Evaluation of the Role of Public Health Nurse with Newcastle Youth Offending Team

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March 2012

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Executive Summary

- In May 2011, Public Health provided funding for the appointment of a Public Health Nurse (PHN), to be based within Newcastle Youth Offending Team (YOT) (although the post is hosted by Lifeline), to work with young people engaged with the service to ensure that any health needs were identified and addressed. It was recognised that many young people engaging with YOT had unmet health needs and as a result of non-school or limited school attendance, were not in contact with healthcare through school nursing teams.
- A significant amount of progress has been made in relation to developing appropriate processes and relationships in order to effectively meet the health needs of vulnerable young people. Building upon existing good practice, all young people engaging with Newcastle YOT with an *identified* health need now have access to specialist assessment and immediate intervention and/or ongoing health plans; effective links and pathways have been developed with and into a range of mainstream health services to ensure clarity of care and seamless support for young people; case workers now have access to clinical support; and, outreach takes place with children, young people and families across a range of locations.
- Twenty-three referrals have been made to external health-related services – most typically, to GPs, dentists, sexual health services, Drugs and Alcohol services (DnA), school nursing teams and Child and Adolescent Mental Health Services (CAMHS) – and Alcohol Identification and Brief Advice (IBA) has been delivered to 55% of young people thought to have alcohol-related problems (20 in total).
- Whilst it was not within the remit of the evaluation to assess the impact of improved health outcomes on the reoffending rates of young people, it is reasonable to assume that in some cases, improved health outcomes will have a corresponding impact, particularly where offending is directly linked to health need.
- YOT case managers who have referred young people to the PHN spoke very positively of the service, reporting additionality in terms of their detailed knowledge of health conditions and treatments; the comprehensive assessment of young peoples' health needs; and, the delivery of accurate information and advice, and appropriate interventions to young people. The capacity of the PHN to engage with young people and the flexible approaches used to foster engagement were identified as key strengths of the work of the PHN. Case managers also spoke of the value of the PHN in relation to YOT being able to respond swiftly to health needs at the critical moments at which young people are willing to engage. Following engagement with the PHN, case managers reported noticeable differences in a number of young peoples' wellbeing.
- The role of the PHN has also been of significant value to YOT case managers, in terms of developing a greater level of awareness of health issues; the provision of timely and valuable clinical support; accessing health information from mainstream and specialist services; and, the organising of relevant training.
- This level of impact has been achieved in the context of several barriers to the effective embedding and operation of the post. Most significant amongst these is complex governance arrangements for the post. Split governance arrangements between Lifeline, YOT and Public Health have hindered effective communication between line managers, resulting in the key priorities of the post remaining yet to be fully established. In particular, consensus is yet to be reached at a strategic level regarding the extent to which the focus of the post should be the provision of a comparable level of healthcare to vulnerable young people in contact with YOT to other young people in the city, rather than a focus on reducing reoffending levels. This has resulted in operational confusion.
- Concerns were also raised that the location of the post within a non-health context has, at times, resulted in a lack of buy-in from health professionals from other agencies and outreach locations, due to concerns over confidentiality and information sharing protocols and systems.

Difficulties in partnership arrangements are likely to inhibit the achievement of improved health outcomes for young people in contact with YOT.

- A consistent framework to underpin health interventions with young people in contact with the criminal justice system (at both Newcastle YOT and outreach locations) is also yet to be fully established; linked to governance arrangements, a lack of information being disseminated about the role of the PHN throughout YOT when appointed and in some cases, the dissemination of conflicting information.
- These issues have been reinforced by cultural differences between YOT and health, in relation to the use of language, style and format of protocols, for example.
- It should be noted that the timeframe for embedding the role within Newcastle YOT may also be explained by the extensive levels of training that have been undertaken by case managers in relation to a range of health issues, such as sexual health and emotional and mental health, raising questions about the operational 'fit' of the post within wider YOT practice.
- Significant demands were also placed on the post holder in terms of the knowledge and skills required for the post. Nonetheless, the post holder has undertaken a significant degree of continuing professional development (CPD) and their commitment and progress made in relation to this should be recognised. They have also faced a number of external problems in relation to the development of the post due to delays in CRB clearance and staffing and service restricting across a range of sectors.
- It is important to stress that although the role of the PHN remains in its infancy, the establishment and embedding of any post is a complex and lengthily process. Nonetheless, a significant amount of progress has been in relation to addressing a critical need amongst vulnerable young people, within a very short timeframe and within a difficult external environment. The research team strongly recommend that this post be sustained in the long term.
- In this context, the recommendations below relate to commissioning and governance arrangements for the post, the embedding of the post within YOT and areas for development, rather than a refocusing of the work of the PHN.
    - Consideration should be given to the most appropriate commissioning framework for the post. Situating the post within a healthcare framework would overcome difficulties relating to the complex governance of the post; confidentiality and information sharing across mainstream and specialist health services; and, integrating the post within a wide range of services tasked with improving the health outcomes of vulnerable young people. The location of the post within a health-related service (such as DnA) would also provide the post holder with the level of clinical supervision needed to develop the post.
    - In the absence of this, consensus should be reached about the remit of the post and joint supervision arrangements established, as well as arrangement for a permanent clinical line manager.
    - YOT staff should be encouraged to adopt a more holistic understanding of health, focusing on lifestyle factors, as well as basic health needs and focus on improving health outcomes in the context of the general wellbeing of vulnerable young people as an end in itself.
    - Mechanisms should be developed to ensure that all young people in contact with YOT are given the option of a comprehensive health assessment by the PHN or receive a health screening as standard practice, to eliminate the risk of unidentified needs remaining unaddressed.
    - The role of the PHN within YOT should be clarified to all staff and the services which they currently offer be disseminated, as well as the responsibilities of the PHN and case managers being more clearly defined.
    - Greater promotion of the role of the PHN should also be prioritised in relation to the target group of young people. Once in contact, positive relationships between the PHN and young

