are particularly salient for reduction of health inequalities in an area with high levels of deprivation and many young people living in challenging circumstances.

**Healthspot in the broader context of local service delivery**

The idea for a GP’s clinic located within a youth service “**basically started with a conversation**” (GP interview). Against the background of concern about Tower Hamlet’s provision for more marginalised or excluded groups of young people, colleagues in the Spotlight youth facility approached a GP that they knew who had established a youth
focused primary care service, with a view to bolstering their offer to the those they were engaging in the youth work service. These young people were known to be vulnerable in a variety of ways, and the youth provision had identified that they had unmet health needs. Meeting these needs fell outside the parameters set around the youth work service. As one of Healthspot’s founding GPs said, “It started as a simple ask really; Could we think about, as a GP, coming in and offering some clinics for the young people?” (GP interview).

Several local GPs already had a professional interest in young people’s health and one of the founding GPs had attended events where new youth-friendly services (from elsewhere) had been profiled. The second founding GP had a specific role as the local Clinical Commissioning Group as a Clinical Lead with a priority list including adolescent health care. There was interest in wider conversations locally around public health responses to reducing youth violence, and the opportunities offered by new discussions about ‘social prescribing’, where traditional health services refer patients out to more holistic, community-based activities for promoting wellbeing. Discussions were beginning about new integrated care models. The new NHS long term plan was launched in 2019 with ambitions to improve healthcare delivery to 0-24 year olds, and with a specific mention for the health needs of young carers, who form part of the Spotlight client group.

However, as one of the GPs involved commented, “I could see that it wasn’t an area that anybody had really championed, at least recently or in a sustained way...there wasn’t a thought through approach to adolescence in the way that was needed”. One of the issues was funding and making a business case. Despite the fact that there was widespread support for the importance of early intervention and prevention, actually designating funds for it was much more challenging; “it was very hard to be able to say; this is how it will save money in a year’s time”.

In the end what was proposed was essentially a reconfiguration of care; “It’s not a new service really, it’s just bringing together partners who are all aware of young people’s needs and have the availability to meet those needs but haven’t been doing it in an integrated way” (GP interview).

Overall Healthspot managed to encapsulate and put into practice some of a higher level discussion in the borough around “right care, right place, right time...It’s about community-based health, population health. It’s all the stuff, social prescribing, Marmot principles, ACE informed, trauma informed. It takes all of that stuff and it’s a real live model that you can smell and touch, and it speaks to all those things and embodies them” (GP interview).
Articulating what success should look like

Developing a full theory of change was one of the tasks that the Healthspot project set themselves in early days, but this has not quite been fully articulated yet. What the existing resources and interviews show is how success has been conceptualised, and this is a first step.

It has been suggested so far that success would include:

- **More youth centred resources, improved local offer to young people**: “we have to change the way we deliver, to be around the young people” (GP interview)

- **A more integrated, holistic offer**, with evidence of the removal of barriers to accessing care for more marginalized young people, and improvement in onward referrals to social interventions (more social prescribing for this age group).

- **Better support for particular subgroups of young people**. For example, better delivery to children with special educational needs and disabilities (SEND), those with learning disabilities, groups vulnerable to exploitation and gang involvement, and other groups. “I would like to see all the youth offending team young people being seen through Spotlight. I’d like to see all the looked after children being seen through Spotlight. I’d like to see all the young people that are currently at the PRU [Pupil Referral Unit] looked after through Spotlight, because I think that Spotlight has something to offer that is hard to expect from primary care as a whole and isn’t currently being delivered at all well” (GP interview)

- **Higher profile for young people’s health in the borough**: “And that’s what we’re hoping to use this bit of work to do, to really raise the profile of the need for young people’s health to be addressed in a more systematic way and with a skilled workforce” (GP interview)

- **Higher levels of health literacy and awareness of rights among young people** “And if in three years’ time, every year nine young person had a clear understanding of what their rights were and what their confidentiality issues were, I think that would be a real success” (GP interview)
4 The intervention journey

As a new, outreach service located outside usual primary care delivery locations, Healthspot had a complicated intervention journey involving a multitude of partners and had to set up various agreements for legal and practical frameworks for delivery.

Planning

Figure 1 sets out the Healthspot journey from the early days of being inspired to try something new, to approval to move forward, as drawn by one of the founding GPs. The early preparatory work is highlighted in the first two lines, setting out early sources of inspiration. As the GP reported in interview, “...out of that began a journey of pushing on money doors and building a case and taking it to whoever would listen ...”.

This also led to exploration of policies and procedures and the establishment of underlying principles, such as being ‘ACE’ inspired (adverse childhood experiences), emphasising the importance of early intervention and prevention, and of working in the context of relational trust between patient, GP and youth workers.

