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# Healthy Youth Centre Pilot Project

## Evaluation Report 2010-2012

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## Abbreviations and Terms of Reference

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|               |  |
|---------------|--|
| CAF           | Common Assessment Framework  |
| CYC           | Chelsea Youth Centre   |
| CYPF DATAP    | Children, Young People and Families' Drug, Alcohol and Tobacco Action Plan |
| DAP           | Drug and Alcohol Protocol  |
| EHWB          | Emotional Health and Well Being  |
| ECYC          | Earls Court Youth Centre   |
| GYC           | Golborne Youth Centre  |
| HYC           | Healthy Youth Centre   |
| HYCC          | Healthy Youth Centre Co-ordinator  |
| HYCL/HYC Lead | Healthy Youth Centre Lead  |
| HYCRG         | Healthy Youth Centre Reference Group                                       |
| LGBTQ         | Lesbian, Gay, Bisexual, Transgender and those Questioning their sexuality  |
| PCT           | Primary Care Trust   |
| PSC           | Pilot Site Co-ordinator  |
| RBKC          | Royal Borough of Kensington and Chelsea                                    |
| SRE           | Sex and Relationship Education   |
| SH            | Sexual Health  |
| YP            | Young People   |
| YSDS          | Youth Support and Development Services                                     |
| YW            | You're Welcome   |

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# Executive Summary

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## Background

In 2009 the Royal Borough of Kensington and Chelsea (RBKC) and NHS K&C jointly identified the potential for youth centres to provide a setting to improve health among young residents of the Borough. The Healthy Youth Centre pilot was introduced in 2010 to promote health and well-being to young people in order to educate, empower and support them into making future healthy decisions for themselves.

Part time youth workers were employed at each of four pilot sites to ensure effective implementation of the project, led by a Healthy Youth Centre Co-ordinator (HYCC) who provided line and performance management. The project was supported by a steering group which included senior youth centre staff and Primary Care Trust (PCT) representation. An operational group comprising the HYCC and the Leads was established to co-ordinate all related work.

## Evaluation approach

The pilot evaluation took place over an 18 month period and utilised a mix of quantitative and qualitative methodologies in order to fully address the process and impact of the pilot.

The evaluation contained a range of different qualitative components. Interviews and focus groups were conducted involving a range of key stakeholders including NHS and Local Authority partners, youth centre staff and young people themselves. In addition, the Criteria and Audit Tool (Toolkit) was extensively used by the evaluators to track progress of the initiative.

A survey was conducted among young people attending the pilot sites at the beginning and towards the end of the pilot with the intention of assessing impact

of the intervention on young people's awareness of health issues, their information-seeking behaviours and various lifestyle factors.

## Overview of findings

Qualitative data indicated the pilot had made a tangible difference to young people's access to advice and information. All of the staff involved in delivering the pilot felt that young people were better informed as a result of the pilot and a positive shift in culture was evident at all sites from the perspective of all HYC Leads and senior youth centre staff.

The Lead role was viewed as the most innovative and successful aspect of the pilot and their relationship with young people was key to engaging them with the aims of the programme and influencing behaviour. The provision of Leads served to improve young people's access to a knowledgeable and trusted adult when making lifestyle decisions with potential health consequences.

Workforce training delivered to the Leads appears to have been utilised successfully to deliver an enhanced health and well-being offer within each pilot site. There was also evidence of knowledge transfer between Leads and other youth centre staff resulting in health messages being incorporated into activities delivered by youth workers other than the Leads.

Anecdotal evidence clearly supports the settings model in the context of the pilot. A major strength of youth centres is that they can potentially engage young members who are not engaging with their school environment (arguably those who are most at risk of ill health). Youth centre staff are well placed to provide information that might otherwise be rejected if it were provided by a health professional or a teacher.

The pilot was successful in achieving all of its operational aims and there was no evidence to suggest that the overall model of delivery should change. In addition it was felt that the pilot had enabled emerging areas to be identified which might otherwise have been overlooked and, crucially, enabled youth centres to respond more quickly than might otherwise have been possible.

The survey results indicate, however, that there is still significant work to do in tackling smoking and alcohol consumption among young people attending the pilot sites. There was also some evidence that local specialist knowledge was not utilised as effectively, or to the full extent, as it might have been.

## Recommendations

The evaluation findings suggest that the existing model of delivery and line management structure in future delivery should be retained. Input from and engagement with senior youth centre staff has been an important success factor, as has their involvement in managing the Leads.

Securing commitment from all key stakeholders from the outset was viewed as essential and enables others who work with the Lead to support them in their role from the beginning. Plans regarding partnership working and stakeholder involvement should ideally be set in place prior to delivery.

Any new initiative for young people needs to make provision for emerging issues and caution should be exercised when defining areas to be addressed in centres by the Lead to allow them to respond flexibly to any observed issues (the current pilot was sufficiently flexible to make provision for this). Some consideration should also be given to the interplay between different health and well-being areas.

Future initiatives may benefit from setting out from the outset the degree of harmonisation between centres they wish to achieve. It is important to bear in mind that there is greater potential to engage senior youth centre staff with an initiative if it can be tailored to meet specific objectives that they perceive to be appropriate for their own centres. Consultation with young people can help ensure their concerns are addressed.

The role of a Lead is complex and demands a number of skills and personal characteristics. Line managers of Leads should be prepared to help them balance management and administrative aspects of their role with youth centre contact time since for many Leads achieving this balance will be a challenge.

A range of measures could help ensure that an HYC-type initiative leaves a legacy following discontinuation. The more that specialist knowledge gained by the Leads is shared with other staff the better a centre is enabled to continue their work following their departure. Where resources allow, training opportunities offered to Leads should be offered to other youth centre staff; also Leads should share knowledge and resources among each other as much as possible.





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# 1 Background

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## 1.1 Background

In 2009 the Royal Borough of Kensington and Chelsea (RBKC) and NHS K&C jointly identified the potential for local youth centres as a setting to improve health among young residents of the Borough. Historically the settings approach to health promotion has been widely used in a range of environments such as workplaces, hospitals, cities, etc. However, interventions aimed at children and young people have traditionally been delivered in schools. Therefore RBKC and NHS K&C set out to explore the question of whether using a health promotion settings model in youth centres can be an effective strategy to promote the health and well-being of young people.

The settings approach to health promotion is more than providing health education in convenient settings. It acknowledges that behaviour change at the individual level is less sustainable if it is not reinforced by supporting policies and environments and thus considers how the setting is organised, managed and resourced.

The Healthy Youth Centre initiative has been developed in line with a range of other local strategies and priorities such as Choosing Good Health Together, the Children and Young People's Plan, the Teenage Pregnancy Strategy, the RBKC Children, Young People and Families' Drugs, Alcohol and Tobacco Strategy, etc.

### 1.1.1 Aims and objectives of the pilot

The Healthy Youth Centre pilot aimed to deliver a health promotional programme to children and young people in RBKC by developing at least four healthy youth centre initiatives in disadvantaged areas for a two year period starting in May 2010. The aim was to promote health and well-being to young people in order to educate, empower and support them into making future healthy decisions for themselves. The specific project objectives were:

- To appoint a Healthy Youth Centre Co-ordinator (HYCC) to effectively lead on and roll out the project by regular and supportive line and performance management.
- To develop a bespoke Criteria and Audit Tool and use this as the basis for a needs assessment within each youth centre.
- To develop a steering group (ie, the Healthy Youth Centre Reference Group or HYCRG) to strategically manage the project effectively by providing terms of reference, assessing programme progress regularly, overlooking budget spend and ensuring communication between partners.
- To develop an operational group (ie, the Healthy Youth Centre Operational Group or HYCOG) to operationally manage the project effectively by providing terms of reference, assessing programme implementation in each pilot site regularly and ensuring communication between the pilot sites.
- To ensure effective implementation of the project by employing part time youth workers in each pilot site.
- To use specialist knowledge by appointing an external project evaluator to lead on the evaluation of the project from start to end.
- To utilise local specialist knowledge by developing Youth Support and Development Services (YSDS) protocols around a range of health areas in order to provide a clear and transparent framework for pilot sites, their staff and young people.
- To work in partnership with a range of health professionals and agencies to improve on site-targeted and specialist support as well as referrals to services.
- To work in partnership with a range of health professionals to increase the amount of health related activities and programmes in the pilot sites.
- To work in partnership with a range of health professionals to develop and deliver workforce training around health.
- To ensure young people's involvement by ensuring participation in planning, operation, evaluation and performance management.

### 1.1.2 Pilot sites selected

Table 1.1 shows details of the organisations included in the pilot. Three large youth centres in the Borough (Chelsea, Golborne and Earls Court) were chosen as pilot sites each offering a wide range of facilities and activities with links to large local communities. This was felt to maximise the potential of the pilot to make impact on people living in surrounding areas as well as the target group of young

people who attend the centres. Collectively there is a broad range of risk groups covered by their attendees, including: 'Pregnant', 'Teenage parent', 'Involvement in negative peer groups', 'Free school meal eligibility', 'CAMHS clients', 'School action/School action+', 'In care/Looked after' and 'Social services support'.

A centre for young people with addictions was also included in the pilot. Insight is geared to providing more specialist, personalised support than a youth centre is able to offer. Running the pilot in this environment therefore offered an opportunity to find out how the HYC model operated in a different context.

**Table 1.1: Demographics of pilot sites (April 2011-March 2012)**

|   | Chelsea | Earls Court | Golborne | Insight*                                 |
|---|---------|-------------|----------|--|
| Numbers attending centre                                      | 329     | 599         | 558      | 24<br>(Tier 2 referrals)                 |
| Male/female ratio (%)   | 76/24   | 62/38       | 48/52    | 67/33                                    |
| BME background (%)  | 62      | 68          | 76       | 42                                       |
| BME YP describing themselves as 'Black'/'White'/'unknown' (%) | 32/39/9 | 33/24/8     | 45/16/8  | 21 'Mixed'<br>17 'White'<br>42 'Unknown' |
| Age 8 to 12 (%)   | 17      | 23          | 14       |  |
| Age 13 to 19 (%)  | 69      | 68          | 73       | 25 (16-18)                               |
| Age 20+ (%)   | 13      | 10          | 12       | 75 (18-24)                               |
| LDD (%)   | 6       | 9           | 12       |  |

\* Based on figures for Q3, financial year 2011-12

Source: HYCC, email communication April 2012

### 1.1.3 Method of approach

The Healthy Youth Centre Co-ordinator (HYCC) was based within the Health and Youth Participation Team within RBKC's Youth Support and Development Service. The HYCC reported to the Service Manager – Health (the Team manager). The Public Health Development Manager NHS K&C served in an advisory capacity, providing PCT input.

Each pilot site had a part time youth worker, Healthy Youth Centre Lead (HYCL /HYC Lead), who was responsible for the implementation of the initiative in that centre. The HYCC was responsible for recruiting and project management of the HYCLs, although direct line management fell under the remit of each individual youth centre co-ordinator.

An overall reference group, Healthy Youth Centre Reference Group (HYCRG), was established to ensure effective strategic management of the programme.

Representatives from RBKC, NHS K&C were also included in this group as well as other key stakeholders such as young people and the external project evaluator.

The Healthy Youth Centre Operational Group (HYCOG) was established to shadow the HYCRG, to co-ordinate all related work and also to facilitate joint working opportunities with the statutory, voluntary and community sectors. The Healthy Youth Centre initiative was a standing agenda item at staff meetings in the pilot sites in order to address local matters.

## 1.2 Evaluation approach

The evaluation took place over an 18 month period and utilised a mix of quantitative and qualitative methodologies in order to fully address the process and impact of the pilot. A formative as well as summative approach was taken to enable lessons learned in early stages to inform subsequent implementation. A range of key stakeholders were involved including NHS and Local Authority partners, youth centre staff and young people themselves. The evaluation framework is set out in Table 1.2, which shows the tools and methodologies employed with respect to different stakeholder groups and evaluation elements. The evaluation aimed to establish the following areas:

- Effectiveness of set-up and implementation of the HYC pilot
- Extent to which the pilot met its aim of enabling young people to make healthy decisions for themselves
- Extent to which services were developed in HYCs
- Effectiveness of the health promotion settings model in youth centres as an effective strategy to promote health and well-being in YP  
and  
Extent to which health promotion in a youth centre setting is effective
- Effectiveness of partnership working between RBKC and NHS K&C
- Sustainability of HYC programmes beyond pilot duration.

### 1.2.1 Quantitative data collection

A survey was conducted among young people attending the pilot sites at the beginning (October 2010) and towards the end (October 2011) of the pilot with the intention of assessing impact of the intervention on young people's awareness of health issues, their information-seeking behaviours and various lifestyle factors such as eating habits, activity levels and use of alcohol and tobacco. The survey

was subdivided into different sections to reflect the five areas that the pilot focussed upon.

### **Survey content**

The majority of questions were taken from surveys which had already been employed in the Borough to allow the possibility of comparison with background population data collected by RBKC. Since extensive piloting was not possible this offered the additional advantage of ensuring the items had been 'tried and tested' in relevant populations prior to survey administration. Wording was preserved from original sources to maximise consistency.