people appear to be quickly developed. The emphasis, therefore, should be on fostering initial engagement with the PHN.

- While the PHN works with young people engaged with YOT on a one-to-one basis in relation to a range of issues, linked to both health and lifestyle, such as smoking cessation and weight management, these types of issues could be addressed through stand-alone forms of service delivery such as specialist clinics.
- Protocols relating to referral and information sharing should be made more accessible to case managers. YOT and Public Health should consider the possibility of developing an 'in-house' style for protocols, which both YOT and health professionals understand.
- Measuring the impact of improved health outcomes on the target group's reoffending rates should be undertaken on an ongoing and longitudinal basis, revisiting young peoples' offending profiles at structured intervals.

Introduction

Background to the Post

It has long been understood that offending behaviour is symptomatic of a range of other problems and needs; often expressed as criminogenic risk factors. A number of studies have established extensive levels of mental health issues and unmet educational and social needs amongst young offenders and indicate that the lifestyle factors associated with these issues place these vulnerable young people at risk of several physical health problems, such as sexually transmitted diseases, lower body mass index, accidents and teenage pregnancy. A range of psychosocial factors are also associated with offending among vulnerable young people, such as parental criminality or drug and alcohol abuse, family conflict or breakdown, harsh or inconsistent parenting practice, socio-economic disadvantage and exposure to traumatic events such as abuse, neglect or abandonment (Callaghana et al, 2001). Accordingly, any attempt to reduce offending rates and increase inclusion among young offenders needs to have a holistic approach which includes addressing health needs.

Recognising this, the Crime and Disorder Act 1998 called for Youth Offending teams (YOTs) to be established in England and Wales, emphasising partnership working in operational and strategic structures in order to reduce and prevent offending behaviour. The integrated teams were expected to contain representatives from relevant agencies including social services, the police, education, probation and health, making them suitably placed to address vulnerable young peoples' needs effectively (Care Quality Commission, 2011). Since then, a number of policies and initiatives have continued to emphasis the role of health in addressing youth offending. For example, *Healthy Children, Safer Communities* (2009) aims to improve the health and well-being of children and vulnerable young people at risk of offending and re-offending, while *Getting it Right for Children, Vulnerable young people and Families* (2012) discusses maximising the contribution of school nursing teams at a community level, including working with YOTs. The Care Quality Commission have undertaken three inspections of the provision of healthcare services in the community for children and vulnerable young people who have offended or are likely to offend. While the first two (*Let's Talk About It* and *Actions Speak Louder*) were critical of the level and quality of support being offered by health services to YOTs, the latest review, *Re-Actions*, confirms that considerable progress has been made towards effectively identifying and addressing health needs for children and vulnerable young people who have offended or are likely to offend. Collectively, the reviews outline a considerable volume of guidance and best practice regarding how YOTs should be responding to the health needs of vulnerable young people (Care Quality Commission, 2011).

The Role of the Public Health Nurse within Newcastle YOT

The Standard Community Contract for NHS North of the Tyne recognises that, '*many vulnerable young people have physical health needs that only come to light through contact with YOTs. Appropriate healthcare while young should help reduce problems in adult life, but a quarter of these vulnerable young people have never been to their GP services and many of those who use conventional GP services say they do not find them helpful'.* It follows that if they are not engaged with mainstream health and education provision, many vulnerable young people will not have the information they need to make choices about healthy living. Accordingly, a public health nurse (PHN) was appointed in May 2011 to work directly within Newcastle YOT to further support and develop the successful approach already in operation to ensure that any young person who is in contact with YOT has the same access and support to healthcare provision as any other resident of the City. Centrally, the introduction of the YOT nurse was to ensure that '*when a young person enters the youth justice system, the YOT has within it the skill and capacity to ensure that their health needs are taken into consideration and addressed effectively'.*

It was envisaged that the post holder would:

- Provide assessment, early intervention and referral to a range of primary and secondary health care services.
- Provide Alcohol Identification and Brief Advice (IBA) training and the delivery of screening and brief interventions for alcohol citywide.
- Target all YOT service users and develop robust assessment and health planning systems.
- Establish a whole systems approach to healthcare and treatment for vulnerable young people in touch with the CJS in Newcastle.

It was also anticipated that they would work in YOT premises, schools and other outreach locations, and work with: young offenders; those who are most socially excluded and in need of a range of primary health care services; those requiring specialist healthcare support around a range of health issues including substance misuse, sexual health and mental health; and those requiring education, screening and early identification around a range of healthcare issues including dentistry, immunisations, childhood obesity, smoking cessation, teenage pregnancy, audiology and vision.

