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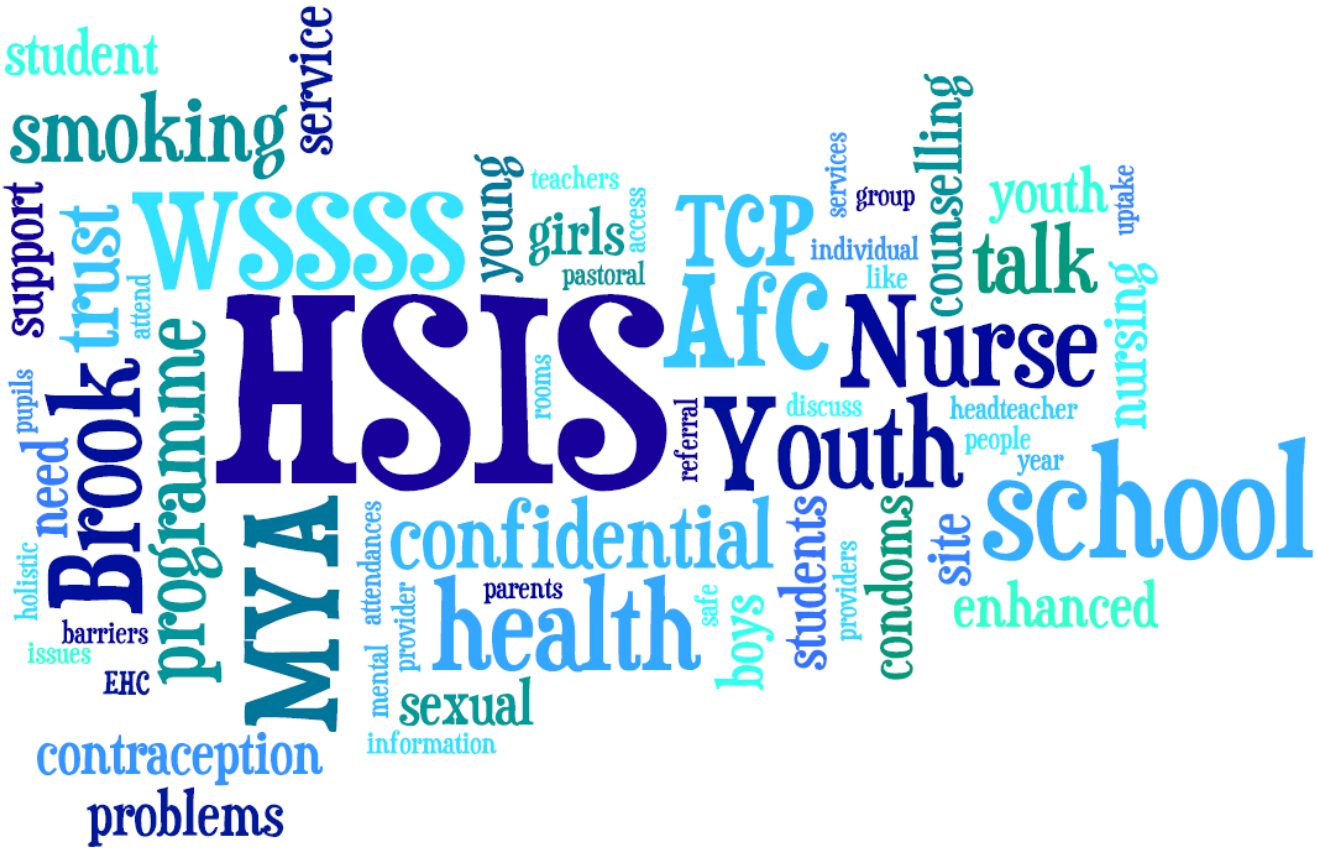

Evaluation of the Wirral Health Services in School Programme

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The Applied Health and Wellbeing Partnership

The Applied Health and Wellbeing Partnership supports the development, delivery and evaluation of the Wirral Health and Wellbeing Strategy, through the innovative generation and application of evidence for effective and sustainable health and wellbeing commissioning.

1. Executive Summary

Wirral Health Services in School is a secondary school based health and well-being weekly drop-in clinic for pupils funded through Public Health in Wirral Borough Council; launched in 2009 and delivered by the School Nursing Service and specialist youth workers, this is known as the 'core offer' and currently 96% of all Wirral secondary schools access the service.