This was followed with a period of building and presenting the case and working out how the model would be delivered within the local framework. As the GPs noted, this could be difficult, and “…there were quite a lot of closed doors and concern about safety”. As the youth workers commented, this was a very time consuming process, “there were so many people involved from the GP Care Group, so it was about meetings, loads of meetings”. Establishing the crucial local partnership arrangements with other voluntary sector partners was also critical before final approval from the Primary Care Development Collaborative to go ahead or what the GP described as “permission to explore”.

As the representative from the CCG reported in interview, “I think everyone including us were very supportive of it. It was finding the fit for it I guess, and where it could be funded...we know it’s difficult for young people to access primary care. Either because they’re not aware they can, or how to, and it’s a gap really in young people accessing primary care.” Addressing health inequalities was a key part of the argument. As the CCG representative commented, “it’s all about equality of access and sort of removing inequality across the borough, so that the whole population, regardless of your age or where you live in the borough has access to extended hours care.”
Figure 1: Developing Healthspot: the journey

Source: Healthspot
**Stakeholders and partnerships**

The Healthspot service is currently delivered by three GPs in collaboration with an integrated team of local partners. Clearly the most important partner has been the youth provision, Spotlight. Spotlight is a multimillion pound, codesigned creative youth service, with a wide range of its own partnerships with local and national organisations investing in supporting young people. Collaborative partnerships sit at the centre of Spotlight’s work, supporting the aim to offer holistic, wrap-around provision.

As a well-established facility, Spotlight was already reaching large numbers of young people before the Healthspot collaboration, and also offered practical benefits such as youth-designed space for consultations. An essential underpinning of the whole journey was provided by the well-established Spotlight ethos of working holistically, supporting young people’s sexual health, substance misuse, and youth justice and child protection issues. As the youth workers commented in interview, “At the end of the day, we’re here for young people, our service is for young people. So it all came about from the fact that young people going to their own GP surgeries weren’t as comfortable…it’s not their comfort zone...that was the aim of providing a safe space....”.

As part of the planning, the primary care practitioners consulted widely with other organisations serving young people in the borough and nationally, including:

- Voluntary sector organisations such as Compass Safe East and Stepforward and outreach to others including violence reduction colleagues

- Other models of innovative primary care for young people, such as The Well Centre, including meeting with the RCGP Adolescent Health Group

- Local statutory services such as school health, SENCOs, the Youth Offending Team, the police, the borough’s youth services lead, Tower Hamlets parents’ forums, Tower Hamlets education service, the local early help hub, and children’s centre lead, amongst others.

- Local health services such as Barts Health NHS Trust including the transition team, East London Foundation Trust (which includes CAMHS) the Public Health commissioner, the Primary Care Trust, local Roald Dahl nurses, local consultant paediatricians, the local Director Children and Young People’s Nursing, and Tower
Hamlets early detection service, NHSE health inequalities team, and colleagues on the Clinical Commissioning Group

- Patient groups, including young people
- Local politicians

Establishing good links was importance as part of the ‘pre-launch’ period, and the team focused efforts on communications and collaborating arrangement with local partners in advance of the service starting.

**Legal and practical frameworks**

Healthspot is run as an innovative extended access care hub, formerly known as NHS walk in centres. In Tower Hamlets extended access hubs (which are commissioned by NHS England) are currently delivered by the local GP Federation (Tower Hamlets GP Care Group). The GPs who provide the Healthspot service remain affiliated to their ‘home’ surgeries. The legal framework for health delivery at Healthspot is therefore provided by the GP Care Group.

The Care Group also delivers a variety of other services including 0-19s, advocacy, and adults community health. The GP Care Group is itself a partner in Tower Hamlets Together, a local partnership. A key supporter for the implementation of Healthspot was based in the GP Care Group, helping the team to explore using a model of an extended access hub for delivery.

Given the close interaction of the Healthspot GPs and the Spotlight youth workers, it has been important to build shared protocols around agreed models of data sharing, access to patient files, and confidentiality; use of chaperones; safeguarding, both for the young people but also safety for the GPs and youth workers; and referral procedures. Much of this was built up in the course of practice in the early months of delivery and agreed by a process of discussion and consensus.
5 Service delivery description

The Healthspot model

Healthspot provides a universally accessible holistic health clinic for 11-19 year olds (or up to 25 if the young people are facing additional challenges such as SEND) embedded in current youth provision (Spotlight). Within the current extended access hub model, the Healthspot GPs do not replace the original GP that the young person may already be registered with. Based on interviews and presentations by staff, the key principles underlying the Healthspot delivery model were:

• Providing a universal service; improving the health offer to young people in Tower Hamlets

• Understanding the importance of relational trust with the youth worker as critical to delivery