### **Survey administration**

Surveys were distributed to young people at the pilot sites by the HYC Leads and other youth workers during the autumn half-term holiday period (this helped ensure maximum response rates since attendance is higher at this time). The 12 month interval between survey waves helped control for any seasonal effects such as participation in sports and the impact of the holiday period on dietary or smoking habits. Two versions of the survey were used; a version without items concerning sex and relationships was administered to young people of 12 years and under.

The surveys were completed anonymously. In order to incentivise young people to respond, a detachable front page was included with the survey to allow participants to be included in a prize draw.

Response rates and a full discussion of the limitations of this aspect of the methodology are presented in Chapter 4.

## **1.2.2 Qualitative data collection**

As shown in the framework (Table 1.2) the evaluation contained a number of qualitative components. Detailed topic guides were produced in order to facilitate all of the interviews and focus groups. These probed issues such as:

- Perceptions of working relationships
- Views on training and support provided to HYC Leads
- Types of activities delivered
- Extent to which messages are incorporated holistically into activities for each of the programme themes
- Suitability of youth centres as a setting to receive health information

- Integration of HYC activities/messages into YC activities and interactions with young people
- Extent to which youth workers at HYCs felt equipped/confident to continue with programme without support from HYC Leads.

In addition, the Criteria and Audit Tool (Toolkit) was extensively used by the evaluators to track progress of the initiative. Supporting information was obtained from management information sources such as HYCRG minutes and pilot site attendance records.

**Table 1.2: Evaluation framework**

| Evaluation component  | Stakeholders  | Evaluation objective  | Tools and methodologies  |
|---|---|---|--|
| <b>IMPACT</b><br>(What difference has the HYC programme of work made?)      | Young people  | Measure extent to which the HYC pilot meets its aim of enabling YP to make healthy decisions for themselves   | Survey for YP administered at baseline and followed up towards end of evaluation period<br>Data from HYC Criteria and Audit Tool<br>Interviews and/or focus groups with HYC users  |
|   | Youth Centres   | Measure extent to which services are developed in HYCs<br>Measure effectiveness of the health promotion settings model in youth centres as an effective strategy to promote health and well-being in YP | Data from HYC Criteria and Audit Tool<br>Other available records indicating YP's exposure to pilot activities including, where possible, demographic composition<br>Interviews and/or focus groups with HYC youth workers and HYC Leads  |
|   | Youth workers   | Measure extent to which health promotion in a youth centre setting is effective<br>Measure sustainability of HYC programmes beyond pilot duration   | Interviews with HYC youth workers, including junior workers, senior workers, managers of HYC Leads and PSCs  |
| <b>PROCESS</b><br>(Did the HYC programme of work do what it set out to do?) | RBKC and NHS K&C includes:<br>HYCC<br>Public Health Development Manager<br>HYCLs<br>HYCRG<br>PSCs | Measure effectiveness of partnership working between RBKC and NHS K&C   | Minutes from Steering group meetings<br>Interviews with:<br>HYCC<br>Public Health Development Manager<br>PSCs/other staff who line manage the HYCLs<br>Focus groups/interviews with HYCLs<br>Focus groups/interviews with external health Stakeholders that are/will be delivering on site interventions |

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## 2 Findings from the Process Evaluation

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### 2.1 Set-up and project initiation

This section draws from qualitative data obtained during the first three months of the pilot. Data collected at this stage of the pilot served to:

- Provide feedback to inform delivery of the ongoing pilot.
- Help learn lessons about the set-up phase that could be of use to future initiatives.

#### 2.1.1 Recruitment and induction of HYC Leads

##### Expectations of Leads

Without exception, the Leads approached their new role with enthusiasm and felt that the pilot presented an opportunity for them to make a difference to young people's lives. The Leads also anticipated that their role would result in significant personal and professional development for them as individuals. In particular they welcomed the prospect of building on their existing knowledge base in the four key HYC health areas. They also viewed that experience in this new role would position them well for undertaking a future career involving work with young people, such as further youth centre work or social work.

The Leads viewed the HYC primarily as an awareness raising exercise which would promote the benefits of leading a healthier life to young people and increase their awareness of sources of advice and guidance. However, there was some concern surrounding how their efforts would be judged, particularly given the different starting points of different pilot sites and the variations in management style at each.



## **Views on suitability to role and development needs**

Three out of four of the HYC Leads were recruited from within existing staff at their respective pilot site (the HYC Lead at the specialist centre was recruited externally). Those Leads viewed that their existing familiarity with youth centre members put them in a potentially better position to engage with young people than external specialists, especially regarding sensitive topics. The remaining HYC Lead (who had experience of working with young people at similar specialist sites) was similarly confident of her ability to engage with young people using the service.

Among the Leads there was a mix of relevant skills and knowledge, including previous experience of working in areas such as substance abuse, healthy eating and sports and all had experience of working to the principles underlying the 'You're Welcome' criteria. All of the Leads viewed themselves as approachable and capable of gaining the confidence of young people and this view was shared by their managers.

There were very positive views on the 'Nudge' training that was delivered via the local PCT in preparation for their roles. There was acknowledgement among some of the Leads that they would need further, more specialised training and hopes were expressed that any development needs in the four main HYC areas would be met over the course of the pilot.

### **2.1.2 Securing buy-in from Co-ordinators and other pilot centre staff**

A major task for the HYCC was to secure support from the youth centre co-ordinators (PSCs) at each of the pilot sites. It was also a priority to bring other staff on board as well, particularly those with direct line management responsibility to the Leads.

#### **Expectations on Co-ordinators and HYC line managers**

The PSCs and HYC line managers generally saw great potential for the pilot to make a positive difference at their centres. They were optimistic that the pilot could help them consolidate existing resources as well as provide added value to the services already on offer.

It was noted that in the past youth centres had often implemented their own initiatives in isolation. It was hoped that the HYC pilot would help to establish good practice guidance which could be shared. There was also a view that having one dedicated individual in place would enable some sites to take a more holistic approach to health and well-being than had been possible in the past.

Among some of the pilot site co-ordinators there was optimism that the pilot would enable faster access to specialist input in HYC health areas. There were also hopes that the HYC Leads could be tasked with identifying suitable professionals to tackle specialist health issues at their centres as they emerged.

### **Views on set-up and project initiation**

Although all PSCs were supportive of the intervention in principle a need was highlighted, particularly at the set-up stage, for greater clarity on the specific objectives and intended hard (and soft) outcomes of the intervention. Also, although PSCs had been briefed and consulted at early set-up stages the other staff at the centres had not. There was a view that it would have been helpful if the HYCC had visited each pilot site and briefed youth workers on the HYC initiative prior to implementation of the pilot. This could have included clarification of the pilot's aims and objectives and how it would work. Ideally this would have stressed to all youth centre staff that the pilot would not free them from their existing responsibilities regarding provision of health and well-being guidance and would have cleared up any potential confusion regarding the HYC Lead role.

There was a general view among the PSCs that the set-up stages of the pilot had been 'paper and meeting heavy'. They considered that a disproportionately large amount of their time had been taken up travelling to meetings at the Borough's YSDS office and felt that this had made disproportionate demands on their time.

## **2.2 Implementation**

In order to provide context this section starts by describing the types of outputs the Leads were able to achieve in their role (more specific examples are provided in Chapter 3). The remainder of the section summarises views on the planning, consultation and administrative processes which supported delivery of these activities and comments on their effectiveness.

### **2.2.1 Outputs delivered**

The work of the Leads primarily centred on planning, organising and delivering the following outputs:

- One-off sessions or activities addressing specific health and well-being issues (either led by the Lead themselves or an external expert).
- Regular on-site sessions/activities focussing upon a particular health and well-being theme.

- Spot-purchase of equipment to improve facilities offered at the site (eg, purchase of water fountains, gym equipment).
- 'Adding value' to existing on-site health and well-being related activities (eg, ensuring cooking sessions use healthy ingredients).
- Ensuring sessions/activities delivered at the pilot sites contain at least one health and well-being message (where appropriate).
- Providing informal guidance on HYC themes to YC members, either on a one-to-one or group basis.
- Making referrals (where appropriate) to suitable external agencies on the basis of information disclosed by YC members.

### 2.2.2 Role of the HYC Leads

As a group the Leads had carried the bulk of frontline delivery of the pilot. Views are presented here on a number of elements of their role.

#### **Strengths of the Lead's role**

As individuals who were already familiar to and trusted by young people it was felt that the Leads were ideally placed to pick up on young people's concerns and either advise in situ or design initiatives to address emerging issues. Previously it had not been possible to make provision for this on a strategic, sustained basis.

A perceived strength of the Lead role was their ability to 'zone in' on the motivations and concerns of young people and personalise information accordingly. This served to support a holistic approach where health and well-being could be addressed in tandem with other goals such as looking attractive (by healthy eating), succeeding at sport (helped by regular exercise), being musically creative (by avoiding drugs to keep a clear head) or maintaining a good singing voice (by giving up smoking). By being attuned to young people's ambitions the Leads were able to tailor health messages to link them to young people's personal goals and values.

#### **Working hours/administration**

Many of the Leads had not envisaged the amount of planning and administration that the role would require and found that this was the most time-intensive aspect of their work. They all reported that their HYC workload could not be completed within the 10 hours per week specified in their contract. All were juggling other work at the pilot site with their HYC role and found that the demands of the former intruded into their other work as well as into their personal time. The most

experienced of the Leads appeared to find this less of an issue than the others, possibly because of the greater familiarity with (and realistic expectations of) administrative processes that she brought to the role. It was noted that Leads gradually became more adept at documenting and evidencing their work as the pilot progressed.

### **Presenting and marketing HYC to young people**

Related to the issue of defining a HYC was a perceived inconsistency in terms of how the pilot should be presented to young people. Some Leads preferred to make their role and responsibilities known while others chose not to. Others chose to take a middle ground and made it known that they were available to advise on and discuss health and well-being issues without mentioning the pilot itself or indicating that any kind of new initiative was on offer. Consequently in some centres there was good awareness of the pilot and/or the HYCL role while in others there was not.

### **Training in post**

In former job roles, Leads had attended training in the four main HYC areas and all completed 'Nudge' training as part of their induction.

Other training in specific health and well-being areas was provided on an ad hoc basis as the pilot progressed. Collectively the Leads underwent training addressing a number of topics, including:

- promotion of condom use/distribution
- child protection and safeguarding
- health and safety
- food and nutrition
- use of social media
- drugs and alcohol misuse
- bullying
- sex and Relationship Education (range of training provided).

All training received was regarded as useful and relevant. The drugs and alcohol training was viewed as particularly helpful in increasing the Leads' understanding of the relationship between individuals who misuse and their preferred drug. The trainer addressed very specific issues about communication and stressed the importance of being aware of the 'trigger words' when addressing these issues

with young people. Training courses on food and nutrition and bullying were also singled out as particularly valuable.

Some of the Leads reported that they felt better equipped and more confident to discuss health and well-being areas one-to-one with young people as a direct consequence of training they received. They also reported increased knowledge of referral pathways and associated procedures as a result of their training.

### **Other perceived training needs**

While the Leads understood there was a finite budget for training they felt that more training would have been useful in the following areas:

- substance abuse
- mental health awareness
- sexual health awareness
- relationships
- agency signposting
- counselling skills.

The Leads expressed a preference for longer more in-depth training over half-day sessions which they felt only 'skimmed the surface' of a topic. While short courses were helpful for one-to-one work with young people, the Leads felt that these did not equip them to deliver sessions themselves to groups of young people. Some had tried to run some sessions but had felt uncomfortable with (what they viewed as) their own lack of knowledge of the topic area. For example some of the Leads felt that that they would have liked a more in-depth understanding of the effects of hard drugs before talking to young people about this. There was also a desire to undertake training that would allow them to further develop their 'soft' skills, for example styles of mentoring that were successful in encouraging attitudinal and behavioural change. One Lead provided an example of a time she had to spoken to a young male about his attitudes to women and sex and had felt the discussion had been compromised by her lack of knowledge about changing attitudes; she had felt that with more knowledge her approach would have been less 'off the cuff'.

Another area highlighted as a development need was emotional health and well-being; the Leads felt that training in this area could be too relationship centred and did not sufficiently address the area outside the context. This HYC area was viewed as particularly tricky to address with young people due to the stigma surrounding mental health conditions. It was felt that ideally training would

address vocabulary to use with young people when discussing mental health that would not alienate or result in confusion.

### **Identifying areas of need and initiating activities**

The Leads were driven by two main factors in planning their programme of work: namely the criteria identified on the HYC Toolkit and areas where their respective PSCs felt their time should be targeted. In some circumstances there could be agreement between the two; the Toolkit was felt to be particularly helpful at the beginning of the pilot for flagging strengths and weaknesses at individual centres. However, there were times where Leads felt under pressure to deliver to a particular PSC's 'agenda' and felt that could sometimes detract from their efforts to meet the wide range of criteria set out on the Toolkit as well as areas requiring action from the perspective of the HYCC. The HYCC acknowledged that this balancing act could be challenging for the Leads and the fact that the Leads had their own interests and specialisms complicated this further.

As the project developed; the HYCC observed that the Leads became increasingly proactive about tackling topics emerging within their individual centres. This was viewed as a positive development and from the perspective of the HYCC this was viewed as compatible with the overarching objectives of the pilot.

A key consideration when planning activities was inevitably the availability of financial resources. The Leads felt that the best HYC initiatives had been those where additional funds from other sources had been available; the HYCC and the PSCs were all instrumental in sourcing external funding when the HYC budget was insufficient to fund a particular initiative.