Public Health Wirral commission seven providers to deliver a range of services under the umbrella of 'health services in school'. In 2012 Public Health Wirral commissioned the Applied Health & Wellbeing Partnership at the Centre for Public Health, Liverpool John Moores University, to evaluate the HSIS programme. The evaluation aimed to examine how the services have been implemented, the challenges faced and how the programme could be improved. The evaluation also aimed to establish the impact of the individual and combined HSIS programme on the health and wellbeing of students.

The first stage of the evaluation was to develop a service map. This exercise collated the information about the services being delivered in each school, how long they had been working in the schools as well as information about the type of services and the uptake. This service map is available on request (contact details at the end of report). Only one school on Wirral has chosen not to host any services. In the 2011-2012 academic year 28 schools hosted the core offer of the Youth Service and the Enhanced School Nursing Service and most schools hosted at least one other service, the most common of these being the Wirral School Stop Smoking Service (WSSSS; 19 schools). Only two schools took up all seven services. The information collected in this mapping exercise was also used to inform the evaluation; the sample for the school staff and student engagement activities was chosen to ensure a wide representation of schools was approached, including those that host many HSIS providers and those with fewer, as well as those with high uptake and those where uptake was low.

To evaluate the process of implementing and delivering the service, focus groups or interviews were conducted with all HSIS providers and with staff at five schools. The uptake and impact of the service was examined through a questionnaire distributed to students at three schools, through case studies of students attending the Youth and School Nursing clinics and also through examination of routinely collected Youth Service and School Nursing Service activity data.

Representatives from the seven providers took part in group interviews. These included managers and staff who worked within the schools delivering the service. The discussions provided a lot of detailed information about the process of setting up and delivering the various services in schools. The providers were very cooperative and forthcoming in their discussions and were honest about challenges they had faced and the barriers that exist in their services, as well as their successes. The main findings from these interviews were grouped into the key themes of; differences between schools; selecting schools; negotiating services; assessing impact; challenges; overcoming barriers and working successfully; uptake; improvements; working with other HSIS providers and targeted and accessible service. These themes are discussed in detail in section 4.2.

Staff from five schools that hosted a variety of types and numbers of HSIS providers took part in focus groups to investigate their experience of the programme and the impact it had had on the school and students. The participants varied between schools and included head teachers, deputy head teachers, heads of sixth form, heads of year pastoral and wellbeing leads, inclusion and home liaison leads, learning mentors and one school nurse. At all but one of the focus groups there was a mix of teaching and non-teaching staff. All participants talked very honestly about the success and challenges of the programme and overall they were very enthusiastic and positive about impact of the HSIS programme. The key findings from these interviews were grouped into the themes of why the schools took up the HSIS programme; before establishing the programme; setting up the programme; parents; successes of the programme; challenges; impact on student health and wellbeing; impact of individual services or the combined programme;

confidentiality; gaps in services; publicising the services; improvements and the school based programme. The full findings from these focus groups are included in section 4.3.

To gather experience and opinions of the students a questionnaire was distributed to year 9 and year 10 students in three schools. One hundred and eight responses were collected. Awareness of services was high with 98% students having heard of at least one HSIS provider; Brook and the school nurse were the services students were most aware of. However, only 22% of respondents were aware that the Youth Service worked in their school. Thirty eight per cent of respondents had attended one or more of the HSIS services. The most common ways students had found out about the services was through the school nurse, school staff or friends. Students really wanted to have more mental health services in their school with 81% saying they would like a service that helped with depression/anxiety and 67% suggesting counselling. When asked about the best location for health services opinion was reasonably evenly split; 32% said that they would prefer to attend services in school, 25% they prefer to attend outside of school and 36% stated they did not mind. Reasons for preferring school based services included confidentiality, convenience, trusting the providers and less stressful or embarrassing. Reasons for preferring services to be outside of school included privacy, people not knowing they were attending and the school not being involved. The most common things that would encourage attendance at a school health services were friendly and helpful staff, a confidential service and more information about what was available. The main barriers that would discourage them from attending a school health service were lack of confidentiality, people finding out they had attended the service, embarrassment and unfriendly staff. Students thought the best way to advertise a school based service was posters, assemblies and talks from service providers. The full findings are presented in section 4.4.1.