• Enabling primary care to reach young people who may be less engaged

• Providing of person-centred care: Providing confidentiality and a safe place “off grid”, enabling clear understanding and collaboration between providers and patients, and allowing for the young person to control whether or not their consultation was shared with their registered GP

• Facilitating of joined-up working: Removing gaps and thresholds and reconfiguring an offer to young people that meets their particular needs

• Building a learning health and case system – digital capture of experiences, engaged and empowered patient

• Supporting the development of improved health literacy, helping young people to understand their rights and confidentiality

In practice, the “service” is a weekly GP clinic with the wrap around care outside of this from the Spotlight youth worker. Clinics were scheduled to be held in a room within the youth work service, but because the pandemic started at exactly the moment that the service was
planned to commence, all delivery from April to November 2020 took place online, through telephone or video consultations. This is described in more detail below.

The role of the youth workers and the Spotlight context are critical to this model, and “...sometimes there is a lot of work needed after a young person has seen [the GPs]. Expressed most simply, as one said, “Spotlight is much more than an appointment that happens on a Tuesday evening”. The youth workers described some of this work before, during and after a weekly clinic and it was estimated that this could take a couple of days a week for each of them. The burden on professionals of young people attending Spotlight is different from the burden in a usual GP practice or indeed usual youth work practice – all of the team were keen to ensure this was clear. The combination of the two services and the possibilities this raised came at a cost particularly to the youth workers who were ‘holding’ the service and remained the main port of call for sometimes very complex cases. As one of the GPs explained it, Healthspot was “rooted in youth work”, with primary care as the “add on”, rather than the other way round.

**Establishing referral pathways**

Figure 2 presents pathways into and on from Healthspot, in a diagram drawn by one of the GPs. Young people can self-refer to Healthspot or can be referred by the youth service or other professionals in the local area.

An important part of the model is that the Spotlight youth workers essentially play the role of medical receptionists. Once the young person self-refers or is referred in, the youth worker acts as the initial point of contact, explaining the service and what is on offer, and exploring the extent to which they young person may want the youth worker to be involved in the consultation. The youth worker collects a fair amount of background information – and indeed may already be aware of much of the relevant information if they young person is a regular Spotlight service user. This is then passed on to the GP in an initial telephone conversation before the consultation.

Onward referral is a key part of routine general practice, and Healthspot is no exception. Indeed, the model is predicated on the importance of networking young people into other providers. While some of these are referrals to other medical providers such as Child and Adolescent Mental Health Services (CAMHS), others are often outside the medical remit, including for advice on, for example, housing issues. Many of these kinds of onwards referrals fall into the category of ‘social prescribing’. Also sometimes known as community referral, social prescribing is a means of enabling health professionals to refer people to a range of local, non-clinical services.
However, as the GPs note, “There are some limitations [as] we can’t do referrals directly, for instance to a paediatrician, but we can do a recommendation to their own GP before that would happen”. However, they went on to say, “…to be honest, most of the other services that we might need them to access, either we or the youth worker can support the young person to self-refer, or we can signpost, or again we can ask their own GP to refer them on...”.
Information sharing

Considerable time was spent in the first year of operation in building a combined information sharing model that could assimilate information from both the GP EMIS system and the youth workers’ Lamplight system. Time was also given to establishing important measures of patient experience and outcomes.
As Healthspot operates within the hub model the GPs complement the young people’s existing GP services, and can view their GP medical notes which has proved helpful and lends itself to a more informed/ safer consultation. The GPs seek the young people’s consent to ensure they gain their permission to information share back to their own GP. Thus far there have only been one or two occasions when the YP did not give permission. It was originally anticipated that organising appropriate access to medical files may be an issue if young people were coming to Healthspot from outside Tower Hamlets area and thus the remit of the GP Care group, but so far all young people have been registered with a Tower Hamlets GP even if they were living out of area.

However, combining and sharing systems was not without challenge. As the youth workers noted, “We already had some sort of knowledge within the youth work sector but obviously with GPs, there’s different confidentiality and different questions you have to ask”. This led to training needs; “Another challenge was getting up to date with the training because obviously it’s a data protected system; we wanted to make sure we do the right thing and don’t make any mistakes....so [youth worker] and myself being trained on EMIS now...has helped a lot because now we can actually just book it ourselves instead on waiting from someone to book it for us”.

Key elements of service delivery in the first year and the impact of Covid-19

The lockdown related to the 2020 Covid-19 pandemic began just as Healthspot became ready to start seeing clients face to face; as the GPs noted, “We’d literally just agreed the colour of the paint”. At first it was not clear if the service could in fact open, but – due to the cooperation of the GP Care Group – agreement was secured for on-line delivery. “Obviously then we had to suddenly work out where we were at and what the new way forward would look like as an interim and, as with the rest of primary care, started with...a completely virtual offer”. In order for this to work the Healthspot GPs had to find a welcoming Practice to physically work out of where they could have access to the IT systems they needed, without being in the Spotlight building.