There was a view among PSCs that the right health areas had been selected to the pilot. However, some issues that were identified by the Leads as priority areas could not readily be assigned to the four main health and well-being headings. Examples of this included:

- Cycling safely to and from the youth centre (road safety and protective gear).
- Travelling to and from the youth centre on foot (concerns around gang culture and street crime).
- Personal hygiene: this emerged as an issue for some young males at one of the youth centres, particularly following sports activities.
- Self administered body piercing: this issue was identified following young people showing up at a youth centre with cosmetic piercings they had attempted to administer themselves.

Some emerging areas crossed several themes. For example, there were reports among PSCs that a small number of young females were being coerced into sex with multiple partners (ie their male partner's peers) as a result of gang culture. This was viewed as an emotional health issue (concerning self esteem) as well as a sex and relationships issue.

### **Use of the Toolkit**

At times the HYC Leads struggled to fill in the Toolkit within the required timeframes and found that they had needed a considerable amount of support from their pilot site line managers and/or the HYCC to complete it. This also impacted on the PSCs and line managers at the pilot sites who found the contact time required to assist Leads to complete the Toolkit had made significant demands on their own work schedules. Feedback provided early in the pilot suggested that the Toolkit was seen as overly complex and as a result of this the Leads were offered the opportunity to suggest changes to it. The evaluation team also provided suggestions to simplify the tool. Despite modification to the Toolkit some concerns remained throughout the pilot partly due to the sheer length of the document and also the lack of 'fit' between some of the changes Leads had implemented at the pilot sites and the specified criteria. For example, where steps had been taken to address topics that fell outside the HYC areas (such as personal hygiene and road safety) it could be difficult for the Leads to judge which section of the form to record this in.

There were some issues that may have arisen from the fact that the document had originally been developed from a Criteria and Audit Tool for RBKC's Healthy Schools initiative: some of the Leads felt that not all of the criteria in the Toolkit worked well in a youth centre environment. Other issues were raised concerning the differences between the memberships of the various pilot sites. The Leads felt that some criteria may be more or less important according to the demographic composition of particular centres (for example in terms of age, or gender bias) and that the Toolkit did not help them prioritise accordingly. This was a particular issue for the specialist centre which helps YP with drug and alcohol issues; some parts HYC criteria for the Drugs Alcohol and Tobacco area were viewed as redundant. Overall it was felt that the tool was too restrictive and did not sufficiently allow for the fact that interventions might be appropriate in one youth centre but not another.

From a more strategic perspective it emerged that not all the Leads had a good understanding of the purpose of the Toolkit ie, that it could potentially serve to demonstrate evidence of the effectiveness of the pilot to independent observers. Many had not seen the strategic benefit of ensuring the contents of the Toolkit reflected as much of the work they had completed as possible, and the potential

implications of its contents for securing future support for the pilot and consequently their own positions as Leads.

Following the departure of one of the Leads, a new Lead was recruited at one of the youth centres towards the end of the pilot but there was not evidence that this had been disadvantageous. Because he had existing working relationships with the pilot site staff and relevant partners the transition was a relatively smooth one and the new Lead felt he was better able to engage youth centre staff than his predecessor.

### 2.2.3 Role of the HYCC

The HYCC was central to the operation of the pilot and served as the link between the commissioning partnership and the participating pilot sites. Two individuals performed this role in succession over the duration of the pilot. Seven months into the pilot (this included the set-up and project initiation phases) an Acting HYCC was brought into post to cover maternity leave. During this time the Acting HYCC was required cover an additional post which placed limitations on the time she was able to commit to the HYC pilot. Although in practice she was able to keep the project running operationally, she was not able to implement all feedback from the external evaluator or develop planned protocols in some of the HYC areas. There was also insufficient time to build new working relationships with health key stakeholders, improve referral pathways, or to adequately support the development and use of social media. The original HYCC returned to post 14 months later, three months prior the end of the pilot. The hours allocated to running the pilot were considered realistic and workable to keep the project running during implementation stages. This was not viewed as sufficient however for the set-up stage or towards the end of the pilot stage when work was underway to re-profile the project.

The administrative responsibilities of the role (such as budget management and business plan development) were viewed as the most straightforward elements of the HYCC role. Management of the Leads, particularly the pastoral element of this, was viewed as more labour intensive. While this could be rewarding at times this proved more difficult than envisaged, particularly from the perspective of the Acting HYCC. Collectively the Leads required a lot of support and reassurance, in part because most of them were dealing with a substantial administrative load for the first time in their career. At times it could be demanding for the HYCC to provide the level of assistance some of the Leads required to complete the Toolkit (which was used throughout the pilot to document their progress and formulate action plans).



Following the departure of a Lead in the closing months of the pilot a key responsibility for the acting HYCC was the recruitment of a new Lead to this role. A suitable candidate was identified quickly and the recruitment exercise was regarded as relatively straightforward.

The Leads were satisfied with the level of support provided by the original and Acting HYCCs during pilot implementation and described the approach of the latter as 'hands on'. The handover that the original HYCC conducted on her departure was viewed as comprehensive: this proceeded smoothly from the perspective of the Leads and the Acting HYCC herself. Views were mixed regarding the handover between the Acting HYCC and the original HYCC which occurred towards the end of the pilot. Some of the Leads felt that the transition could have been smoother and they would have preferred to spend less time briefing and updating the returning HYCC.

There was a feeling among the Leads that a structure that enabled them to report straight to the HYCC could simplify a reporting process which could seem overly bureaucratic at times due to the requirement to report to the PSC (or designated line manager) at their respective centres. However (see section below) PSCs confirmed that they were keen to maintain their input into the delivery of the pilot and viewed this as essential. Reacting to this preference among some of the Leads would, therefore, have risked maintaining the engagement of senior youth centre staff with the project.

The change in HYCC was viewed as 'difficult' for the project although it was not felt to have impacted on overall outputs.

#### **2.2.4 Role of the PSCs and HYCL line managers**

All of the PSCs as well as line managers of the HYCLs based within youth centres were supportive of the HYC initiative and were committed to playing their part in facilitating its implementation.

#### **Delivery model**

There was agreement among Leads and their managers that the model of delivery of the pilot offered a completely new approach. The most innovative aspect was perceived as the creation of the Lead role, ie tasking one individual with maintaining a health and well-being focus within the youth centre and providing resources to enable this. The availability of dedicated members of staff (including the HYCC) enabled greater creativity to be employed in promoting the health agenda than before (for example introducing rollerblading lessons, or new, healthier ways of preparing food).

Another advantage of the 'Leads x 4' model was that it enabled each Lead to focus on health and well-being issues that were specific to their particular centre. For example, at some of the youth centres smoking was a pressing issue while, at the specialist site for drug and alcohol issues, relationships and general aspects of self-care such as food preparation were a greater priority.

### **'Vision' of the pilot**

A view among some of the PSCs was that they did not feel that the pilot had a clear 'vision' or specified outcome. Initially there was felt to be lack of a clear concept of success or failure of the initiative. There was some confusion surrounding the definition of a Healthy Youth Centre, what one would look like and what it would offer, for example:

- A 'badge' that would denote a youth centre fulfilled all the criteria specified in the HYC Toolkit
- Any youth centre with a commitment to work to those criteria and maintain them
- Any youth centre where an HYC Lead was employed
- Some combination of the above.

However, once the initiative had become more established the Leads and their line managers appeared to become better synchronised regarding the main objectives of the pilot. There was also a feeling that the experimental nature of the pilot itself was not compatible with having rigid expectations and that it would not have been appropriate to clarify all of its outcomes in advance.

The HYCC viewed that there had been insufficient time to conduct assessment at each centre of their needs and highlighted that this may have had an adverse effect in terms of adding to the administrative load of the PSCs prior to the pilot.

### **Workload**

There was agreement among this group of professionals that there were limitations to what could realistically be achieved within the hours the Leads were contracted to work on the pilot. In general they were supportive of the Leads using other hours that they were contracted in order to achieve their HYC objectives since this was both compatible with their other work and beneficial to the centre. However, as a result of their other priorities and a heavy workload the PSCs and HYCL line managers struggled to give the initiative and the Leads themselves as much time as they would have liked.

### 2.2.5 Involvement of other youth centre staff at the pilot sites

In general the PSCs and other HYCL line managers sought to encourage other staff to support the pilot to ensure that the Lead was not working in isolation. There were several means by which PSCs were able to ensure other youth workers at the pilot sites became involved in the pilot:

- Inviting the Lead to YC staff meetings so they could brief other staff on planned events and activities.
- Prompting the Lead to arrange staff training in HYC areas requiring staff development (as indicated in the Toolkit).
- Encouraging the Lead to work with other youth workers to enable them to introduce health and well-being themes into their own work with young people.

All of the Leads felt that the pilot had resulted in youth workers at their respective sites engaging with health and well-being issues to a greater extent. They also reported that staff approached them when unsure how to deal with health and well-being topics and looked to them to provide expertise on these issues.

There was a view among the Leads that all youth workers would have benefited from the 'Nudge' training they received at the beginning of the pilot and that this would have amplified the potential impact of the pilot across the sites.

### 2.2.6 Partnership working and involvement of other stakeholders

Following implementation of the pilot the input of the Kensington & Chelsea PCT was mainly limited to representation at HYCRG meetings.

The Leads reported that they would have welcomed more input from the PCT, especially in relation to delivering sessions where health expertise was required. However, they reported that they were not approached by any individuals from the PCT and that they did not know who to approach themselves. There was a feeling that this could have helped them to overcome difficulties they experienced in obtaining input into the pilot from external agencies.

There was a view among the Leads that the contribution of the PCT and other stakeholders should have been formally specified or at least outlined before the pilot had been implemented. This would also have provided some leverage when negotiating input from external stakeholders. The Leads could not always identify suitable individuals to involve in the pilot and the HYCC confirmed that that this resulted from the fact that no local provision was available in some health areas. However, the HYCC felt that possibly the Leads had not 'chased' assistance from professionals in their directory of contacts as hard as they might have done and

that they had possibly not been aware of the extent to which they would need to do this.

From the perspective of a stakeholder who contributed to the evaluation the pilot had been effective in ensuring that his organisation delivered tailored, relevant support to the pilot centres. His general view of the pilot was positive but his impression was that the pilot lacked an overall 'vision' of what it was setting out to achieve. Liaison between the Leads and his organisation had been effective although there was also a view that a more co-ordinated approach may have been possible if the Leads had worked together and that this may have yielded more efficient use of the resources his organisation were able to offer.

## **2.3 Differential impact on youth centres**

There was no evidence of any site-specific characteristics impinging on implementation of the pilot. All of the Leads were successful in adapting the HYC programme to fit the needs and demographic make up of their respective centres. Some differences in emphasis were apparent however, particularly in the area of Physical Activity and Healthy Eating. For example, the presence and size of on-site gyms impacted on the types of classes and training sessions that the Leads were able to offer. Similarly, the availability of an outdoor space on-site offered the possibility of engaging more young people in team games and delivering healthy eating and other lifestyle advice in that context.

Insight already offered a holistic approach to the health of service users before the pilot and it was felt that the pilot had enabled the Lead to take an approach that was consistent with this to enhance their health and well-being offer. Initially there had been some concern that the model was not tailored to the specific needs of that site. However, over the course of the pilot the Lead was able to adapt the HYC programme successfully to achieve good 'fit' with the needs of the centre. This was achieved by working closely with her line manager and other staff at the centre signalling that the HYC concept can successfully be adapted for specialist as well as mainstream young people's services.

### **2.3.1 Views among young people**

Young people offered a range of views about the pilot via focus group and one-to-one interview, although in some cases a lack of understanding about the pilot and its aims resulted in them giving more general views about their youth centres. Nevertheless a number of commonalities emerged among their responses.

## **Presenting and marketing HYC to young people**

Due to inconsistency in terms of how the pilot should be presented to young people in some centres there was good awareness of the pilot and/or the HYCL role while in others there was not. Some young people who contributed to the evaluation expressed a preference for the Lead to make their role obvious 'so we know who to talk to' and suggested that there should be a means to distinguish the HYCL from a regular youth worker role through logoed clothing or a badge. Others tended not to have strong views about this.

When considering this point it could be useful to bear in mind that some PSCs suggested that a 'uniform' could serve as a disadvantage for a young person seeking advice on a sensitive issue, since observed discussions with a clearly identifiable Lead could prompt their peers to assume they had a health problem. This issue had arisen in the past when health professionals such as GPs had visited the centres.

## **Young people's perspective on their own health and well-being concerns**

One potential challenge for the pilot was the difficulty of aligning its approach with young people's own concerns. Young people who contributed to the evaluation identified a number of issues including:

- Youth centre environment: although not a health area in the strictest sense, many young people said that environmental issues affected how they felt (see text box below).
- Crime: fear of crime was a potential cause of stress and anxiety.
- The law and the rights of young people (again an area with potential implications for well-being).

There was a view among some young people that there was 'too much (focus) on drugs and sex' and 'not enough (focus) on personal values' and 'getting along with others'. Among some junior members there was a feeling that information on hard drugs was not applicable or useful for their age group.