Remit of the Evaluation and Methodology

The remit of the evaluation was to review the types and level of activity undertaken by the PHN since the being appointed; identify and quantify improvements in the health outcomes of vulnerable young people as a result of engagement with the PHN; and, develop a series of recommendations regarding the future development of the role.

The research was conducted using a mixed-methods approach, combining analysis of project data, interviews with stakeholders associated with the role of the PHN and a review of relevant academic, policy and published research literature.

Information relating to the background to the post and job specification was provided by YOT management staff, allowing the research team to understand the rationale and anticipated operation of the post.

Data documenting all activity undertaken since being in post (protocols developed, engagement with vulnerable young people and CPD) was provided by the PHN, enabling the research team to gain an overview of progress made in relation to the stated aims and objectives of the post and undertake a basic analysis of the impact of the post on the health outcomes of vulnerable young people.

Given the resource constraints of the research, it was not possible for YOT and the research team to undertake a rigorous analysis of the improved health outcomes on the offending rates of vulnerable young people, nor was it possible to undertake qualitative interviews with a sample of vulnerable young people who had engaged with the PHN. There was concern that this may also have ethic issues as the vulnerable young people may not wish for it to be disclosed that they had received support in relation to their health needs.

Informal, semi-structured interviews were undertaken with a range of key stakeholders, which included YOT management, health management, the PHN and a mix of YOT case managers who both had and had not referred vulnerable young people to the PHN (the aim being to explore the experiences of those who had engaged with the PHN and to identify any reasons accounting for the lack of engagement with the PHN by those who had not). Following this, the views of stakeholders were compared and analysed in relation to emerging key themes. The interviews were conducted at YOT properties for logistical reasons and to ensure that stakeholders would be more forthcoming in an environment in which they felt at ease. A schedule of interview questions was developed for each

stakeholder group, addressing a standard set of issue; this was particularly important for the interviews with YOT case workers, for purposes of consistency and to ensure comparison across the interviews. Each interview was recorded with the consent of the participant.

The discussion and analysis contained in the report draws upon a review of relevant research and academic literature. This allows for the development of discussion of the results in the context of broader policy requirements and findings from previous research studies.

The research was conducted with the approval of the Research Ethics Committee of Northumbria University. All participation was on the basis of informed consent and anonymity.

Findings of the Evaluation

Assessing and Addressing Vulnerable young peoples' Health Needs within Newcastle YOT

Since being in post, the PHN has made considerable progress and developed the following:

- A referral process from case managers to the PHN.
- A comprehensive health assessment tool for all vulnerable young people referred to the PHN.
- Links with a range of organisations operating across Newcastle who may be able to support the health needs of vulnerable young people referred to YOT.
- A series of pathways from the PHN to external services, in relation to a range of health issues.

Referral to the PHN

As outlined previously, the intended role of the PHN was to ensure that all vulnerable young people in contact with Newcastle YOT have the same access and support to healthcare provision as any other resident in city. It was clear from interviews with all stakeholders, however, that effective processes to facilitate this are yet to be developed. Case managers explained that at the point of entry into YOT, all vulnerable young people receive an initial screening as outlined on the 'Care-Works' system, which includes the collection of basic health information such as: GP and dental registration details, immunisations history, current conditions/medications, relevant family history and Chlamydia/C Card screening. Following this, vulnerable young people are referred to the PHN if: a specific health concern is raised; the young person is not registered with a GP or dentist; they score >2 on Asset; or they have missed significant schooling. Case managers reported, however, that referrals are made to the PHN if they consider a young person's health needs to be directly linked to their risk of re-offending, rather than in relation to their wellbeing as a whole, and that in many cases, health needs are rarely linked to a young person's likelihood of re-offending. The statements below reflect this:

> '*Our assessment is always linked to the likelihood of them re-offending, so in the assessment it is one of the areas that is least focused upon'*
>
> *'Our assessment is always linked to the likelihood of them re-offending and a physical health need being linked to their reoffending is so small … I don't think I have ever come across it'*
>
> *'I can only think on one young person when their physical health was linked to their risk of reoffending'*
>
> *'I see health as being more of a welfare issue*'
>
> *'To be honest, health isn't a priority when you are doing the initial assessment. It tends to amount to little more than 'do you have any physical health issues?...I find it difficult to see the link between health and contributing to the risk of reoffending'.*
>
> *'I couldn't say it confidently that all vulnerable young peoples' health issues are picked up in the initial assessment....unless it's evident or they tell me, I'm not going to know really'*
>
> *'I do think the screening process needs to be opened up so she can access more vulnerable young people'.*

Case managers suggested, however, that they would be unaware of a young person's health need unless it was apparent or disclosed to them by the young person, their parents or their school.

Rarely would case mangers investigate a young person's health status by contacting their GP, for example. Similarly, Public Health commented, 'I would question whether or not case managers can assess whether the conditions will impact upon their future' .This raises questions about whether the ASSET assessment is an appropriate screening tool to referring vulnerable young people to the PNH and the extent to which YOT staff are encouraged to adopt a more holistic approach to understanding the health needs of vulnerable young people beyond the immediate connection to their offending. At present, it may be that some vulnerable young peoples' health needs are not being identified and addressed upon contact with YOT, but that development of current process are allowing this to be addressed for future service users.