A total of 51 young people were seen in 84 consultations delivered in 31 clinic sessions held by the service between March 2020 and 15 February 2021. For the majority of this time the service consisted of several hours of clinic once a week attended by one of the GPs, and most of the clinics were conducted on the telephone. There was an average of two or three young people seen at each clinic session, although these numbers could vary.

The majority of referrals for these came through Spotlight youth workers. Other referrals from CAMHS, self-referral, or other GPs or other voluntary sector organisations. Nearly all the young people were already registered with another GP.
Client demographics

Based on the details taken at their first visit, on average the young people were 17 years old at the time of consultation, but Figure 3 demonstrates a wide age range from 11 to 21.

Figure 2: Age at time of first consultation

Two thirds (67%) of the young people were listed as being with female patients. The majority gave their postcodes as E14, E1 and E3. In one case a young person had previously been E14 but was living outside London at the time of the consultation. E14 is the postcode of Spotlight itself.

Reflecting the local population, the majority of young people using the service were either from Bangladeshi or white British backgrounds (Figure 3). There was also approximately 10% from Black African or Caribbean backgrounds.

Figure 3: Ethnicity as recorded at first consultation
Presenting health issues

Figure 4 presents a word cloud derived from open ended reasons for the first consultation as recorded on the data collection spreadsheet, completed by youth workers after the consultation. The most frequent reasons given related to anxiety, mood, sexual health and periods, long term conditions such as asthma, and weight. Other more unusual issues related to Covid-19, abdominal pain, gender identity issues, bereavement and, in one case, to an incident of stabbing and torture. Potential sexual abuse was not systematically recorded but on a small subset of nine cases seen in January 2021, the issue came up three times.

A significant proportion (approximately a third) of the young people reported in their interactions with staff that they had long term health concerns, even if these were not the primary reason for presentation. These included long term mental health problems, chronic skin problems, behavioural disorders, chronic pain, a degenerative eye condition and cerebral palsy.

In many cases these responses closely reflect what we know about young people’s health concerns in the general population (Hagell and Shah, 2019). However, responses relating to torture and stabbing are more unusual and are likely to relate to the inner city location of the clinic and the presence of refugees and asylum seekers in the local population. The rates of long term conditions are higher than we would expect in a usual population sample of this age group.

Figure 4: Reasons for initial consultations March 2020 – February 2021
As Figure 5 demonstrates, when asked what they wanted of the consultation, the young people suggested that the largest need was for advice, followed by onward referral for more specialist intervention (a key function of primary care).

*Figure 5: What the young people wanted from the consultation*

The young people were also asked if they had sought help for this problem before and 71% said they had. They reported that barriers to getting help in the past had included that they had been reluctant to trust professionals, had found it difficult to make appointments at their own GP, had a lack of awareness of how to get to see their own GP during covid-19 and had problems with accessing CAMHS.

**Outcome of consultation**

The Healthspot GPs recorded the outcome of each consultation as free text. A categorisation of the responses for the first 51 patients is presented in Table 2. The largest categories of outcome were advice and signposting. The close relationship with the host organisation, Spotlight, was clearly revealed in the notes; many of the follow up activities related to actions to be taken by youth workers. As a part of the extended hub service, the usual route for onward medical referrals was via the young person’s own GP, in which case recommendations were made in the ‘discharge’ notes, but in some cases the Healthspot GPs were able to action referrals themselves, for example to local voluntary sector organisations.
Direct medical interventions were listed relatively rarely. Again, as an extended hub location ordering blood tests etc was a little complicated, as initially the results would not return to Healthspot but to the ‘home’ GP. Arrangements have now been made to make this smoother.

Table 1: Outcome of consultation for first 51 Healthspot consultations

<table>
<thead>
<tr>
<th>Advice</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Advice and education (eg, how to access own GP)</td>
</tr>
<tr>
<td></td>
<td>Treatment options</td>
</tr>
<tr>
<td></td>
<td>Health support options</td>
</tr>
<tr>
<td></td>
<td>Medication advice</td>
</tr>
<tr>
<td>Signposting</td>
<td>To local voluntary sector organisations</td>
</tr>
<tr>
<td></td>
<td>To broader Spotlight youth workers’ services</td>
</tr>
<tr>
<td>Referral</td>
<td>Recommendation to own GP for onward referral by them</td>
</tr>
<tr>
<td></td>
<td>Direct to local voluntary sector organisations</td>
</tr>
<tr>
<td></td>
<td>Direct to psychology/CAMHS</td>
</tr>
<tr>
<td>Direct medical</td>
<td>Prescription issued</td>
</tr>
<tr>
<td></td>
<td>Request to GP for blood test</td>
</tr>
<tr>
<td>Offer of follow up</td>
<td></td>
</tr>
</tbody>
</table>
6 Initial assessment of impact

Young people’s experiences

In the initial survey of 152 young people using Spotlight youth services, respondents had been asked to write down three words to describe their most recent experience with their own primary care service, if they had used it. Figure 6 presents a word cloud of their responses. Overall, 47% of the words were positive, 36% were negative, and 17% were neutral.