## **Young people's preferences regarding youth centre activities**

When consulted as part of the evaluation young people tended to express a preference for activities they perceived as fun. There was also a request for more overnight trips, more team-building sessions and more space to play sports. With this in mind, it is unsurprising that the Leads tended to find it easier to engage young people in activities that fell within the remit of 'Physical Activity and

Healthy Eating' than the other areas which were arguably more serious or sensitive in nature.

Similarly, young people reported that they had little patience with long 'boring' sessions or any approach that is seen as too formal. They expressed a preference for sessions which had a good 'fit' with their needs, presented in a format where they could be interactive. Year-round access to activities was identified as a need as was longer opening times.

It could be challenging for the Leads to find ways of engaging young people that aligned with things they liked doing although many of the Leads were successful in taking a creative approach to this (see Chapter 3 on impact). There were obvious resource implications for many of the activities that were popular which the Leads and their managers needed to consider. In addition many of the Leads felt that they had to offer incentives (usually refreshments) to encourage attendance at sessions dealing with serious topics: this also had resource implications.

### **Young people's preferences regarding youth centre environment**

As part of the evaluation, young people were asked what a Healthy Youth Centre should look and feel like. This resulted in more engaged responses than other more specifically health-related questions. There was general consensus that a HYC should be 'clean', 'bright' and 'have an uplifting atmosphere' (also see text box below). Cleanliness was also raised, as was the external appearance of the building more generally. Some young people complained that lack of daylight and peeling paint was not good for their sense of well-being. Many of these concerns fell outside the HYC remit but are important to consider as they potentially affect young people's perceptions that their centre is conducive to their well-being.

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#### **Environmental concerns identified by young people**

"The building needs some repairing"

"Toilets need to be upgraded"

"Not enough gym equipment"

"Upgrade the equipment"

"Need to repair the PS3 player"

"More fruit should be on offer"

"No deodorant is supplied to users"

"Upgrade the air conditioning"

"Put better lighting on the bridge"

## Receptiveness of young people to receiving health and well-being information

The intervention needs to be considered in the context of the range of possible, alternative sources that young people receive health and well-being information from. This can potentially affect their receptiveness to further information provided at their youth centre. Junior members reported viewing school as their main source of health information, while older members tended to provide a broader range of responses including their GP, the television, parents and other family members, and the internet. Some also cited organisations which work with youth centres such as Brook and Coram. There was a general agreement that they did not like health professionals, particularly GPs who were viewed by some as 'overbearing' or 'patronising'. There was also resistance to materials such as leaflets that were not easy to read or 'user-friendly'.

Some young people who contributed to the evaluation said that they viewed youth workers as 'role models' and as sources of advice on a range of issues from personal and social problems to difficult homework. Arguably, the HYC role potentially allows youth workers to capitalise on the position of trust and authority they already offer.

Despite the large range of sources of information about health they had exposure to, the focus groups indicated that young people were receptive to receiving additional health-related information at their youth centre: there was a general view that their youth centre provided them with 'about the right amount' of health and well-being information and it appeared to be valued. They also praised the approachability of the staff and the 'non judgemental environment' of the centres.

They felt that their youth centre was trying to push a variety of messages including keeping fit (via exercise), healthy eating, 'stop smoking', 'say no to drugs and alcohol' and '5-a-day'. 'Everyone is equal' was mentioned (with respect to anti-bullying messages as well as 'enjoy and achieve' in relation to self esteem. They also talked about having a 'healthy mentality' and 'positive thinking' and 'feeling good as a person'. Some cited sports activities as a means of relieving stress.

## Resistance of young people to changing behaviours

In common with the population as a whole it can be difficult to motivate changes to behaviour through provision of information, whatever the mode of delivery. When asked what they thought prevented them from making healthy choices, young people blamed 'laziness and lack of willpower' and in some cases attributed it to their age 'it's all too much to take in when we are quite young'.

### Use of youth club as a setting for the pilot

There are clear incentives for young people to visit youth centres, (see box below) such as recreational facilities that they would not be able to access freely anywhere else (such as a computer room, music studio, etc.) as well as the more obvious social element.

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#### Reasons provided by young people for visiting their youth centre

“Safe”, “fun”, “somewhere to keep busy”  
“It’s an open facility for the public”  
“It has a positive atmosphere”  
“There’s always something entertaining going on”  
“Dance classes”, “Experienced gym trainers that train us”, “Table tennis”  
“Staff make it hard to get bored”  
“Friendly staff”

The Leads felt that a youth centre was the ideal environment to engage young people as it offers a more informal atmosphere and provides an environment where they feel more comfortable than a school or a GP surgery.

The sheer size of the local populations they serve ensures the Leads have a greater reach than organisations that offer solely education or health advice. However, the fact that young people visit youth centres voluntarily was viewed as a potential challenge as well as strength. The potential of an HYC to make a difference to a young person’s choices about health and well-being is clearly limited if they attend on an infrequent or very temporary basis.



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## 3 Impact Evaluation: Summary of Qualitative Data

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This chapter provides a summary of activities which took place as a result of the pilot. It is not intended to be exhaustive and serves as an overview of actions documented in the Criteria and Audit Tools completed by the Leads, and/or raised during depth interviewing with Leads. These findings are grouped by theme but it should be noted that many activities recorded had a bearing on more than one health area, in particular most topics were felt to have some crossover with Emotional Health and Well-being.

### 3.1 Physical activity and healthy eating

Activities around healthy eating had been stepped up at all of the HYC pilot sites. Most significantly, cooking at all of the pilot sites had become more regular as a result of the initiative. In one centre some young people who had reportedly never cooked before were now cooking twice a week.

One-off events were also used to address this area. For example, a training session focussing on abdominal toning for young females was held at one of the youth centres. This was accompanied by an explanation of the HYC Lead role and presentation of healthy lifestyle information including fat and salt content of foods. A weekend residential in the South Downs provided an opportunity to encourage young people to survive on their own cooking skills.

More specifically Leads reported that young people had become more aware of health considerations when preparing food as well as time and convenience. For example, they would choose to grill rather than fry chicken, and also consider different types of cooking oil. One Lead had observed that young people had started to pay greater attention to hygiene and washing their hands and kitchen surfaces before cooking. The Leads agreed there was great potential for young people to learn from each other in this area: when new members saw other youth

club cooking they would often want to try it and would tend to follow their peers in taking a healthy approach.

The Leads were also able to observe changes in young people's knowledge base regarding healthy living. For example, following a healthy eating quiz one Lead noticed young people discussing the salt contents of food they were sharing. One Lead observed that young people at his centre seemed more 'body aware' now; for example, he had heard them commenting on how much of their body is made up of water (and therefore how important it is to drink the right amount) and the specific exercises they need to do at the gym to affect different parts of the body.

Awareness of the difference between healthy and less healthy foods was evident in the evaluation focus groups. Junior members in particular cited access to healthy food as a positive aspect of coming to their youth centre. There was demonstrable awareness of concepts such as '5-a-day' across the pilot sites.

At one centre the gym was used as a focal point for the sessions about healthy eating. This ensured that young people using the gym were exposed to messages about healthy foods and the nutrients required by the body.

### **3.2 Sex and relationships**

HYC Leads felt they had been able to make a significant impact in this area, especially through working with young people on a one-to-one basis. There was general agreement that the training they had received for their role enabled them to broach sensitive issues around Sex and Relationship Education (SRE) with young people more confidently. All of the Leads were able to report situations where they had successfully engaged young people in conversation about their relationships allowing them to introduce health and well-being related content into the discussion.

International Women's Day was used by most of the Leads as a platform to raise female-only health and well-being issues. A major event was held at one of the youth centres which provided an opportunity to offer sessions about sex-related health issues and emotional issues around relationships to a large, female-only audience. An event was also organised to mark World Aids Day which aimed to increase awareness of STIs in general as well as HIV, which around 80-90 young people attended.

A rave event at one youth centre was used as an opportunity to publicise key agencies and provide young people-friendly information. The TXTM8 service was promoted and The Haven attended the event to promote awareness around rape. Brook were also represented and condoms were given out at the event. Over 250

young people attended the rave from across the Borough. Young people were also offered STI tests at the rave.

The Leads felt they had been able to help their respective centres respond to emerging areas that might otherwise have been overlooked. At one centre the manner in which males spoke to females was identified as a problem and in discussions with young females at the centre it emerged that they experienced this as a kind of sexual bullying. The Lead was able to speak to young females in small groups about ways of responding to this and asserting themselves. It was reported that this had demonstrably resulted in females feeling more empowered at their youth centres. Conversations overheard among young women at the centre indicated that they were now encouraging their younger peers not to tolerate this kind of behaviour.

A related area which was identified and addressed as a result of the pilot was sexual exploitation of young women. A representative from Tender was invited to one of the youth centres to hold a workshop to help promote self esteem among young women. (The Tender project encourages young people to think about what a healthy relationship means, exploring concepts such as respect, trust, sexual consent and communication).

The Leads felt that one area where they still had a lot of work to do was in encouraging tolerance and respect towards Lesbian, Gay, Bisexual, Transgender and those Questioning their sexuality (LGBTQ) groups.

### **3.3 Emotional health and well-being**

The Leads agreed that this could be a difficult area to address directly because of the stigma surrounding mental health. Efforts to promote mental well-being tended to focus on relating to others. In one example, one the Leads prompted a conversation among young males about their friendships. She was able to overcome initial awkwardness through her relationship with them and stimulate conversation about rewarding aspects of their friendships. Her aim was to help them analyse their relationships with their peers and understand positive and negative influences on their well-being. The conversation served to help one young person realise a particular friendship was harmful to him (ie, it was getting him into trouble in some, unspecified way). Following a conversation with the Lead he backed off from that relationship, a move with potentially positive ramifications for his future.

In other examples, mental well-being was addressed through building opportunities to gain skills and boost self esteem. A rollerblading event at one youth centre was targeted at young mothers with this aim in mind.

The Leads emphasised that emotional well-being was an area that crossed over into other areas. Where possible they had ensured it was addressed alongside other health issues such as substance misuse (eg, mental health risks associated with drugs use) and sex and relationships (eg, the link between self-esteem and domestic violence).

The HYCC acknowledged that this is an area where there was room for future development and, at the end of the pilot, was planning to work with Parkside Clinic to seek further support in training and partnership working.

### **3.4 Drugs, alcohol and tobacco**

The input of the Leads ensured that all of the centres were able to mark National No Smoking Day by holding special events. A smoking cessation project called *Fitstop* attended three of the pilot sites on a regular basis. Nicotine patches and gums were distributed during these sessions. These activities were reported as being instrumental to several young people giving up and cutting down on smoking. Prior to the pilot, a group of young people at one of the youth centres would congregate in a small outdoor area where they were permitted to smoke. By the end of the pilot phase this area was often empty: many young people had reportedly stopped smoking altogether as a direct result of the work that has been undertaken by the HYC Lead.

One of the Leads had worked closely with two young people to tackle their cannabis habit and believed that this had resulted in them reducing their usage. He attributed this to improved awareness he was able to give them about the drug's adverse physical effects. The Leads acknowledged, however, that hard impacts with respect to illegal substances were usually only possible with specialist intervention; and that referrals were necessary to make a real difference in this area.

#### **3.4.1 Cross-cutting issues and events**

A number of areas have been addressed outside of the HYC Pilot remit, for example road safety (for those cycling to the youth centre) and personal hygiene (showers have been installed at one centre). At another centre the Lead explored the possibility of holding sessions on self-checking for breast/testicular abnormalities in young women/men.

At the drugs misuse treatment unit, the Lead ensured that resources available to service users include cosmetics and appropriate toiletries for young women. She also worked to ensure that discussions about SRE at the centre were inclusive of aspects that concern young women.

The Leads have worked to publicise a range of calendar events, including:

- International Women's Day
- National Bike Week
- National Food Safety Week
- National Coming Out Day
- Knife Crime awareness events
- No Smoking Day.

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## 4 Impact Evaluation: Summary of Quantitative Data

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This chapter presents quantitative data obtained from the evaluation survey of young people which was undertaken at the beginning and towards the end of the pilot. The chapter also contains information supplied by RBKC regarding staff hours worked, learning hours achieved, provision of sessions, attendance and accreditations.

### 4.1 Comments on impact data

Before drawing any conclusions from the quantitative data obtained from the young people's survey a number of methodological details and contextual factors need to be considered. This chapter therefore begins with a detailed commentary on each of these.

#### 4.1.1 Low response rates/different sample composition at follow-up

From Tables 4.1 and 4.2 it can be seen that the response rate for the follow-up survey was approximately half that obtained at baseline. This may have arisen from the fact that the RBCK was conducting other surveys in parallel during Autumn 2011 and young people may have been subject to a degree of 'survey fatigue'. This low response rate may have implications for the generalisability of findings to the wider population of young people attending the pilot sites. It should also be noted that far fewer junior members responded to the follow-up survey. This may have biased the findings reported here although it is not possible to be specific about the nature of any such bias.