As only six questionnaires were returned from students who had used the HSIS they are presented as individual case studies in section 4.4.2. Five of the individuals spoke very highly of the support they had received from the school nurse and the youth worker, and talked about how it had had a positive impact on their health and wellbeing by improving happiness and making them more aware. However, one student reported a mixed experience of the nurse and youth worker at their service and did not feel it had had any impact on their health and wellbeing.

Routinely collected Enhanced School Nursing Service and Youth Service data were analysed to understand more about the students attending these core services and identify the types of issues that were dealt with by the nurse and youth worker. These data are presented separately in section 4.5.1 and 4.5.2 but will be discussed together here. The School Nursing Service dataset for the academic year 2011-2012 included 1,132 individual students who were seen a total of 2,269 times. The mean number of attendances per individual student who attended was two (range=1-22, median=1). The Youth Service dataset included 366 individuals, and repeat attendances were not recorded. Almost two thirds of the students seen by the nurse were female whereas only half of the students seen by the youth worker were female. This reflects the general wellbeing focus of the youth workers, as opposed to the contraception priority of the nurses. Across the schools the School Nursing and Youth Services were accessed by students from every year group with year 9, year 10 and year 11 being the most frequent attendees. The main issues that the nurse addressed were sexual health (58% of attendances) whereas for the youth worker it was emotional health and wellbeing (47%). The nurses also conducted 196 pregnancy tests (10 girls tested positive), 232 chlamydia tests and emergency hormonal contraception (EHC) was provided a total of 166 times to 134 individuals. The majority (82%) of the individuals who received EHC only had it once in the academic year, however, 20 individuals (15%) received it twice and four individuals received it more than three times.

The discussion (section 5) draws together the findings and triangulates all the different data collection methods to pull out common themes and issues. The details of the service delivery and implementation are discussed in the context of the service map and findings from the Youth Service and School Nursing Service datasets are combined with findings from service providers, school staff and students are used to discuss

service use and uptake. The experiences and perceptions of those who use and interact with the service (service providers, school staff and students) are discussed in section 5.3.

Finally ten recommendations are made in section 6, and briefly these include; more publicity in schools; improvements to the location of rooms; instigating a review and feedback process; expanding the Action for Children service; further dialogue with schools before changing contracts; clarification of the role of the youth worker; reducing occasions where groups of students are taken off timetable and further discussion about at which schools services should be targeted.

Acknowledgements

The authors would like to thank all the HSIS providers for supplying information about their services, for being open and honest about their experiences and for facilitating the student data collection. Thanks go to the senior management teams in the schools who were able to take part in the focus groups. We appreciate that time is very limited in a school day and these staff were very welcoming and open about their experiences of the HSIS programme. Thanks must especially go to the senior staff and form tutors at the three schools who were able to facilitate distribution of questionnaires to their students.

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2. Background

In the context of high teenage pregnancy rates and high adolescent sexually transmitted infection rates, government policy asserts that sex and relationship education and school based sexual health services are pivotal to reducing these rates (Formby et al., 2010). The focus on the 'wellbeing' of children is now understood to extend beyond their physical health, and includes issues such as their mental and sexual health as well as bullying, drugs, alcohol and smoking.

2.1 Background to the Health Services in School Programme (provided by Public Health Wirral)

In 2007-8 in the light of high teenage pregnancy rates, and a focus on risk-taking behaviours, Public Health developed a Wirral Health and Well-Being Charter for Children and Young People, which was a signed commitment from Wirral leaders to enable the development of health and wellbeing services to young people when and where they wanted them.

By mid-2008,the stubborn Teenage pregnancy rates ensured a high level 'support and challenge' visit from the Department of Health, National Support Team, around the same time a consultation event with young people (Youth Voice) pointed to the fact that a health and wellbeing service for young people would be well placed and welcome in Wirral secondary schools. There was Executive and elected member buy-in at Children's Trust Board, CEO support in the primary care trust (PCT) and a small pro-active team in Public Health came together to develop a plan, using the Charter as a mandate. This development was referenced as an action in the PCT Strategic Commissioning Plan (2009-12) and local authority Children and Young People's Plan.