Figure 6: Young people’s descriptions of their usual primary care experiences

![Word cloud of young people’s usual primary care experiences](image)

Source: Spotlight health needs survey, n152

Figure 7 presents the words they used to describe their experiences with Healthspot, providing a ‘before and after’ contrast. Comments after being seen by Healthspot were overwhelmingly positive. Representative comments included “lovely, and she made me feel comfortable”, “understanding and she listened to me”, “I felt comfortable and free to tell her everything and my feelings”. 

![Word cloud of young people’s Healthspot experiences](image)
As noted, the involvement of youth workers before, during and after the primary care consultation was central to the model. Young people were asked how it felt to have the youth worker present, and again the responses were very positive. Practical and emotional support was appreciated, and the comments emphasised the benefits of trust, relationships and ‘being known’. Examples included “Good, ‘cause she knows about my problems”, “Felt supported and I trust her”, “Felt calm, was supported and helped, was able to express myself”, “Helpful because she translated for me”, and “Really good to have someone there who knows me in a personal way, and to help if I couldn’t explain things properly”.

Of the 31 (out of 51) young people who completed the post-consultation questionnaire, the majority said that there was nothing they would change about the service. Any requests for changes focused on whether there could be more of a service, in terms of being able to provide a wider range of treatments and being available on more days. To mirror the standard NHS Friends and Family Test, the young people were asked if they would recommend the service to a friend, and 100% said they would. Nationally the score in England for GPs is 90%, and young people score lowest of all age groups (Sizmur et al, 2015). The young people visiting Healthspot all also 100% agreed that the conversation felt confidential, and that Healthspot felt like a safe space.
Overall, the young people were very appreciative of the youth-friendly, personal and supported service. As one with a long-term and debilitating skin condition noted, “Healthspot has benefitted me massively and honestly speaking, if I did not have Healthspot to turn to then I wouldn’t know what to do”.

**Staff and stakeholders experiences**

A formal assessment of stakeholder views of Healthspot impact has not been undertaken yet. In addition, service level metrics for assessing success are difficult to identify and evaluate in relation to this innovative intervention. The work of beginning to share the journey and patient experiences is only just beginning.

The staff and agencies responsible for delivering the service are very positive about its impact both on individual young people but also on the pattern of provision in the area. Summarising the impact, one of the GPs said “This is a very popular new model which the Care Group are very proud of and very excited that it has been launched successfully, and the feedback has been amazing. I think it’s very likely this...can weather the changes in structural funding over the coming few years. I think we’re in a very good position”.

At a more basic level, as one of the youth workers noted, “there are some of the patients that are the same so they’re coming back. So of course they must have had a good experience to come back”. For them the success is largely due to the location of the service in the young people’s existing world, rather than asking them to go to somewhere ‘owned’ by professionals; as one youth worker said, “I think it goes back to their comfort. It’s their safe space, it’s their world”. This wasn’t necessarily easy to set up, but in the end as the GPs described it, “…we’ve got out of our ivory tower of a classical GP scary consultation room, we’ve gone out to where the young people are, where they feel comfortable to be. We’ve taken what skills and experience we have and we’re working joined up with other people, so true integration”. In a reversal of the usual doctor/patient balance, the GPs were “invited in…it needed to be a safe place and they’ve invited us into that, which is a huge privilege. And alongside that, there are other partners that are already welcome there, who we can work much more closely with than we can in reality when we’re in our practices”. One of the major successes that has accompanied this as far as the staff are concerned is the development of shared governance and information sharing that allows a much more rounded picture of the young person to be developed (“a warm transfer of information”), and thus enabling a much more holistic and wrap-around response to complex cases.

The staff also commented specifically on Healthspot’s success in delivering during the pandemic, against a backdrop of reduced access to health care services particularly among
young people. As one GP noted, “across all sectors we know there has been less sight of young people. I think all things considered, we’ve proportionately seen a lot more than a lot of other services did”.