**Table 4.1: Survey response rates: Wave 1 (baseline, 2010)**

|   | Chelsea | Earls Court | Golborne | Insight | Total |
|---|---------|-------------|----------|---------|-------|
| Senior respondents (13 years and over)  | 67      | 22          | 70       | 12      | 171   |
| Junior respondents (12 years and under) | 11      | 26          | 6        | 0       | 43    |
| Total                                   | 78      | 48          | 76       | 12      | 214   |

**Table 4.2: Survey response rates: Wave 2 (follow-up, 2011)**

|   | Chelsea | Earls Court | Golborne | Insight | Total |
|---|---------|-------------|----------|---------|-------|
| Senior respondents (13 years and over)  | 36      | 29          | 15       | 8       | 88    |
| Junior respondents (12 years and under) | 0       | 24          | 0        | 0       | 24    |
| Total                                   | 36      | 53          | 15       | 8       | 112   |

Secondly, the sample composition in terms of age and youth centre attended were unmatched, ie the samples were different across the two waves, further hindering comparison of 'like with like'. It is also relevant to consider here that (unlike, for example, schools) attendance levels at a youth centre fluctuate and some young people attend for a short period and/or infrequently. Therefore it is not possible to capture the same audience a year later; also the anonymous nature of the survey did not allow researchers to purposefully target young people who participated in the baseline survey on an individual basis.

#### 4.1.2 Low response rates to particular items/veracity of responses

In both rounds of survey some individual questions yielded low response rates, particularly those with content relevant to sexual health or drugs, alcohol and tobacco. It is also possible that there were systematic differences between those responding and not responding to a given question; for example a young person who has never smoked may have considered a question which mentions smoking as irrelevant and have failed to record that they do not smoke. Conversely, a drugs user in denial about the extent of their own misuse may prefer not to answer questions about drugs.

The veracity of responses should also be viewed with caution. Deliberate fabrication of responses is likely to occur to some degree when surveys deal with issues of a sensitive nature and this is arguably more likely to occur when young people are repeatedly required to fill in surveys with similar content.

### 4.1.3 Difficulty of capturing impact of health promotion interventions

As remarked in the HYC Project Initiation Document, successful health promotion programmes can take a considerable amount of time to bed down and begin to show concrete health benefits. For example, efforts to educate young people about the adverse effects of smoking may result in cessation among some individuals over the long rather than short-term. Similarly, increased awareness of '5-a-day' may not lead directly to increased fruit and vegetable consumption: it is possible that, despite this awareness, some young people may not make changes to their diet until they reach adulthood, or indeed not at all.

Another important consideration is that the Leads reported several changes that would not have been picked up by the survey particularly those in areas falling outside the main HYC areas such as personal hygiene or sexual bullying. Also some 'softer' outcomes like a 'culture change' (manifested in the way young people talk about health issues amongst themselves) would have been missed by a survey focussing on harder outcomes.

### 4.1.4 Contextual factors

The pilot was launched against a background of cuts to wider local government services which may have limited the potential of the pilot to make measurable improvements to the health and well-being of young people in the Borough.

#### **Factors to consider which may have boosted baseline measures**

The local Healthy Schools Programme ran in RBKC for 10 years based in its Youth Support and Development Services (YSDS). Many of its activities extended to the wider youth service. Examples include health related information, activities, events, resources and workforce training. Healthy Schools was closed down in March 2011 due to the removal of the Central Government grant that resourced the programme. This was the same year as the HYC was initiated. This may have contributed to some young people having a relatively high knowledge and awareness around health at the onset of HYC.

Other health promotion services (SRE/Teenage Pregnancy/Peer Mentoring and Substance Misuse) sitting within YSDS have historically delivered programmes and activities to the youth centres as part of other roles and remits. Youth Participation also sits alongside the health work areas in the Health and Participation team and enables the team's professionals to have direct and regular access to young people with regards to consultation and decision making. These may also have contributed towards high standards in some of the health areas at the onset of the pilot.



## Factors to consider which may have been to the detriment of follow-up measures

An integral component for the success of the HYC pilot was intended to be the support from health professionals. The HYCC confirmed that the support from some key stakeholders has been declining since the commencement of the project. There is a range of reasons for this such as end of funding for some projects. The decline is most apparent in the SRE remit, for instance, the removal of community-based Chlamydia Screening (CS) Project/s during 2011/12 due to a review of CS targets nationally and reducing budgets. The abolishment of the Raymede Contraceptive Services Outreach Worker is another example.

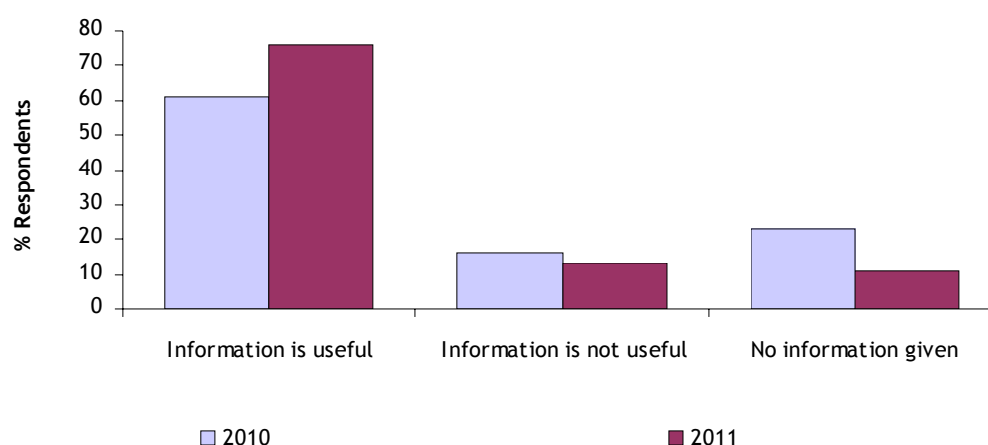
The HYCC felt that in some areas, such as Healthy Eating and Emotional Health and Well-being, the HYC pilot had hardly any support at the onset and this has not changed throughout the implementation of it, due to a lack of services, expertise and capacity.

### 4.1.5 Physical activity and healthy eating

#### Perceived usefulness of information provided at YC

There was an increase in the proportion of YP responding that they found information provided on this subject useful (from 61 to 76 per cent). There was also a drop in the proportion who said that no information had been given on this topic (from 23 to 11 per cent). The response rates for these items in the baseline and follow-up surveys were 80 and 67 per cent respectively.

**Figure 4.1: Views on support/information provided on Physical Activity and Healthy Eating**



Source: HYC survey of young people 2010/11

### Portions of fruit and vegetables eaten on the previous day

The average number of fruit and vegetables young people reported eating on the previous day remained constant across survey waves at 2.3, falling significantly short of the '5-a-day' target. Response rates for this item were high at baseline and follow-up, totalling 96 and 89 per cent respectively.

### Days per week that breakfast was eaten

The number of times young people reported eating breakfast in a week fell slightly from 4.6 to 4.1. The response rates for this item in the baseline and follow-up surveys were 84 and 80 per cent respectively.

**Figure 4.2: Portions of fruit and vegetables eaten previous day/ days per week breakfast eaten**



Source: HYC survey of young people 2010/11

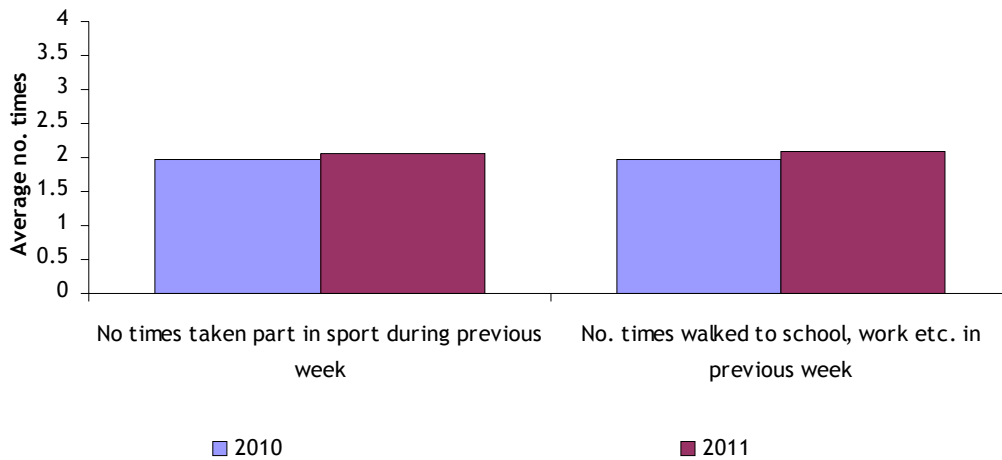
### Number of times reported participating in sport during previous week

The number of times YP reported participating in sport remained approximately static, averaging at 2.0 and 2.1 at baseline and follow-up respectively. The response rates for this item in the baseline and follow-up surveys were very high: 98 and 91 per cent respectively across the two waves.

### Number of times reported walking to school, work etc. in previous week

The average number of times YP reported walking to school, work or some other place remained approximately static, at 2.0 and 2.1. As with other items regarding this health area, the response rates for this item were very high across the two waves, at 97 and 91 per cent respectively.

**Figure 4.3: Number of times participating in sport per week/  
Number of times walking to school, work etc. per week**



Source: HYC survey of young people 2010/11

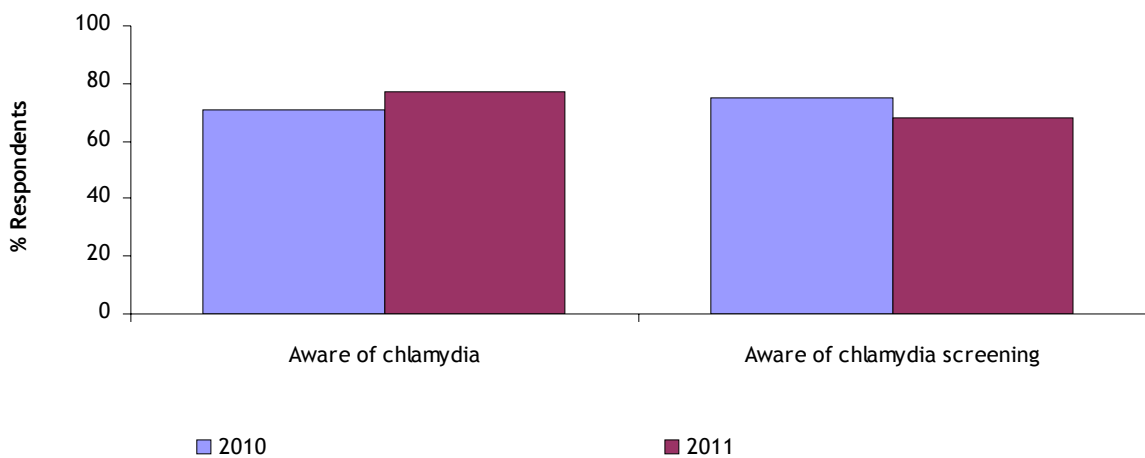
#### 4.1.6 Sex and relationships

The results reported below apply to survey respondents who completed the questionnaire aimed at YP aged 13 and over.

##### Awareness of Chlamydia and Chlamydia screening

The proportion of respondents (of the entire 13+ years sample) that reported being aware of Chlamydia as an STI increased from 71 to 77 per cent, while the proportion reporting awareness of a screening service fell from 75 to 68 per cent.

**Figure 4.4: Awareness of Chlamydia/awareness of Chlamydia screening**



Source: HYC survey of young people 2010/11

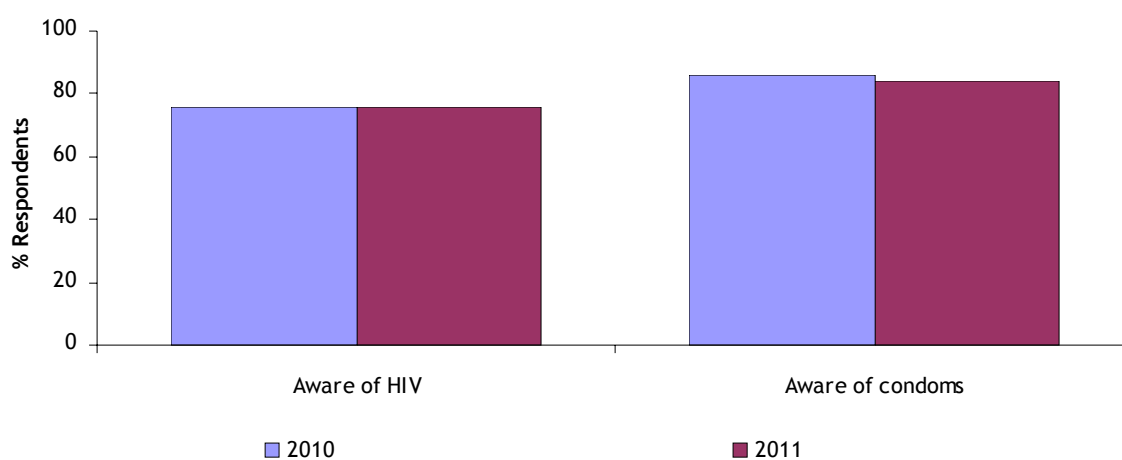
### Awareness of HIV

The proportion of respondents (of the whole 13+ years sample) that reported being aware of HIV as an STI remained approximately static remaining at 76 per cent across both waves.

### Awareness of condoms

Reported awareness of condoms among the same group of respondents fell marginally from 86 to 84 per cent.