A further issue relates to a lack of clarity regarding the division of responsibilities between the PHN and case managers in relation to vulnerable young peoples' basic health needs and the thresholds and referral criteria for the PHN and services such as CAMHS. For example, when asked about protocols in relation to basic health needs, case managers gave mixed responses about appropriate action in relation to issues such as registering a young person with mainstream health services. While some understood this to the responsibility of case managers and said they felt comfortable fulfilling this duty, others reported that they would refer the young person to the PHN in this instance and others said they would encourage the young person to register themselves. Managerial stakeholders agreed, however, that this should be within the remit of case managers as such tasks would not constitute an effective use of the knowledge, skills and expertise of the PHN. Analysis of secondary project data indicates that the PHN has facilitated access to mainstream health services for a number of vulnerable young people since being in post. While happy to assist, they reported finding it difficult to establish the boundaries between their responsibilities and those of case managers. Such issue appear to be linked to a lack of information about the role and responsibilities of the PHN when appointed and in some cases, the dissemination of conflicting information about the post.

Such issues have been reinforced by 'cultural differences' between YOT and health. The PHN has developed a number of protocols outlining the key pathways from case manages to the PHN and from the PHN to external health services. While this is a positive development, case managers either reported a general lack of understanding in relation to the style, format and language used – thus, hindering the effective implementation of the protocols into wider YOT practice – or did not recall receiving the protocols. This lack of clarity was evidenced by the analysis of both primary and secondary data which indicated that referrals to the PHN have been made by only a limited number of case workers. These issues could be readily overcome, however, by the dissemination of clear messages within YOT at the strategic level. Offsetting this, however, it should be noted that case managers spoke of extensive training and experience in supporting vulnerable young people and a long history of referring them to other services and agencies such as CAMHS, DnA and sexual health services and suggested that they have continued to do this since the introduction of the PHN. In some instances, case managers interviewed who have not made referrals to the PHN said this was in part because they had not needed to due to the experience (through previous training) and contacts for referral that they already had.

Comprehensive Health Assessments by the PHN

When a young person is referred to the PHN, they will generally receive a comprehensive health assessment. As there is no standard health assessment tool used by PHNs working within YOTs nationally, the PHN within Newcastle YOT has developed their own assessment tool, drawing upon extensive nursing knowledge and experience and advice from other PHNs working with vulnerable young people across the region. Indeed, the tool is comprehensive; adopting a holistic understanding of health, looking at a range of lifestyle factors, as well as health needs and conditions. Nonetheless, the PHN stressed that the tool is '*work-in-progress*' and is regularly

reviewed to ensure that it reflects vulnerable young peoples' health needs. Following the health assessment, the PHN will typically deliver appropriate advice and information to the young person and refer them to relevant services, where necessary. This is in line with best practice which emphasises that because children and vulnerable young people who offend have difficulties in gaining access to mainstream services, the primary role of healthcare workers should be to help increase such access to vulnerable young people, rather than to provide healthcare services themselves. In some instances, however, the PHN has provided treatment directly to vulnerable young people where, due to multiple and complex factors, it was judged to be the only opportunity for them to receive medical attention. Again, this reflects best practice.

Analysis of secondary data from YOT confirmed a considerable level of health need amongst vulnerable young people engaged with the service in relation to physical health, sexual health, emotional and mental health, diet and weight management and substance misuse. Since May 2011, twenty-three referrals have been made to external health-related services – most typically, to GPs, dentists, sexual health services, Drugs and Alcohol services (DnA), school nursing teams and Child and Adolescent Mental Health Services (CAMHS) – and Alcohol Identification and Brief Advice (IBA) has been delivered to 55% of young people who were thought to have alcohol related issues (20 in total). Case managers who have referred vulnerable young people to the PHN spoke very positively of the service, reporting a significant level of additionality in terms of their detailed knowledge of health conditions and treatments; the comprehensive assessment of vulnerable young peoples' health needs; and, the delivery of accurate information and advice, and appropriate interventions to vulnerable young people. Case manager feedback included, '[*vulnerable young people] have a lot of respect for the PHN and what she says',* '*she is a greater source of information for vulnerable young people' and the PHN has a medical background...if she says something to a young person, it has more weight...I think that is a benefit'.* They also spoke of the value of the PHN in terms of the capacity to respond swiftly to vulnerable young peoples' health needs at the critical moments at which they are willing to engage.