All the core staff hope the work will continue and expand; “We’re hoping that it continues. It is a great service”. Success to the GPs “would be us actually doing ourselves out of a job”, in the sense that other GPs in the area start to become more youth-friendly. In this sense Healthspot is seen as a critical part of the local health service offer. It has also improved communication within the sector, so that as one GP noted “the feedback we’ve had from other health partners is that there is lots out there but even they don’t know about it”, suggesting that by working with Healthspot they had learned about new resources they could also use.

**Addressing health inequalities**

A major aim of Healthspot was to reach young people who may be reluctant to use formal primary care services, or not in a position to find out how to do so (because of, for example, digital exclusion). Being situated within Spotlight gave a short cut to this and enabled outreach to be relatively straightforward, in that the young people who were in some of the target groups were already using the facilities and already knew the youth workers. This included, for example, young people at risk of exclusion from education. The location of the service and the skill of the youth workers is completely central to Healthspot’s ability to reach young people who are sometimes more marginalised from traditional services. Although the range of issues that young people presented with were broadly representative of what we know about health complaints in this age group, the list also contained a number of issues that suggested young people in particularly difficult situations were finding their way to the service, such as the young person who had been stabbed. Simply put, one of the GPs commented that from the primary care perspective in relation to their usual case load, the family contexts of the young people who attend Healthspot are clearly different from many of their peers in the area.

Initial analysis of data collected on the first 51 patients provided preliminary information about barriers that the young people perceived previously in accessing their own GPs. These included:

- Reluctant to trust professionals but established trust with youth workers
- Finds it difficult to make an appointment with own GP
- Issues with getting regular repeat prescriptions from own GP and difficulties understanding or using electronic ways of making appointments
- Covid restrictions impacting on access to own GP
We would note that the datasets being developed by the GPs and youth workers will offer considerable opportunity for more detailed analysis on the particular characteristics of the clients who attended, including, for example, the proportion already known to social services or in contact with the youth justice system.

Key contributors to the improved access young people experienced at Healthspot included the ability to consult without others being aware that they were going to a doctor. Thus, as one youth worker said, “...they’ve just felt comfortable...in a space that was close to them and people didn’t know what they were doing, they were just coming into a room. They could just say “yes I’m going for a football session’ but really they’re going to do something else...”. Another element was the sense of being ‘known’ already by the service; “I think it goes back to their comfort? It’s their safe space, it’s their world...and they don’t have to go through this whole story again and again and again each week. So I think that’s why they like coming in”. Finally, as one GP noted, “It’s about removal of barriers within the service themselves, working together”, so that young people with multiple needs can be treated holistically.

In addition, the ready access to mental health support through a local voluntary sector partner (Docklands Outreach) to be a draw for young people. A number of young people appeared to be using the Healthspot slots because they could not get access to child and adolescent mental health services, or because they did not like the way CAMHS appointments were organised, or because of lack of engagement or confidence in CAMHS services.

The team would be the first to admit that more could be done in terms of reducing health inequalities for young people in Tower Hamlets. One issue is numbers; new services take time to bed down, and throughput will no doubt increase in the second and third years of operation, enabling more people to be seen. But the aspirations are high; “I’d like to see all the youth offending team, young people being seen through Spotlight. I’d like to see all the looked after children being seen through Spotlight. I’d like to see all the young people that are currently at the PRU [Pupil Referral Unit] looked after by Spotlight...None of those groups currently have good vision for their health, their physical health or their integrated health, and I think we can do better than that if we have this specialist or focused approach” (Healthspot GP).
Considerations when costing the service

Healthspot is a complex service both in terms of how it is set up and in terms of the young people using it. As such it is challenging to calculate its costs, quite apart from cost effectiveness. This is a larger task than the current evaluation can address. However, we did begin the process of beginning to think about what some of the issues might be.

In the first year, of course, costs included both set up and capital costs as well as weekly running costs and included the challenges of delivering during the pandemic. Setting up and decorating the consulting room alone cost several thousand pounds, and the amount of staff time needed to get the service off the ground did not necessarily reflect the time it would need to run on a routine basis.

In the remainder of the year, when the service was up and running, costs included staff time, use of space, telephones, and IT support. In terms of staff costs throughout the year, all the staff were already employed on full contracts and were working with organisations that were able to support staff time for innovation. There is a difference between simply costing the staff time and determining what their time has actually cost in terms of grants or contracts and money being moved between accounts. In Healthspot’s first year, many of the staff costs were covered by people’s existing roles. As the staff described it, a major advantage for the set up was that they all came from “mature organisations” (Spotlight, the GP Care Group and the CCG), with the confidence and flexibility needed get something new off the ground.

The other challenge in terms of costing is that although the clinic only runs for a few hours on a Tuesday afternoon, the service is much larger than this, and the work seeps into the everyday roles of the youth workers in particular, as they continue through the week.