**Figure 4.5: Awareness of HIV/awareness of condoms**

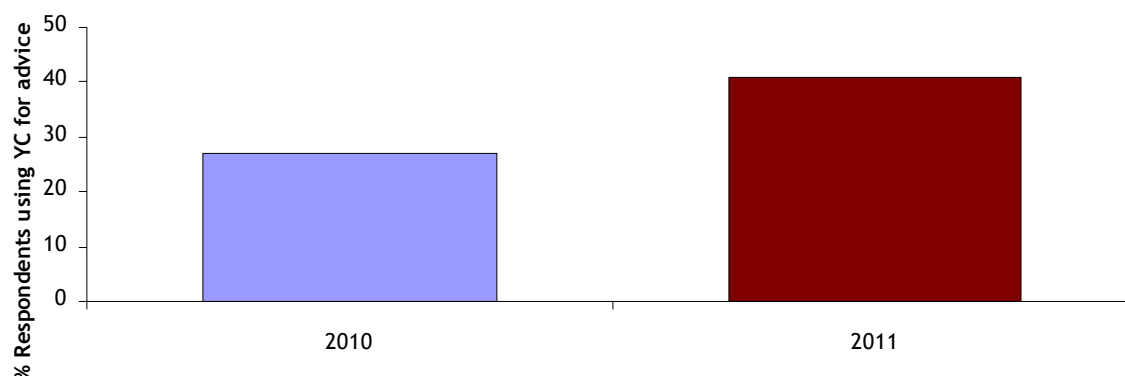


*Source: HYC survey of young people 2010/11*

### Use of YC for sexual health advice

There was a marked rise in the proportion of young people who reported using their youth club as a source of advice for sexual health: this changed from 27 to 41 per cent between survey waves. As above, these figures refer to the entire sample aged 13+ years.

**Figure 4.6: Use of YC for sexual health advice**

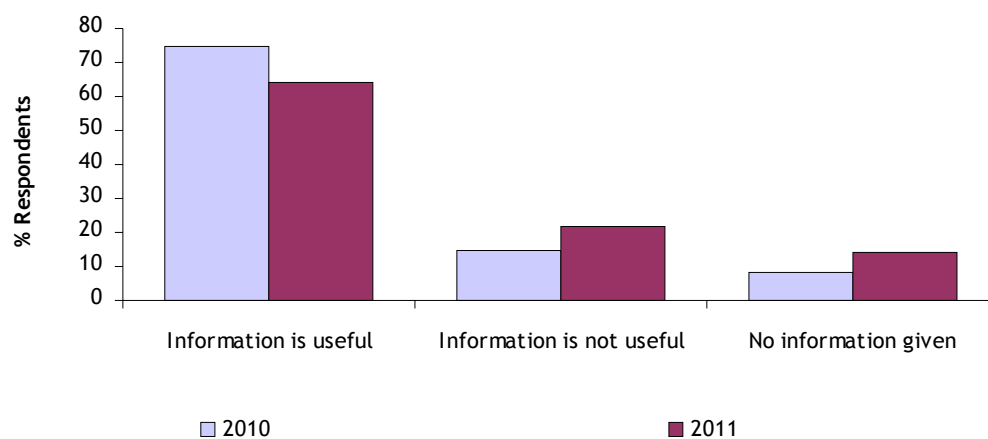


Source: HYC survey of young people 2010/11

### Perceived usefulness of information provided at YC

There was a small drop in the proportion of YP responding that they found SRE information provided at their YC useful (from 75 to 64 per cent). The response rates for these items in the baseline and follow-up surveys were 80 and 72 per cent respectively.

**Figure 4.7: Views on support/information provided on sex and relationships**

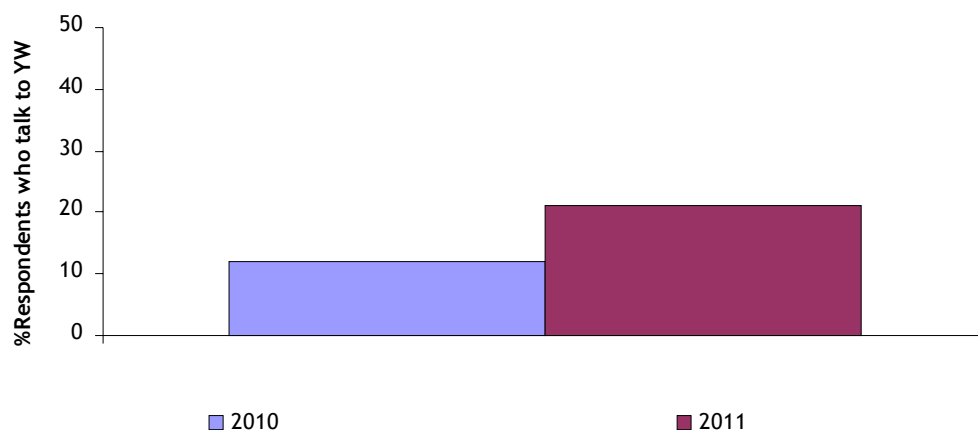


Source: HYC survey of young people 2010/11

## 4.1.7 Emotional health and well-being

### Talking to youth workers to cope with feelings

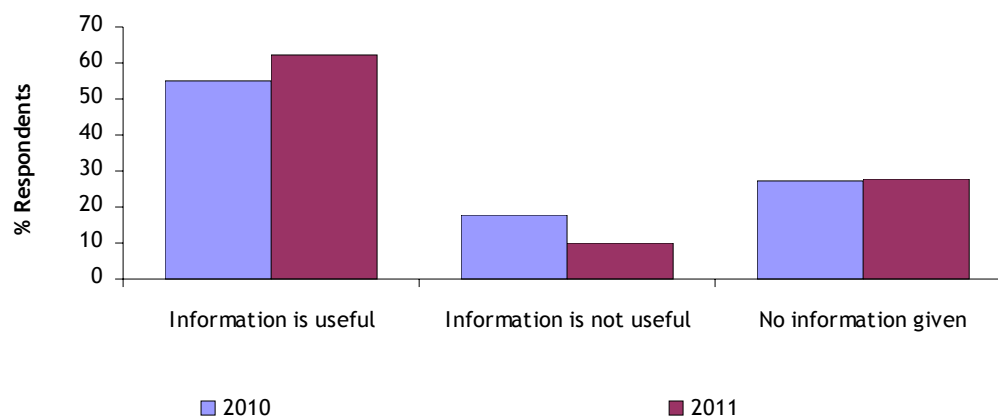
There was a marked rise in the proportion of young people who reported talking to youth workers to help cope with their feelings of anxiety, stress or depression: this changed from 12 to 21 per cent between survey waves.

**Figure 4.8: Young people reporting talking to youth workers to cope with feelings**

Source: HYC survey of young people 2010/11

### Perceived usefulness of information provided at YC

There was a slight increase in the proportion of YP responding that they found SRE information provided at their YC useful (from 55 to 62 per cent). The response rates for these items in the baseline and follow-up surveys were 72 and 61 per cent respectively.

**Figure 4.9: Views on support/information provided on Emotional Health and Well-being**

Source: HYC survey of young people 2010/11

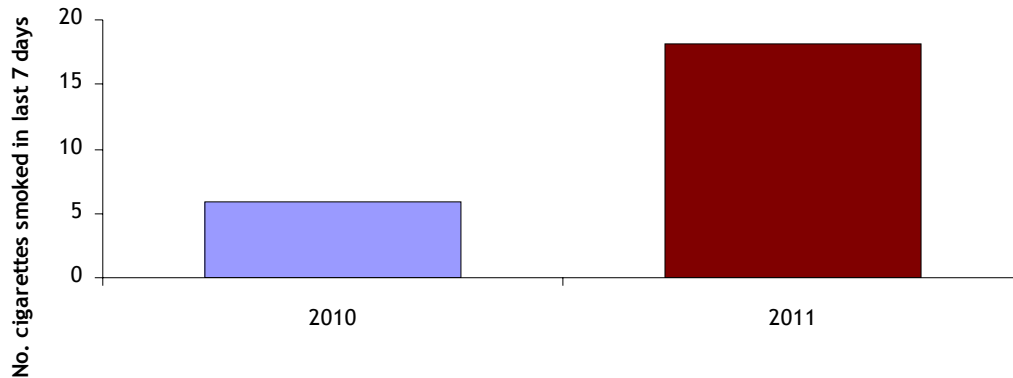
## 4.1.8 Drugs alcohol and tobacco

### Average number of cigarettes smoked in previous week

The average number of cigarettes that young people reported that they had smoked in the last week increased from 5.9 in the baseline survey to 18.2 in the

follow-up. Response rates were poor for this item: this figure was 65 per cent across the sample for both surveys.

**Figure 4.10: Average number of cigarettes smoked in previous week**

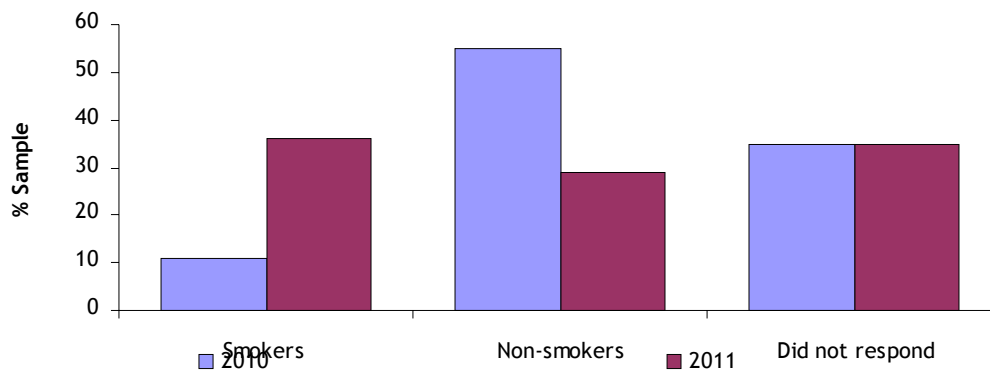


Source: HYC survey of young people 2010/11

**Proportion of smokers, non-smokers and non-respondents**

As shown in Figure 4.11 the percentage of respondents who reported that they smoked (ie, those who reported smoking one or more cigarettes in the last week) increased between the two survey waves from 11 to 36 per cent. The proportion who reported that they did not smoke (ie, those who reported not smoking any cigarettes in the last week) fell by the same proportion from 54 to 29 per cent. Response rates were poor for this item: this figure was 65 per cent for each wave of the survey so should be interpreted with caution.

**Figure 4.11: Proportions of smokers, non-smokers and non-respondents**

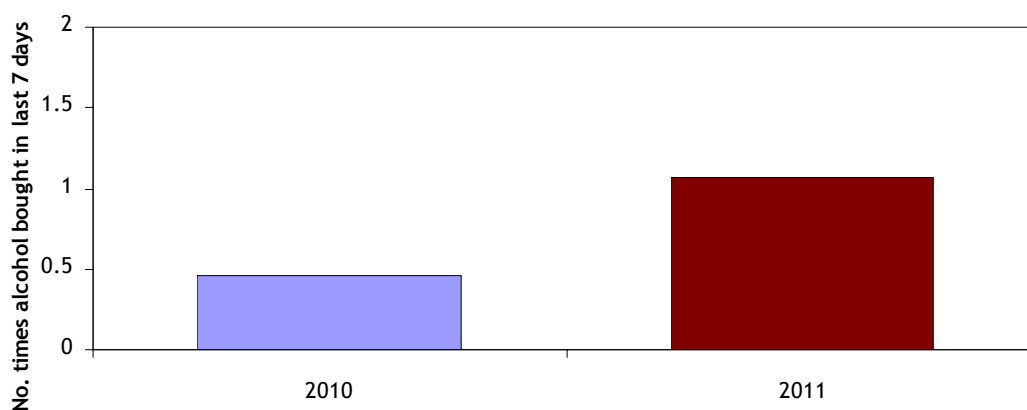


Source: HYC survey of young people 2010/11

### Average number of times alcohol bought in previous week

The average number of times that young people reported that they had bought alcohol in the previous week increased from 0.5 in the baseline survey to 1.1 in the follow-up. Response rates were poor for this item: these figures were 70 and 68 per cent respectively for each wave of the survey so should be interpreted with caution.

**Figure 4.12: Average number of times alcohol bought in previous week**

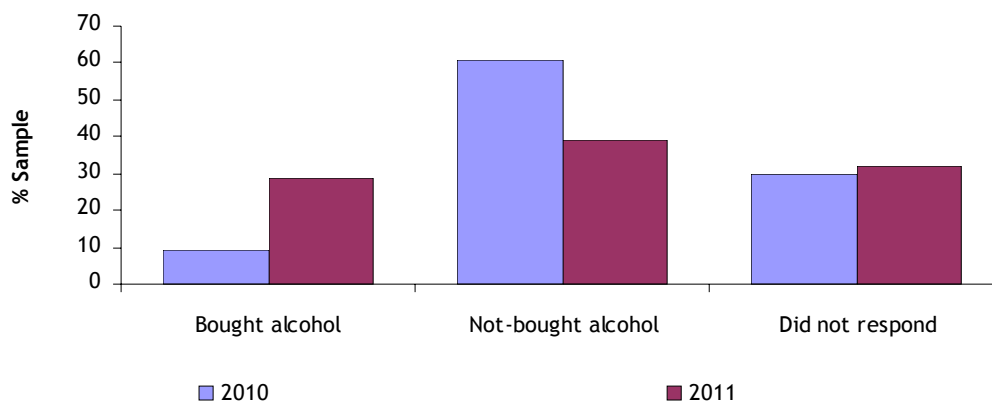


Source: HYC survey of young people 2010/11

### Proportion who bought alcohol, did not buy alcohol and non-respondents

As shown in Figure 4.13, the percentage of respondents who reported that they had bought alcohol in the week prior to the survey increased between the two survey waves from 9 to 29 per cent. The percentage who reported that they had not bought alcohol (ie, those who reported not smoking any cigarettes in the last week) fell from 61 to 39 per cent.