The PHN reported mixed experiences in terms of levels of engagement from vulnerable young people with the service. Evidenced by activity reports, a significant minority of vulnerable young people have engaged with the PHN on a long term, ongoing basis and have reported appreciating having someone to talk to in confidence about personal issues, who can offer them impartial and factual advice. Others, however, have been reluctant to address their health needs. This may be linked to negative experiences with health professionals in the past, in the context of A&E and the CJS, for example, or are from deprived homes and family environments where there are concerns relating to poor parenting and accordingly, they have never been encouraged to think about their health. In these cases, the PHN has used various strategies to foster the engagement of vulnerable young people, such as: reassuring them that they are not linked to the CJS and that their role is intended to help them address their health needs only; focusing on the young person's primary health need only at first; being persistent in efforts to get in touch with vulnerable young people via phone, text or home visits; transporting / accompanying vulnerable young people to and from appointments; and meeting vulnerable young people at informal, neutral environments to discuss their health needs. Indeed, the ability of the PHN to foster the engagement of reluctant vulnerable young people in health interventions was praised the case managers who have made referrals to the PHN, reporting, for example, '*she has a manner which engages people and promotes trust'*. Speaking in relation to one young person, the case manager reported, '*The PHN has given him stability and is someone who he can seek out if he becomes distressed'.* Following engagement with the PHN, case managers reported noticeable differences in a number of vulnerable young peoples' wellbeing.

In some cases, the support provided by the PHN has had a direct impact on the offending outcomes on vulnerable young people. For example, one case manager recalled a recent case where young

person reported that they were unable to attend YOT appointments because they were too tired. The PHN assessed the young person in relation to a sleep disorder. As the young person's disorder was impacting upon his engagement with YOT, it could have resulted in him breaching his order so it was important that his condition was addressed.

The role of the PHN has also been of significant value to case managers, in terms of developing their awareness of health issues; the provision of timely and valuable clinical support; accessing health information from mainstream and specialist services which case managers report being unable to access (although the extent to which this should be the case is unclear); and organising relevant training for them. Comments included, *'I feel she has brought a great deal to YOT in such a short space of time...it has benefitted me in terms of my confidence, in talking to vulnerable young people [about health issues] and signposting them on to services'* and *'I think her being in the YOT is a strength...it's added to what practitioners would already do'.*

Service Developments

In addition to the core services outlined above, stakeholders discussed a number of additional services which are at various stages of development, such as a weekly drop-in surgery. It must be stressed however that many of these developments are still in their infancy; due both to the range and volume of work the PHN has undertaken across the role and also due to the time it takes for these activities to become embedded within day-to-day working practices. Many of these service developments are clearly adding value to the work undertaken by YOT with vulnerable young people but need more time to become mainstream within their service provision. For example, the PHN felt it important to have a drop-in session available to those vulnerable young people who may be reluctant to request a formal appointment in advance. To date, however, no vulnerable young people have attended the surgery. This appears to be related to two factors; the timing of the session (weekday morning) and a lack of promotion of the surgery to case managers and vulnerable young people. This, once again, raises fundamental questions about the information flow relating to the role of, and service provided by, the PHN throughout YOT. It also suggests the need for the greater promotion of the service to vulnerable young people through posters, leaflets and business cards, placed in a variety of locations which are accessible for young people.

A key area for development highlighted by stakeholders was health promotion. Stakeholders within YOT suggested that they would like to see the delivery of a range of activities and specialist clinics, linked to smoking cessation and weight management, for example. Indeed, YOT management stated, '*the role should be preventative, as well as reactive...[It] should be encouraging YOT to think more holistically about vulnerable young peoples' wellbeing'*, but appreciated that to date, the PHN has had to focus on '*getting the basics right'* before introducing more sophisticated forms of service delivery. This is an area that the PHN has also recognised as having value, and has began planning to develop, deliver or facilitate (where appropriate) sessions of this nature. The PHN currently engages with young people in relation to these issues on a one-to-one basis but intends to address issues through stand alone service, through specialist clinics, for example. The PHN also suggested that to raise vulnerable young peoples' awareness of health issues, those involved in an Intensive Supervision and Surveillance Programme (ISSP) could be given the option of undertaking Heart-Start training and basic first aid, in addition to the current programme of activities.

YOT management were very supportive of case workers collecting health information about vulnerable young people as a matter of course as this would be instrumental to effective planning to improve key outcomes for vulnerable young people, but felt that YOT should be doing more analysis around health needs across age groups, ethnicity, geographical location etc, and to develop effective interventions to address this. Clearly this is another area where the PHN could support and bring

additional value to the work of YOT but the original screening mechanisms need to be reconsidered as consistently the relationship to the ASSET score has been questioned, with statements such as *'there is no direct link between offending and health ASSET score'* being made on a regular basis.

Outreach

Another key feature of the work of the PHN is engaging with vulnerable young people in contact with the CJS via outreach into their homes and education establishments; this is another area of activity undertaken by the PHN but again due to the range and volume of work undertaken in a short period of time outreach work is very much in its infancy. Domestic outreach occurs when vulnerable young people are known to have unmet health needs, but are not engaging with agreed health interventions. Where family outreach takes place, it was typically described as a joint endeavour between the PHN and case managers. The wellbeing of siblings is flagged as a safeguarding issue when concerns are raised as a result of domestic outreach, but 'whole family' outreach and parenting support in relation to health issues remains limited, but it is recognised that this would go beyond the remit of the PHN and YOT.