One consideration in terms of calculating costs relates to what might be saved by the ‘wrap around’ approach that Healthspot takes, compared to more traditional routes of support. Many of the young people using the service had a range of different needs. In usual care they may have been moved between services or received input from organisations without any central point of reference holding the package together. Their traditional primary care services will only have been a small and potentially quite distinct part of the picture. Many young people with more complex needs will bang on a number of different doors in their efforts to get help or will slip between cracks entirely. This is undoubtedly a less efficient model than the ‘one stop shop’ approach offered by Healthspot, but it not easy to demonstrate the savings that can be made. The burden presented by these young people is different from that presented by young people in either usual primary care or usual youth work and this needs acknowledging in any attempt to cost the service. In many ways
Healthspot is more usefully regarded as complementing the current GP offer, rather than replacing it.

In addition, we do not know yet the extent to which Healthspot reduces pressure on other parts of the system; how many young people are seen at Healthspot rather than CAMHS, and how any are diverted from emergency care? These are all considerations in calculating the economic costs or benefits of the new service, and understanding more about patient characteristics, needs and journeys will be key.

In terms of the funding going forward, Healthspot has ongoing funding for its second year as part of the current extended hub offer. However the ongoing development of Primary Care Networks and reconfiguration of primary care in the area will require ongoing input in order to ensure there is continued support. An issue for further consideration is the economies of scale that might be provided if there were more outposts or clinics, or if different delivery models were developed.
7 Overview of successes and challenges

Healthspot’s first year of operation ran from March 2020 to February 2021 and coincided with the Covid-19 pandemic. Despite these challenges, the service started as planned and delivered a fully functioning, integrated primary care and youth work service to 51 young people (many attending several times) across the first 11 months. The infrastructure, relationship building and partnership working necessary for delivery were successfully achieved. The young people attending reflected the needs and demographics of the target group. Initial measures of outcome from both the young people and service providers were very positive. The aim of delivering a holistic and youth centred service was clearly met.

However, the effort required to start from zero at the beginning of the pandemic meant that this is not necessarily a fair or accurate reflection of the pace of delivery of an established service, and further evaluation will be needed as the service picks up speed and becomes better known. Delivery under lockdown restrictions meant that even delivering some of the basic elements of the Healthspot model was a challenge; “because it’s lockdown and we’re not seeing people in real life...some young people might be referred from outside organisations like the social worker or even the GP, but it’s hard to build that connection over the phone because they’ve never seen us so, can they trust us? During the Covid situation, that was quite difficult....how can someone really open up to you when they don’t really know you. But the regular ones, no problem at all, they know us. “

Overall, delivering Healthspot has been a big and complex job, operating as it does at the intersection of sectors, and the challenges faced reflect this. The challenges have been essentially organisational and practical and are common to these kinds of innovative new services. They have included:

Understanding and articulating how Healthspot works:

- **How to determine what components are critical to success.** In the view of the service providers, clearly the combination of youth work and primary care is critical. The staff and the young people gave a number of reasons why this was so, based largely on the importance of being in a trusted place where relationships had already been established, and the availability of wrap around support that addressed the wider social and wellbeing needs of young people as well as their immediate health needs. In addition to this, the role of passionate and pioneering staff who shared a common aim and were prepared to go above and beyond usual practice to achieve it
was clearly essential, as was the support of ‘can do’ host organisations. But questions remain; as the CCG representative asked, “Is it something that is more about how practices are delivering their care to that age group, or is it the safe place in the site? It is probably a bit of both isn’t it?”

- **Acknowledging the effort involved in combining cultures**: Despite excellent relationships between the key delivery services (“That has been a highlight and I must say they’ve been great”) there has still been time consuming work involved in building relationships and partnerships, and on occasion overcoming unfamiliarity between services. Articulating the particular and critical contribution of the youth work elements has been important; “I think, with the people at the CCG, [they] don’t understand our role as youth workers.”; “…we’re always constantly sharing concerns, or issues, which is good but trying to sort it all, obviously takes time”.

- **Communicating availability and success**, and letting people know about the service “At the moment, I don’t think there’s an awareness in PCNs and practices of this service and what it’s delivering”.

Improving efficiency:

- **How to develop more efficient and streamline processes?** This is a work in progress, and the processes are already more streamlined than they were at this time last year. However, there are still challenges that occur in relation to ensuring all-round communication and liaison with other health professionals. This includes continuing develop of collection protocols & formats. As noted, GPs and youth workers had parallel but not identical systems, as well as their own languages (*I did not understand any of the stuff she was collecting. It was abbreviated, I was like ‘what’s this?!’*). There was inevitably some duplication and then cases of data that did not match. There could also be confusion over who held what information (one example related to whether or not the young person was involved with the local youth offending team), and how to decide how much information is really needed (“because a young person might just want to come for a prescription and you don’t need to know if they’re a looked after child, if they’re a carer, all those questions. It does become a lot for them to answer”).