The initial aim was to establish a multi-agency pilot in six schools in wards with the highest rates of teenage pregnancy, adult smoking prevalence and lower life expectancy. The pilot would be evaluated and it was anticipated there would be roll-out.

The proposal was taken to the Wirral Association of Secondary Heads (WASH). They considered the proposal would further stigmatise and risk the reputations of the six schools identified. WASH delivered their response that the PCT should provide the service in all schools, or none. Also included in the response from WASH was the concept that the schools 'hosted' the service and were therefore not ultimately responsible for any fall-out, so the PCT had to shoulder any perceived risk.

The PCT reviewed the proposal, and re-presented a model to WASH of a staggered programme of service implementation which would have at the centre the 'core offer' for all secondary schools. WASH agreed the model and after another nine months of negotiations and consultation with faith leaders, school heads, parents and governors, the first 12 schools began offering the core service in the second half of the Autumn Term 2009.

Health services in school (HSIS) is a portfolio of services commissioned through Public Health Wirral to provide a holistic and enhanced on-site, drop-in and appointment, entry level range of health services to pupils. Public Health Wirral currently commission seven providers to deliver a range of services under the umbrella of 'health services in school'. Each school hosts a different number and combination of services and each is delivered slightly differently to fit round the requirements of the schools. One further education college and 28 out of the 29 schools in Wirral host at least one of the following services:

- Enhanced School Nursing Service
    - Part of the core offer which provides an extra three hours of school nursing service per week in each school. In the majority of schools this is an extra drop-in clinic where the nurse is trained to deliver condom distribution and emergency hormonal contraception.

- Youth Service
    - Holistic health education, advice and support delivered in conjunction with the School Nursing Team, a core offer is provided through designated confidential health 'clinics'. PSHE lessons, group work and one-to-one interventions are also delivered outside of clinic times (with or without support from the school nurse).

- Brook
    - Provide contraception, chlamydia and gonorrhoea testing, treatment for positive chlamydia, referral for termination and counselling for people under 25 years. Brook also have an education team who deliver programmes in all Wirral high schools.

- Action for Children (AfC)
    - One to one counselling for young people aged 11 – 18 years. The aim is to address emotional wellbeing and reduce the number of referrals to mental health services. Students are initially offered six sessions which are delivered in school during lesson time.

- Wirral School Stop Smoking Service (WSSSS; provided by Bridgewater Community Healthcare NHS Trust)
    - Provide drop-in smoking cessation clinics for 12 weeks at a time in each school. They deliver a confidential support and guidance service and can provide a variety of nicotine replacement therapies. They also deliver a peer influence programme called ASSIST to year 8 students with the aim of reducing uptake of smoking.

- Tranmere Community Project (TCP)
    - A peer education programme produced and delivered by young mums to teach young people the realities of being a young parent, with the aim of reducing teenage conceptions.

- Merseyside Youth Association (MYA)
    - Provide an award that schools can achieve by showing their 'whole school approach to mental health' this includes training for key staff and support to meet the award criteria.

School based sexual health services have been shown to reduce births to teenage mothers and chlamydia infection rates in young men, although most of this evidence comes from the United States. Some evidence from the UK shows that holistic service models, not restricted to sexual health, may have the greatest impact as they increase privacy and confidentiality, offer a wide range of products and services and maximise service uptake. However, a recent systematic review and health technology assessment (Owen et al., 2010) found very few school based health services have been rigorously evaluated and most of the evidence comes from US studies. As well as few controlled, experimental studies on health services in schools, there is a dearth of evidence on 'real life' services and qualitative information about best practice and the impact of such services.

3. Methodology

In 2012 Public Health Wirral commissioned the Applied Health & Wellbeing Partnership at the Centre for Public Health, Liverpool John Moores University, to evaluate the HSIS programme. This evaluation covers the period 2011-2012.

Various methods were proposed to measure the impact and process of this service. Two applications were made to Liverpool John Moores University Research Ethics Committee to review the ethical implications of the proposed participant recruitment and data collection. The evaluation design and methods for the two phases of the evaluation were approved as being ethically sound (ethical approval reference numbers 12/HEA/043 and 13/HEA/060)

The methodology was developed in conjunction with key stakeholders. The commissioners at Public Health Wirral were involved in planning the methods to ensure it met their needs. The principal researcher attended a meeting of the HSIS Provider Network to discuss the proposed methodology, gain feedback and be introduced to the providers. The researcher also attended a meeting of Wirral Association of Secondary Heads (WASH) to present the proposed plans and obtain feedback on the feasibility of the evaluation in schools.