**Figure 4.13: Proportion who bought alcohol**



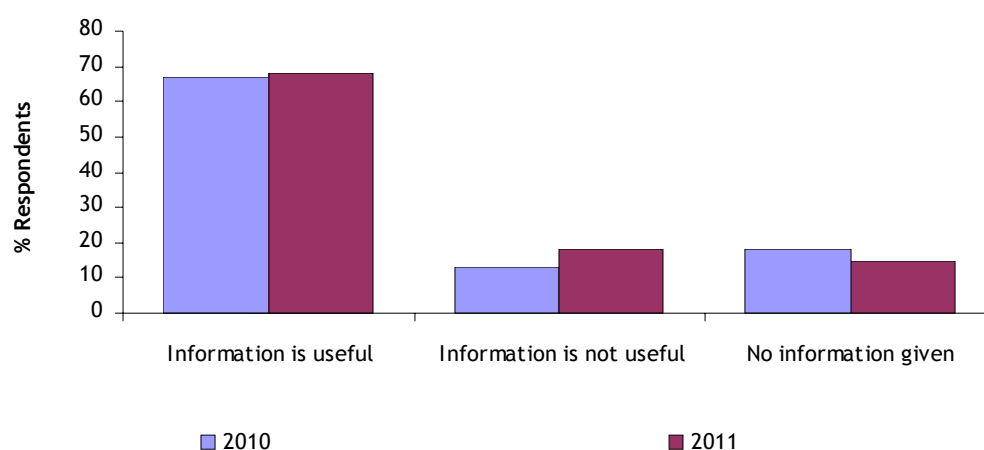
Source: HYC survey of young people 2010/11



## Perceived usefulness of information provided at YC

The proportion of young people responding that they found information on drugs, alcohol and tobacco at their YC useful remained approximately constant across the two survey waves (67 to 67 per cent respectively). The response rates for these items in the baseline and follow-up surveys were 65 and 61 per cent respectively.

**Figure 4.14: Views on support/information provided on drugs, alcohol and tobacco**



Source: HYC survey of young people 2010/11

### 4.1.9 Management information supplied to evaluation

The following tables contain information supplied by RBKC regarding staff hours worked, learning hours achieved, provision of sessions, attendance and accreditations. All of the youth centres exceeded their learning hours and accreditations targets (with the exception of Insight where these criteria do not apply). There is significant monthly fluctuation with respect to all of the measures shown so, on the basis of this data, it is not possible to discern trends over time or draw any firm conclusions regarding the impact of the pilot.

**Table 4.3 Summary statistics for pilot**

|  | Chelsea                            | Earls Court | Golborne | Insight |
|--|------------------------------------|-------------|----------|---------|
| Overall hours worked                     | 3214.25 hrs=approx. 10.4 hrs/week* |             |          |         |
| Learning hours 2011-2012 (April - March) | 4526                               | 5193        | 6502     | 978**   |
| Annual learning hours target             | 3720                               | 3616        | 5292     | N/A     |
| % learning hours target achieved         | 122                                | 144         | 123      | N/A     |
| Accreditations 2011-2012 (April - March) | Target of 90 exceeded              |             |          |         |

\* Based on 4.3 weeks per month over 18 months, divided across 4 pilot sites

\*\*April - December figures

Source RBKC, email communication May 2012

**Table 4.4 Learning hours by month**

|       | Chelsea | Earls Court | Golborne | Insight |
|-------|---------|-------------|----------|---------|
| Total | 4526    | 5196        | 6502     | 978     |
| Oct10 | 692     | 295         | 132      | N/A     |
| Nov10 | 405     | 0           | 54       | N/A     |
| Dec10 | 264     | 178         | 332      | N/A     |
| Jan11 | 223     | 175         | 380      | N/A     |
| Feb11 | 0       | 305         | 472      | N/A     |
| Mar11 | 437     | 530         | 612      | 90      |
| Apr11 | 0       | 278         | 496      | 30      |
| May11 | 0       | 550         | 668      | 85      |
| Jun11 | 105     | 398         | 630      | 115     |
| Jul11 | 154     | 510         | 880      | 120     |
| Aug11 | 1526    | 0           | 314      | 90      |
| Sep11 | 0       | 224         | 426      | 72      |
| Oct11 | 105     | 463         | 70       | 129     |
| Nov11 | 93      | 284         | 270      | 136     |
| Dec11 | 144     | 0           | 118      | 111     |
| Jan12 | 138     | 253         | 226      | N/A     |
| Feb12 | 117     | 338         | 348      | N/A     |
| Mar12 | 123     | 415         | 74       | N/A     |

*Source RBKC, email communication May 2012*

**Table 4.5 Sessions by month**

|        | Chelsea | Earls Court | Golborne | Insight |
|--------|---------|-------------|----------|---------|
| Total  | 36      | 81          | 97       | 32      |
| Oct10  | 4       | 4           | 2        | N/A     |
| Nov 10 | 3       | 0           | 1        | N/A     |
| Dec10  | 1       | 3           | 4        | N/A     |
| Jan11  | 2       | 3           | 7        | N/A     |
| Feb11  | 1       | 4           | 8        | N/A     |
| Mar11  | 5       | 7           | 9        | 3       |
| Apr11  | 0       | 4           | 6        | 1       |
| May11  | 0       | 9           | 9        | 3       |
| Jun11  | 1       | 6           | 8        | 4       |
| Jul11  | 1       | 7           | 8        | 4       |
| Aug 11 | 5       |             | 6        | 3       |
| Sep11  | 0       | 3           | 7        | 3       |

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|       | Chelsea | Earls Court | Golborne | Insight |
|-------|---------|-------------|----------|---------|
| Oct11 | 2       | 8           | 1        | 4       |
| Nov11 | 3       | 7           | 6        | 4       |
| Dec11 | 2       | 0           | 3        | 3       |
| Jan12 | 2       | 4           | 5        | N/A     |
| Feb12 | 2       | 5           | 6        | N/A     |
| Mar12 | 2       | 7           | 1        | N/A     |

*Source RBKC, email communication May 2012*

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**Table 4.6 Attendance by month**

|       | Chelsea | Earls Court | Golborne | Insight |
|-------|---------|-------------|----------|---------|
| Total | 925     | 2068        | 3164     | 339     |
| Oct10 | 152     | 118         | 66       | N/A     |
| Nov10 | 81      | 0           | 27       | N/A     |
| Dec10 | 22      | 68          | 166      | N/A     |
| Jan11 | 51      | 70          | 190      | N/A     |
| Feb11 | 0       | 122         | 236      | N/A     |
| Mar11 | 112     | 212         | 280      | 30      |
| Apr11 | 0       | 111         | 248      | 10      |
| May11 | 0       | 220         | 346      | 30      |
| Jun11 | 35      | 159         | 315      | 40      |
| Jul11 | 14      | 204         | 367      | 30      |
| Aug11 | 218     | 0           | 157      | 25      |
| Sep11 | 0       | 77          | 213      | 43      |
| Oct11 | 35      | 185         | 35       | 47      |
| Nov11 | 31      | 120         | 135      | 47      |
| Dec11 | 48      | 0           | 59       | 37      |
| Jan12 | 46      | 101         | 113      | N/A     |
| Feb12 | 39      | 135         | 174      | N/A     |
| Mar12 | 41      | 166         | 37       | N/A     |

*Source RBKC, email communication May 2012*

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#### 4.1.10 Concluding comments

Headline findings from the impact survey may initially appear disappointing but, in the light of the issues highlighted at the beginning of the chapter, can be considered as unsurprising. However, (even when interpreted with caution) the results suggest there may be significant work to do on tackling smoking and underage alcohol consumption among young people who attend the pilot sites.

The overall picture of findings is not entirely negative. Improvements were observed in the following areas:

- Perceived usefulness of support/information provided on Physical Activity and Healthy Eating.
- Use of youth centres for sexual health advice.
- Young people reporting talking to youth workers to cope with feelings.

These results are consistent with the accounts of Leads and reinforce qualitative findings indicating that young people view the Lead as someone they feel able to approach for support and advice on personal concerns and health information.

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## 5 Conclusions

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This chapter first addresses the achievements of the pilot in relation to the pilot objectives. It also sets out the findings of the evaluation in relation to the evaluation objectives as specified in the framework.

### 5.1 Comments on pilot objectives

- To appoint a Healthy Youth Centre Co-ordinator to effectively lead on and roll out the project by regular and supportive line and performance management
- To develop a bespoke Criteria and Audit Tool and use this as the basis for a needs assessment within each youth centre
- To develop a steering group to strategically manage the project effectively by providing terms of reference, assessing programme progress regularly, overlooking budget spend and ensuring communication between partners
- To develop an operational group to operationally manage the project effectively by providing terms of reference, assessing programme implementation in each pilot site regularly and ensuring communication between the pilot sites
- To ensure effective implementation of the project by employing part time youth workers in each pilot site
- To use specialist knowledge by appointing an external project evaluator to lead on the evaluation of the project from start to end

The pilot was successful in achieving all of the above operational aims as evidenced by management information such as minutes from HYCRG and HYCOG meetings. There was no evidence to suggest that the overall model of delivery should change and no indication that any pilot-specific roles or groups were redundant in any way.

- To utilise local specialist knowledge by developing YSDS protocols around a range of health areas in order to provide a clear and transparent framework for pilot sites, their staff and young people
- To work in partnership with a range of health professionals and agencies to improve on site targeted and specialist support as well as referrals to services
- To work in partnership with a range of health professionals to increase the amount of health related activities and programmes in the pilot sites
- To work in partnership with a range of health professionals to develop and deliver workforce training around health

There was some evidence that local specialist knowledge was not utilised as effectively, or to the full extent, as it might have been. There was a perception that local NHS partners as well as other stakeholders could have made a greater contribution to delivery of the pilot.

However, workforce training (delivered to the Leads) appears to have been utilised successfully to deliver an enhanced health and well-being offer within each pilot site. There was also evidence of knowledge transfer between Leads and other youth centre staff resulting in health messages being incorporated into activities delivered by youth workers other than the Leads.

Nevertheless, it is relevant to consider here that the Leads did not feel that the training they received equipped them to lead group sessions themselves. Arguably, more in-depth training could have enabled the Leads, at least in part, to have substituted their own expertise for the perceived shortfall in contribution from NHS partners.

In regard to YSDS protocols, the Criteria and Audit Tool provided a good starting point for establishing a clear and transparent framework for delivering relevant services in the five HYC areas.

- To ensure young people's involvement by ensuring participation in planning, operation, evaluation and performance management

All of the Leads were successful in increasing the level of feedback from young people at their site; the 'You're Welcome' criteria listed under 'Monitoring Evaluation and Involvement of Young People' was instrumental to achieving this.

## 5.2 Comments on evaluation objectives

### Effectiveness of set-up and implementation

The set-up and implementation proceeded broadly as planned and in line with planned timescales. However, both sets of respondents spoke in very general terms of what was perceived as a lack of clarity regarding a 'vision' of what a Healthy Youth Centre could, or should, look like. There was also a general feeling that the pilot's desired outcomes could have been defined more specifically. Although this did not hinder roll-out of the pilot this appeared to have had some impact initially upon buy-in at PSC level. As the pilot progressed and the benefits became more evident at centre level this situation appeared to improve and the Leads, their line managers and the PSCs appeared to reach a mutual understanding of its broad objectives.

### Extent to which the HYC pilot meets its aim of enabling YP to make healthy decisions for themselves

Qualitative data indicated the pilot had made a tangible difference to young people's access to advice and information although the quantitative data is less compelling. In particular, the survey results indicate (even when interpreted with caution) there is still significant work to do in tackling smoking and alcohol consumption among young people attending the pilot sites.

All of the staff involved in delivering the pilot felt that young people were better informed as a result of the pilot and a positive shift in culture was evident at all sites from the perspective of the HYCLs, their line managers and the PSCs. All were confident that their ability to respond to the health and well-being needs of young people and their potential to influence the choices that YP made around health issues had improved. The pilot also served to improve young people's access to a knowledgeable and trusted adult before making decisions with potential health consequences. In addition, it was felt that the pilot had enabled emerging areas to be identified which might otherwise have been overlooked and, crucially, enabled YCs to respond more quickly than might otherwise have been possible. Given the extent to which young people are influenced by their peers it was viewed as very important that the pilot had enabled staff to provide information and advice quickly before potentially negative behaviours (such as self body piercing and negative influences of gang culture on young women) became more widespread.

Environmental changes have widened young people's options in a practical sense such as greater availability of water dispensers and fresh fruit. Similarly, improved sports facilities like gym equipment provides greater opportunity for

young people to improve to their health in a more immediate sense and to foster positive lifestyle choices.