Educational outreach is currently taking place through the pupil referral unit (PRU) at a specialist school in the area. The PHN currently works with a number of pupils at the school on an ongoing basis (some of who are intermittently suspended from school, but can be accessed via outreach to their family home or VCS organisations) and feeds into a weekly multi-disciplinary meeting at the school where information regarding pupils with the most critical needs is shared and appropriate actions are agreed. The PHN also contributes to a number of vulnerable young peoples' personal development programmes, delivering one-to-one sessions with them in relation to a range health issues including personal care, grooming, exercise, alcohol limits, the effects of substances, weight, diet and healthy eating. The PHN also delivered a workshop to pupils as part of a 10-week 'Wise up to the Community' programme on the importance of good health. Whilst outreach at the school has been relatively ad hoc to date, the PHN intends to deliver two outreach sessions at the school per week (on alternative days to the school nursing team to maximise the coverage of healthcare within the school across the school week).

Despite these developments, establishing the post within the school was reported to be one of the most challenging aspects of the post to date and the embedding of the post within the school remains in its infancy. A number of changes have take place at the school in recent months (most notably, changes to the school nursing team) which have impeded upon the ability of the PHN to learn about the establishment and its associated rules and procedures; to define their role at the school; and to establish effective working practices with the existing school nursing team (such as attendance hours, caseloads and information sharing practices and procedures). The role of the PHN is significantly different to that of the school nursing team and there is concern that this is sometimes not recognised; the PHN is often asked to work outside the original remit of their role. One interviewee, for example, stated that the '*school nursing team at the school have a very different remit – very much around safeguarding, not holistic health care which is what the PHN does'.* Furthermore, the PHN and school nursing team do not have a system in place for the sharing of information. Medical notes made by the school nursing team are located on an NHS system which the PHN does not have access to. Information regarding pupils is shared verbally, but as the PHN and school nurse do not have formal meetings, this takes places on an ad hoc basis. The PHN has access to pupils' school reports but these contain limited information. Both of these issues raise fundamental questions about the commissioning framework and governance arrangements for the post (see 'Line Management' section). Furthermore, more long term vision of the overall purpose of having the PHN based within the School and development of the relationship to the School nurse needs to be undertaken.

Information Sharing

Issues concerning information sharing apply across a number of routes and avenues. These include:

- Between the PHN and YOT case managers
- Between the PHN and the School Nursing Team
- Between the PHN and line managers collectively
- From the PHN to each of the line managers individually
- Across the line managers

Clearly the number of routes through which information can be shared is both extensive and also an area which is dependent upon robust and effective governance structures. Reflecting the issues outlined in the 'line management' section, the commissioning arrangements for the post have, in part, hampered effective information sharing practices between the PHN and external health organisations and school nursing teams.

Service delivery by the PHN is underpinned by the principle of pathways to ensure clarity of care and seamless support for individual service users. Since being in post, pathways have been established with a range of external organisations in relation to: general health, sexual health and obstetrics/gynaecology. Links with safeguarding, drugs and alcohol services (DnA) and child and adolescent mental health services (CAMHS) were already established, but the pathways to these services have also been formalised by the PHN. The PHN reported varied levels of engagement and willingness to engage in partnership working by external healthcare provides. Particular praise was given to the engagement of sexual health services. Difficulties were reported, however, in relation to partnership working with GPs and dentists, who were reported to be unwilling to take on vulnerable young people due to high non-attendance rates at appointments and in relation to drug and alcohol services and to share information. This was echoed by YOT stakeholders who reported the perception that YOT are willing to share information about a young person, but health services are less willing to engage. Furthermore, it was reported that despite the co-location of the PHN and DnA within YOT premises, there remains a lack of communication regarding vulnerable young people under the guise of both services. In this respect, frustration was reported at the '*fragmented nature of service delivery*' by the PHN. Learning lessons from the development, embedding and emulation of processes currently used by CAMHS would undoubtedly have a positive impact, in that they have been through this process and set up appropriate protocols and pathways which are used by YOT staff.

Furthermore, although many agencies feed into the Care Works system, only a limited amount of information is put on to the system for the purposes of confidentiality. This sometimes makes it difficult to gain an accurate understanding of the young person's circumstances and needs. Again, sexual health services were praised by the PHN for their willingness to feedback information about vulnerable young peoples' attendance and the outcomes of appointments. Other services (such as DnA and CAMHS) were reported to be less forthcoming with feedback, but it was suspected that this is due to high caseloads rather than a lack of willingness to engage.

In relation to the PHN and school nursing teams, effective information sharing processes and protocols remain undeveloped. Indeed, issues in relation to information sharing in this element of the role are much more complex as the school nursing team input their data to a NHS system, rather than Care Works. This inhibits the establishing and embedding of the role of the PHN within the school at which they undertake outreach, affecting both the nature of the information available to the PHN and the time it takes to be able to build up a case profile of the vulnerable young people being supported. It also renders it difficult for the PHN and school nursing team to target their

respective resources strategically and effectively. Furthermore, when attending the regional school nursing forum, confidential issues cannot be discussed in the presence of the PHN, resulting in the PHN missing out on the nursing support that is needed for the development and embedding of the post. This links back to the hosting of the post within a non-health setting.