In order to identify how successfully HSIS was being delivered in Wirral, a process evaluation was undertaken to understand how HSIS was being delivered in each school, and to examine the acceptability and feasibility of the service delivery. An interim report was produced in December 2012 and focused on this process evaluation. This final report also includes the impact evaluation and aims to identify the impact and changes that have occurred as a result of the HSIS programme.

The process evaluation element of this evaluation aims to:

a) Examine the implementation of the service in each school;
b) Assess which services have been fully and easily implemented;
c) Assess which services have not been successfully or entirely implemented;
d) Suggest ways to improve the services to have a greater impact on student health.

The impact evaluation element of this evaluation aims to:

a) Identify the changes that have taken place in schools as a result of the HSIS programme;
b) Identify the changes in students' health as a result of the HSIS programme;
c) Establish how each service has contributed to the changes in health;
d) Establish how the combined HSIS programme has contributed to changes in health.

Throughout this report the school names have been removed and each school has been allocated a random code. It was decided that schools would be kept anonymous as some schools do not actively promote their services and some would not want to be identified. We were also aware that we wanted providers and school staff to speak openly and honestly about the challenges they have faced. To avoid jeopardising any working relationships by drawing attention to challenges in service delivery we have not included any school names in this report. By removing school names we have also ensured confidentiality for the students.

3.1 Service Mapping Exercise

An initial mapping exercise aimed to establish which services are provided in each school. This is an important part of the evaluation to provide context to the rest of the evaluation and allow comparisons between schools. Compiling all this information in one map simplified the existing information and made it easier to use.

The information obtained in the mapping exercise was used to inform the school selection for the staff interviews and student engagement. The schools for staff interviews and student engagement schools were chosen by purposive sampling methods, in that the schools chosen represented a variety hosting different numbers and combinations of services. The information gathered was also used to inform the discussion with school staff, enabling the interviewer to be aware of any issues or challenges that providers have experienced at specific schools. The mapping information was also linked to the analysis of the impact at schools, in that discussions with staff and student engagement may be influenced by the number of services at each school. We could hypothesise that schools that host all seven services will have seen a bigger impact on student health and wellbeing than schools that only host the core offer (School Nursing and Youth Services).

A template was developed in collaboration with Public Health commissioners and designed as an Excel spreadsheet to be as simple to complete as possible. The template included the names of all schools and asked for key information on the provider activities at each school. The fields requested for each school is presented in Box 1.

Box 1. Fields in Service Mapping Template

- Do you currently provide services in this school?
- Month and year of 1st session/ start delivering in school?
- If you provided for a limited period, which months/year?
- How many sessions/hours each week? (Currently or when active in the school)
- Is/was the service drop in or appointment based?
- How is uptake? Are all the slots filled?
- Is the service available to all students in the school (irrespective of age etc.) or is it targeted? If targeted, how are the students selected?
- *Where is the service accommodated? Are you happy with this?
- *Ease of setting up in school (easy/ok/challenging).
- *How well do you feel the service is performing in this school? (Very well/ok/not great)
- *Any other issues or comments to highlight?
- *Who is your main contact at this school/staff member you have dealt with?

*(Fields marked with * are not be included in the final map but were used to inform sample selection and discussion in school staff interviews. This information was confidential and was not revealed during school staff interviews but used to provide background and inform interview questions where necessary.)*

Each service provider was emailed a MS Excel template requesting key pieces of information on each school (see appendix A for a screen grab of the template). Each provider returned the completed template via email. The relevant completed template was reviewed by the researcher before each service provider interview and used to enhance the interview question and ask for elaboration if necessary.

The completed templates from each provider were merged into one Access database and that showed information about all services provided at all schools. The data were cleaned and attempts were made to standardise it, ensuring no information was lost. The final Service Map is discussed in section 4.1 and, due to the size, is available on request.