- **Relatedly, establishing information sharing protocols** (who explains rights, how to ensure informed consent), and the need for digital/virtual consultation policy necessitated by the pandemic and remote consulting (eg, econsult queries, photos sharing, processing of images). Much of this was common to all health delivery to young people during pandemic, and not specific to Healthspot situation.
• **Communicating with the ‘home’ GP.** The transfer of responsibility between the Healthspot GPs and the GP where the young person was already registered created some challenges early in the process. This was partly because young people could access Healthspot through the youth workers, but to access their ‘home’ GP they often had to use a confusing e-consult process that was not ideal for meeting young people’s specific rights and needs. Thus, “they might come to us after an appointment and say they need an appointment with their own GP and they have to complete an eConsult [form], but they have to be 18 plus to complete it themselves. If they’re younger than 18 then a parent has to complete it. …that’s why we work with Safe East and Docklands Outreach…rather than doing an eConsult [if it is sexual health]”.

Developing the service:

• **How to reach more young people:** both in terms of communicating the availability of the service but also in terms of supporting the GPs and youth workers in the fact of increased demand. There is a tension between wanting to increase the numbers, but also in acknowledging the limits of what can be done. As one staff member commented, “to start off with, it was the right numbers. Because I think if we had too many people it would have been difficult for even us to manage…some days we are really busy and we did feel quite stretched…”, and “People that we don’t even know how they found out about Healthspot are starting to book so the word is spreading and I think it’s going to get busier”. But going beyond Spotlight will be difficult; “It’s for, I guess, the people that attend that centre. We’ve got an issue obviously that’s much bigger - if you look at the numbers of the age of that population across the borough, they won’t all be accessing it through Healthspot, and some of them won’t go to Spotlight. But I guess it’s what learning can we take from that, whether there’s other satellites or hubs that it could extend to the rest of the borough, so that there isn’t just be one?”.

• **How to find out more about the ways in which the service can address health inequalities:** learning more about the barriers that even accessing Healthspot may have, introducing more on trauma and ACE informed work.

• **How to replicate and extend to different kinds of settings.** Is it possible to develop a template for working in this way which could potentially be taken forward by other agencies and locations? Are there other ways in which existing services could learn from Healthspot even if they do not replicate it (such as in the development of more youth friendly approaches in regular primary care)?
• **The challenge of handing leadership on to other practitioners;** “I think it’s very driven by - in my view - by two very committed GPs, who just absolutely have their heart and passion for this and have delivered it and made it happen. So what I wouldn’t want is if those two were ever removed - what we don’t want is for it to be completely dependent on these two people, really the CCG and the GP Care group are both just vehicles for this, or enablers”.

• **How to provide realistic and useful estimates of costs:** As we have noted, costing an integrated service is challenging. These were all services that already existed; the alchemy was in putting them together. Making a business case will prove challenging but will be necessary for further roll out. This centres on the importance of helping others to understand the nature of the task and thus to use appropriate metrics and measures of success. Healthspot is clearly supporting some very vulnerable young people. While these are often a stated priority by providers and commissioners, actually acknowledging the amount of professional time and investment needed can make this kind of service seem more expensive than it actually is if the wider ramifications of these young people’s unmet needs are taken into account.

• **Finding a sustainable funding model in a shifting landscape.** The current funding is as a CCG commissioned service that the federation provides on behalf of everyone, but the funding will be moving across to primary care networks, as a PCN direct enhanced service, which may pose other challenges. Extended hours access funding has traditionally been national funding rather than locally commissioned. If the funding is borough wide, there may be discussions about how to extend the locations. Another challenge may be rebuilding the awareness within the PCN of the service and what it is delivering.

There is a huge appetite to take on these challenges within the service, and much interest in it from outside. To end with a quotation from one of the youth workers, “We’re hoping that it continues. It is a great service and the fact that a lot of people outside the borough are quite keen in running some kind of similar work... So I think that’s great stuff, and if we can share learning, I think it’ll help other people and other communities”.
8 Conclusions and next steps

Healthspot has had an eventful, challenging and successful first year. A lot has been learned and the underlying model of the interface and joint working of primary care and youth work has been shown to be critical. Primary care for young people has been embedded in well-established and trusted safe place, building on the established relationships underpin that trust. Young people have used and valued the service and have returned again and again.

The next year will undoubtedly be one of consolidation, particularly as the service will now have to partly reinvent itself to work in post-pandemic conditions. The next steps include meeting some of the challenges outlined and developing accessible outputs and ways of communicating about the service.

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