In relation to the PHN and case managers, no problems were reported regarding the flow of information between relevant parties. Case managers and the PHN both feed into the Care Works system and communication is supplemented via email, telephone calls and informal discussions. The PHN was found to be meticulous in 'following up' on the outcomes of agreed actions with vulnerable young people, their case manager and relevant external agencies, in relation to confirming whether the young person attended an appointment and if so, the outcome of this, and communicating this information back to case managers. The PHN raised concerns, however, about the lack of integration of the role into wider YOT meetings, such as case manager team meetings. They suggested that only if a care meeting is held about a specific young person will they attend. Whilst it may not be necessary for the PHN to share any further information about the vulnerable young people being discussed, they suggested that it would be useful for them to attend in order to have a clear understanding of vulnerable young peoples' backgrounds as this would inform the focus and their approach to engagement with individual vulnerable young people. As such, the PHN reported feeling like they are working '*in isolation'* from the wider YOT team at times. Of course, if the PHN were to attend these meeting, this would have resource implications, but effective working practices should be considered to ensure that the role of the PHN is appropriately embedded within YOT and that consideration of the health needs of vulnerable young people are central in decision making processes.

Continued Professional Development

In reviewing the above, it is important to remember that the role of the PHN remains in its infancy and that the establishment and embedding of any post is a complex and lengthily process; indeed, stakeholders agreed, '*everyone is finding their feet with it...[and] it takes years to develop and embed a post...but we have learned a lot in the past year'.* Significant demands have been placed on the post holder in terms of the knowledge and skills required for the post. The post holder described the first six months of post in particular as '*a big learning curve*'. They have undertaken a significant degree of continuing professional development (CPD) in relation to services, protocols, processes and staffing across the criminal justice, education and health sectors within which they work since being in post and should be praised for their commitment and progress made in relation to this; Public Health agreed commenting, '*while the PHN is a very competent nurse, they had little knowledge about vulnerable groups and the CJS...so for the first few months, she had to develop that knowledge...they could not have done what they have done without that lead in time'.* The PHN has also faced a number of external problems in relation to the development of the post due to delays in CRB clearance and staffing and service restricting across a range of sectors.

Line Management

Whilst considerable progress has been made by the PHN in a relatively short period of time, having a direct positive impact of the services provided to vulnerable young people, the most significant barrier to the development and embedding of the post is the multiple and often fragmented governance arrangements for the post; originating from the hosting of the post by a third sector organisation, rather than a health body, due to public sector funding cuts and an uncertain organisational landscape at the time of commissioning. This resulted in split governance arrangements between Lifeline, YOT and Public Health. Indeed, one stakeholder commented, '*effective governance of the role is lacking...the role is not as well established or embedded as it*

should be after this length of time'. The research team felt that considerable progress in relation to establishing the role has been undertaken, but embedding of the post is possibly not as developed due to the fragmented line management.

The PHN reported meeting with each line manager on a regular basis and described these meetings as '*very useful'.* The PHN was particularly grateful for the level of clinical support received. At present, however, there are no joint supervision arrangements in place. This has been argued to have hindered the quality and nature of communication between line managers, and key priorities across all agencies are yet to be fully agreed and ratified. For example, consensus is yet to be reached regarding the extent to which the focus of the post should be the provision of an equal level of healthcare to all vulnerable young people as opposed to a reduction in reoffending levels. While there was suggestion from YOT that resources should be targeted at the most vulnerable cohort of young people engaged with YOT, whose health needs are perceived to be directly linked to their offending behaviour (current referral arrangements to be the PHN from case managers are underpinned by this principle), Public Health raised concerns that this may be resulting in unidentified health needs remaining unaddressed. Health stated, they:

> '*lose sight of the fact that it is meant to be a public health post – equal level of healthcare to all vulnerable young people and addressing the fact that they don't get it – basic immunisations; sight and hearing test. So it's about targeting the most vulnerable, but also about engaging with all children....for me, we need to protect the idea that it's about improving health...and we would hope that it has an impact on offending in the long term'.*

Indeed, a number of case managers suggested that they often struggle to understand the links between health and reoffending and are often unaware of vulnerable young peoples' health needs unless they are apparent or are disclosed to them by the young person.

At times, the complex governance arrangements have resulted in confusion over reporting mechanisms and when there has been a lack of agreement between line managers regarding future actions, the PHN reported feeling '*pulled in different directions*'. Similarly, Public Health stated, '*because the PHN has 3 managerial components, she can get confused by different demands and what is meant to be the structure. That is one of the real things I would like us to work on if we can maintain the post'.* Furthermore, the infrequency of supervision meetings due to busy workloads has also sometimes left the PHN unable to progress the role until authorisation was sought.

Consensus is also yet to be reached regarding the most appropriate commissioning and governance framework for the post. Concerns were raised that the location of the post within a non-health context has, at times, resulted in a lack of buy-in from health professionals from other agencies and outreach locations, due to problems of confidentiality and information sharing protocols and systems. Difficulties in partnership arrangements are likely to inhibit the achievement of improved health outcomes for vulnerable young people in contact with YOT. One stakeholder commented:

> '*the PHN is a valuable resource and there is only one of them and their time will come to be increasingly divided across a number of locations and tasks … It has never been clarified to what extent the PHN should be integrated with wider YOT*'.