### **Extent to which services are developed in HYCs**

There was a substantial body of anecdotal evidence supporting the efficacy of the evaluation in terms of the outputs it was able to deliver to young people. Services have been developed in a range of different respects including provision of regular sessions (such as exercise classes and cooking) one-off sessions (to address specific, emerging topics), and health-focussed events (to mark dates such as No Smoking Day and International Women's Day). The pilot has also impacted on pilot site activities in a wider sense in prompting youth workers to 'hook' health messages into contexts that are non health-focussed where possible (for example, by stressing the adverse effects of drugs during sessions for young people in recording studios). The Leads felt that the best HYC initiatives had been those where additional funds from other sources had been available; both the HYCC and the PSCs were both instrumental in sourcing external funding when the HYC budget was insufficient to fund a particular initiative.

The Leads have also been successful in securing greater access to health and well-being professionals from external agencies than would otherwise have been possible. Also, in the context of a financial environment resulting in the withdrawal of some relevant services the pilot has enabled the Leads to spot potential gaps in service provision and take action to address them. The pilot has resulted in enhanced response of the pilot sites to current concerns of young people and facilitated faster access to relevant expertise.

The availability of the HYCL in each centre has helped ensure that young people at the pilot sites receive support and advice about health issues on a one-to-one basis as and when required. Training provided to the Leads has enabled them to feel more confident in delivering this type of support. They have also become more aware of the systems and policies around referral and become more confident to refer young people on to other organisations.

### **Effectiveness of the health promotion settings model in youth centres as an effective strategy to promote health and well-being in YP and**

#### **Extent to which health promotion in a youth centre setting is effective**

Anecdotal evidence clearly supports the settings model in the context of the pilot. Generally speaking young people (including adults at the pilot site specialising in substance misuse) appear to have a positive attitude to receiving health and well-being promotion at their youth centre. The youth club environment offers a more informal setting to access health information than a school or a GP surgery and



this is an important factor for young people who can find other sources of information and support 'patronising', 'over-bearing, or 'not user-friendly'. A major strength of youth centres is that they can potentially engage young members who are not engaging with their school environment (arguably those who are most at risk of ill health). Youth centre staff are well placed to provide information that might otherwise be rejected if it were provided by a health professional or a teacher.

The Leads emphasised the importance of peer influence in young people's lives: if they see others giving up smoking or eating healthily then they are more likely to follow any advice provided on these topics. A youth centre also provides an ideal environment to capitalise upon the natural tendency of young people to aspire towards behaviour they admire in others who are older. For example, if younger women observe older peers taking a stand against sexual bullying (after receiving advice on this from a Lead) they are likely to apply similar standards to their own treatment.

Young people are also susceptible to role models and youth centre staff are often viewed in this way. In this sense the qualities of the Leads as young adults with the potential to set an example have been key to the pilot's success. Their ability to gain young people's trust and engage with them at their level puts them in a better position to influence young people directly than external specialists.

A potential disadvantage of a youth centre which should be noted is that youth people visit them by choice and attendance can be erratic. This can be a disadvantage in the sense that some young people may have missed out on services delivered at the pilot sites due to infrequent attendance and/or regular attendance at other local youth centres outside the pilot. The transient nature of youth centre attendance makes it very different from a school and therefore 'reach' of any service provided is limited by the fluctuating motivations of individual young people to attend.

### **Effectiveness of partnership working between RBKC and NHS K&C**

Joint working between the Borough and PCT had given rise to the original concept of the 'Healthy Youth Centre' model and the role of the PCT was critical in securing funding. The support of the PCT during the commissioning stage of the pilot was valued highly as they were instrumental to project planning, recruiting the external evaluator and designing the audit tool. The PCT also provided 'Nudge' training which was viewed as instrumental to the Lead's ability to influence young people and bring about attitudinal change.

However, the pilot was launched amid a background of changes to the NHS at a national level and accompanying local organisational changes which

compromised the involvement of the PCT in the HYC pilot during its delivery. Also, several individuals in succession were charged with the responsibility of attending HYCRG meetings resulting in a lack of continuity of support from this element of the partnership. Among all RBCCK and pilot site stakeholders there was some disappointment at the level of involvement, support and engagement from the PCT as there was a view that the more specialist health expertise and assistance could have enhanced the level of service provision the pilot was able to offer.

### **Sustainability of HYC programmes beyond pilot duration**

The Leads were confident that they had been able to make a difference to some young people's attitudes towards health and well-being issues which could potentially influence their decision-making beyond the duration of the pilot and, quite possibly, beyond the duration that they attended their youth centre. The Leads also felt that they had been able to achieve changes within service delivery within the youth centre itself that would outlast their own positions; they viewed that other youth workers were now better positioned to incorporate positive health and well-being messages into their own work and, in some cases, had increased awareness of relevant external agencies and potential referral pathways.

However, in order to embed cultural changes within the centres and bring about sustained changes in behaviour there was agreement that further work was required and longer term, strategic commitment to the HYC objectives was necessary. It was felt that this would not be possible without dedicated youth worker time and there was a consensus that extended provision of resources which allowed the Leads to continue in their role would be required to achieve this. There was also a view that without a Lead to consult, some staff would flounder when young people presented with health and well-being issues as they had become somewhat dependent on the Lead as a source of knowledge to consult and as a colleague that they could suggest young people could take specific queries to.

The Leads felt they were well positioned to take forward the work programmes they had developed during the pilot duration to deliver further benefits to their respective sites. There was agreement that this would be difficult for their colleagues to achieve in their absence unless they were able to receive similar training and similar, additional allocation of working hours.

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## 6 Recommendations

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The following recommendations arise from the findings of the evaluation. These are intended to be useful to agencies considering future, similar initiatives as well as those with a direct interest in the RBCK HYC pilot. It is important to keep in mind that the purpose of a pilot is to learn lessons (in advance of any wider roll-out) and the pilot's innovative and experimental approach was ideally suited to this.

### **Retain the existing model of delivery and line management structure in future delivery**

As evidenced by the process aspects of the evaluation many structural elements of the pilot worked well. The Lead role was the most innovative aspect of the pilot and their relationship with young people was key to engaging them with the aims of the programme and making a real difference. Input from and engagement with senior youth centre staff has been an important success factor so their involvement in managing the Leads (alongside the HYCC) should ideally be retained in any new, similar initiative or any plans to extend the current project. Some young people who contributed to the evaluation said that they viewed youth workers as 'role models' and as sources of advice on a range of issues from personal and social problems to difficult homework. Arguably the HYC role potentially allows youth workers to capitalise on the position of trust and authority they already offer.

One area of uncertainty is how an intervention of this type should be presented and marketed to young people. During the HYC pilot, some Leads preferred to make their role and responsibilities known while others chose not to. Leads may be best placed to make this judgement on a site-by-site basis based on their 'feel' for what would work better in their respective environments.

### **Ensure buy-in from key stakeholders from the outset**

Although senior youth centre staff welcomed the benefits of the pilot once it was underway, there was some scepticism in its early stages due to what was felt to be a lack of 'vision'. In order to achieve commitment from all key stakeholders from the outset it can help if the potential benefits of any planned initiative are given clarity prior to implementation. Examples of possible outputs and activities, and/or desirable outcomes for young people and youth centre staff can help engage senior youth centre staff and help secure their support. Efforts to share this vision with youth workers more widely (for example through site visits or open meetings) can help ensure that preconceptions of what the pilot has to offer are positive and foster enthusiasm. It is important to bring other staff on board, particularly those with direct line management responsibility to the Leads. This enables others who work with the Lead to support them in their role from the beginning.

### **Plan partnership working and stakeholder involvement**

One issue for this pilot was that NHS partners and some other stakeholders did not contribute to the pilot to the level anticipated. Future pilots of this type could benefit from defining these inputs from the outset. A recommendation for future initiatives is that commitment from key professionals and organisations is set in place prior to delivery. One possibility is that a framework could be developed setting out minimum number of days/hours to be delivered rather than specific activities so that flexibility to be responsive to the particular needs of the youth centres or groups of young people is not compromised. A separate budget could potentially be set aside to 'buy in' services from services outside the framework on an ad hoc basis.

Co-ordination among Leads should take place to ensure that the resources stakeholders are able to offer are utilised in a more efficient manner: joint sessions attended by young people from more than one youth centre can be helpful in maximising impact of potentially limited resources.

### **Select health and well-being areas to be addressed carefully**

Areas selected for the current pilot were viewed as broadly appropriate to the needs of young people and their youth centres, however new, 'emerging' areas such as personal hygiene, body piercing, road safety and concerns about social influences of gang culture did not sit easily within those definitions. Any new initiative for young people needs to make provision for emerging issues and caution should be exercised when defining areas to be addressed in centres by the Lead to allow them to respond flexibly to any observed issues (the current pilot was sufficiently flexible to make provision for this).

Some consideration should also be given to the interplay between different health and well-being areas, for example young people may be more willing to take risks with their sexual health or personal safety if they are under the influence of alcohol or drugs. Also emotional health and well-being issues can be difficult to tackle in isolation and may be more meaningfully addressed in the context of other issues such as relationships, personal safety and fitness/body image. In addition, the evaluation showed a tendency for young people to focus on visible aspects of the youth centre environment: this may be an important theme to consider as local surroundings appear to influence young people's perceptions that their centre is conducive to their well-being.

Results suggest there is still significant work to do on tackling smoking and underage alcohol consumption among young people attending the HYC pilot sites. Assessment of specific site needs and identification of problem areas before launching a pilot of this type is likely to maximise its potential to make headway in problem areas.

### **Consider balance between 'one size fits all' approach and tailoring to sites**

It became evident during the current pilot that different sites had different needs and that the Lead needed to balance the requirements as set out in the Criteria and Audit Tool (and those as seen from the point of view of the HYC project co-ordinator) with priorities as seen by site co-ordinators. While this was dealt with successfully in the current pilot, future initiatives may benefit from setting out from the outset the degree of harmonisation between centres they wish to achieve. It may also be helpful to decide whether any objectives can be set aside if other, higher priority objectives are identified at a particular site. It is also important to bear in mind that there is greater potential to engage senior youth centre staff with an initiative if they see an initiative can be tailored to meet specific objectives that they perceive to be appropriate for their own centres.

Consultation with young people using focus group methodology can help ensure their concerns are addressed. It should be noted that the Leads are potentially well placed to facilitate focus group discussions and also that these tend to work best when different age groups and genders are consulted separately.

### **Define required competencies of Leads**

The role of a Lead is complex and demands a number of skills and personal characteristics. Enthusiasm and commitment to the initiatives objectives are essential, as are versatile communication skills that enable them to work successfully with stakeholders as well as young people. Although efforts should be made to minimise the administrative burden on the Leads it is important that they are made aware that planning and recording activities are an essential part of

their role. Line managers of Leads should be prepared to help them balance management and administrative aspects of their role with youth centre contact time since for many junior youth workers achieving this balance will be a challenge.

### **Simplify documentation of progress**

Effective management information tools to document progress of an initiative can be difficult to develop but the Toolkit provided a good starting point and worked well as a standard setting instrument. Ideally though a shorter and more user-friendly document than the current Toolkit should be used for future initiatives. One approach for the immediate future may be to retain the current format as a reference and supplement this with individual project plans for each site. Also, the possibility of adopting Healthy Youth Centre status as a mark of quality assurance should be considered.

### **Set and assess realistic outcomes**

The current evaluation demonstrated that it is not always possible to demonstrate hard outcomes in behavioural terms from this type of initiative especially over a relatively short timeframe. Consideration should also be given to the difficulty of comparing 'like with like' before and after delivery due to the transient nature of youth centre populations. It is also important to bear in mind that young people are prone to survey fatigue. Where possible it is desirable to build extra questions into existing surveys or ensure that any new surveys introduced are short and user-friendly. Focus groups and interviews can be successful in yielding views from young people on health topics although these methods place obvious restrictions on sample sizes.

Given the difficulty of measuring hard outcomes ideally 'soft' outcomes should be set on a site-by-site basis, in collaboration with PSCs at the beginning of the initiative together with agreed methods of assessing whether these have been achieved. These could include indicative measures of impact such as attendance at events or numbers of activities held that allow messages on particular themes to be incorporated.

### **Ensuring sustainability of HYC programmes beyond pilot duration**

As suggested by the quantitative impact data, producing sustainable changes in behaviour among significant numbers of young individuals would be expected over a longer timeframe than the duration of the pilot. An extension of the pilot in its current form is likely to help bed in its work to date.

A range of measures could help ensure that an HYC-type initiative leaves a legacy following discontinuation. The more that specialist knowledge gained by the Leads is shared with other staff the better a centre is enabled to continue their work following their departure. Ideally, training opportunities offered to Leads should be offered to other staff where possible: in the case of this pilot it was felt that 'Nudge' training would have helped ensure that other youth workers were able to reinforce the work of the Leads. The presence of the Lead at youth centre staff meetings can also potentially be used to share experiences and knowledge and help secure sustainability. It may also be helpful for Leads to share materials produced (such as healthy recipes or dossiers of external contacts) and knowledge about particularly effective stakeholder-run sessions should also be shared between sites.

An important aspect of the pilot to sustain is the 'culture change' many Leads described who saw an increase in young people's curiosity and interest in health and well-being issues. This change was underpinned by the connection the Leads were able to make with young people and their ability to tap into young people's motivations and concerns. This underlines the importance of the Lead and the potential difficulties of building on the achievements of the HYC pilot if sites cease to have access to this resource.