Conclusion and Recommendations

Overall, the findings of the evaluation indicate that the role of the PHN within Newcastle YOT has had a strong and positive impact on both YOT staff and vulnerable young people. There has been a significant amount of progress made in relation to developing appropriate processes and relationships in order to effectively meet the health needs of vulnerable young people in contact with Newcastle YOT. Building upon existing good practice, the following outcomes have been achieved:

- All vulnerable young people in contact with Newcastle YOT with an *identified* health need have access to specialist assessment and the subsequent development of personalised care plans.
- A robust and effective tool is in place for the identification of health needs.
- Effective links and pathways have been developed with and into a range of mainstream health services.
- There is a health presence at YOT premises, at least part time, to support both vulnerable young people and offer clinical support to case managers.
- Outreach takes place with children, vulnerable young people and families at a range of locations, including family homes and education establishments.

Twenty-three referrals have been made to external health-related services and IBA has been delivered to 55% of vulnerable young people assessed with alcohol-related problems (20 in total). The results of these changes are improved health outcomes for vulnerable young people in contact with CJS and it is reasonable to assume that the continuation of the work of PHN would, in some cases, have a corresponding impact of reoffending rates.

It should be noted, that the level of progress achieved has made been in spite of several barriers, including: unconventional governance arrangements for the post; at times a lack of clarity regarding the focus of the post; cultural differences between stakeholders working within the CJS and healthcare; the absence of rigorous and complementary information sharing protocols and practices across the multiple sectors involved in the work of the PHN; and communication issues within YOT regarding the roles and responsibilities of the PHN and accordingly, the responsibilities of case managers in relation to this. It should be recognised, however, that these issues would be expected when developing and embedding a new service within an existing framework and complex organisational landscape. Other difficulties encountered by the PHN included: a delay in gaining CRB clearance which had a direct impact on the nature of the roles that they could undertake for a number of months; complex line management arrangements; and a significant degree of learning required in terms of the CJS as a whole, as well as staffing, rules and procedures within Newcastle YOT, and the same in relation to a complex and non-conventional education setting, and a range of services within Newcastle across a broad spectrum of health issues. The impact and nature of the work that the PHN has been able to achieve within this environment and the commitment shown by the PHN to the development of the post should be commended. With additional time, this role can undoubtedly become more embedded within YOT and the direct benefits made apparent and impactful to both staff and vulnerable young people engaged with YOT.

In reviewing the above, it is important to emphasise that the role of the PHN remains in its infancy and the establishment and embedding of any post is a complex and lengthily process. A significant amount of progress has been in relation to addressing a critical need amongst vulnerable young people, within a very short timeframe and within a difficult external environment. Accordingly, the research team strongly recommend that this post be sustained in the long term. In this context, the recommendations below relate to commissioning and governance arrangements for the post, the

embedding of the post within YOT and areas for development, rather than a refocusing of the work of the PHN. The key recommendations are:

- Consideration should be given to the most appropriate commissioning framework for the post. Situating the post within a healthcare framework would overcome difficulties relating to the complex governance of the post; confidentiality and information sharing across mainstream and specialist health services; and, integrating the post within a wide range of services tasked with improving the health outcomes of vulnerable young people (i.e. DnA and CAMHS). The location of the post within a health-related service (such as DnA) would also provide the post holder with the level of clinical supervision and CPD required for the effective functioning and further development of the post. If such an approach were adopted, the PHN could be ideally conceived of as 'vulnerable young people nurse'. This would remove the sense of isolation experienced by the PHN in relation to other agencies and services as a result of the roles association with YOT and would promoted the role of the PHN as an accessible resource available to a host of health-related organisations. In the absence of this, consensus should be reached about the remit of the post and joint supervision arrangements established, as well as arrangement for a permanent clinical line manager.

- YOT staff should be encouraged to adopt a more holistic understanding of health, focusing on lifestyle factors, as well as basic health needs and focus on improving health outcomes in the context of the general wellbeing of vulnerable young people as an end in itself.

- Mechanisms should be developed to ensure that all young people in contact with YOT are given the option of a comprehensive health assessment by the PHN or receive a health screening as standard practice, to eliminate the risk of unidentified needs remaining unaddressed

- The role of the PHN within YOT should be clarified to all staff and the services which they currently offer be disseminated, as well as the responsibilities of the PHN and case managers being more clearly defined.

- Greater promotion of the role of the PHN should also be prioritised in relation to the target group of young people. Once in contact, positive relationships between the PHN and young people appear to be quickly developed. The emphasis, therefore, should be on fostering initial engagement with the PHN.

- While the PHN works with young people engaged with YOT on a one-to-one basis in relation to a range of issues, linked to both health and lifestyle, such as smoking cessation and weight management, these types of issues could be addressed through stand-alone forms of service delivery such as specialist clinics.

- Protocols relating to referral and information sharing should be made more accessible to case managers. YOT and Public Health should consider the possibility of developing an 'in-house' style for protocols, which both YOT and health professionals understand.

- Measuring the impact of improved health outcomes on the target group's reoffending rates should be undertaken on an ongoing and longitudinal basis, revisiting young peoples' offending profiles at structured intervals.

Overall the research team conclude that the introduction of the PHN with YOT is clearly adding significant value to the services previously provided to vulnerable young people; the

recommendations identified above are to ensure greater embedding of the service and to allow the areas of good practice to be further developed

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