3.2 Service Provider Interviews

The principal investigator and Public Health commissioner met with the HSIS Provider Network and discussed the evaluation and possible approaches with them. At this meeting the commissioner introduced

the researcher and explained the importance of the evaluation. This contact and initial meeting helped to build trust between the providers and researcher as well as facilitate introductions that should increase participation and engagement.

Semi-structured interviews, either one-to-one or in groups, were conducted with professionals from each of the seven services, including the lead/manager and at least one member of staff who worked within the schools. This provided perspective from front line delivery and work with young people and experience from the perspective of strategy, management and leading implementation. The participants from each provider were chosen by the manager and invited to take part. The research team did not specify which staff should be included in the interviews but left it up to the manager. Each provider is very different in terms of service delivered, structure and number of frontline and management staff. Being less prescriptive with who attended the interviews would allow more flexibility and ensure the appropriate members of staff to attend. These interviews aimed to examine their experience of implementing and delivering the HSIS and their perception of the impact of their service.

All interviews took place at the service provider's office, apart from the interview with Tranmere Community Project which was conducted over the telephone. The interviews comprised of between one and five participants and included a variety of staff. All participants were given a participant information sheet when they were invited and written consent was obtained before the interview commenced. When the interview was set up, usually with the service manager, this contact was sent an email with the participant information sheet and asked to forward it on to their colleagues who would be attending the interview. A copy of the participant information sheet was also handed out at the start of the interview and consent forms signed before the interview commenced.

The interview guide was developed in collaboration with the Public Health commissioner and covered topics including:

- *What barriers/challenges have been faced in different schools?*
- *How/if these barriers have been overcome?*
- *What further changes/support is needed to implement the services?*
- *If schools have refused to host services what does the provider understand to be the reason?*
- *How they define the 'success' of their service/what they measure as success?*
- *How successful they feel their service has been and how this differs between schools?*

Interviews were audio recorded (with consent) and detailed notes taken from the recording, rather than full transcription. Notes were then analysed using thematic content analysis. The results of the service provider interviews can be found in section 4.2.

3.3 School Staff Focus Groups

School staff were interviewed to examine their experience and opinion of HSIS and gain insight into the impact they think it has had on their school. The principal investigator and Public Health commissioner met with the Wirral Association of Secondary Heads (WASH) and a number of head teachers to discuss possible approaches to the research and to find a way to balance getting high quality data without causing too much disruption to teachers and school timetables.

A face to face semi-structured focus group was conducted with groups of school staff. The exact people interviewed varied between schools and depended on who is involved in organising, approving and encouraging access to HSIS. Some head teachers are very 'hands on' and had knowledge about HSIS, in other schools they have delegated to a deputy or assistant head.

Following on from the service mapping exercise seven schools were selected to be approached based on the types of school (single sex and mixed, religious and non-religious schools and grammar and comprehensive schools). These schools were decided on after discussion between the commissioner and the principal researcher. Once the schools were chosen the commissioner provided a name of a key contact and the principal investigator approached them via email and telephone to invite them to take part in a group interview. Two of the schools were unable to take part in the group interviews so the final sample consisted of five schools.

Focus groups took place at the school at the convenience of the participants. All participants were given a participant information sheet at invitation and written consent was obtained before the interview commenced. Interviews were recorded (with consent) and detailed notes taken from the recording, rather than full transcription. Notes were analysed using thematic content analysis. Interview guides covered topics such as:

- *If the HSIS is seen as a priority by SMT and services are seen as most important.*
- *How well has each service been received by management, teachers and students.*
- *If the services have had any impact on the health of the students within the school.*
- *If schools have refused to host some services why this was.*
- *Any problems or challenges they had faced with the HSIS programme.*
- *Any changes or improvements that could be made to services.*
- *If the HSIS has had any impact on the number of students leaving school premises to attend other health appointments and if this has affected absenteeism.*

3.4 Student engagement

During the five school staff interviews all schools agreed, in principle, to take part in the student engagement element of the evaluation and provide access to their students. Initial discussions revealed that each school would be able and willing to engage in a different way. Therefore we proposed three different data collection methods and these were offered to the schools as a menu of options.

There were two groups of students from whom data were be collected; 1) the general school student population to establish how aware they are of the services, how accessible they view them and what proportion of the them have used the various services; 2) those who have already attended HSIS to establish their experience of the service and the impact it has had on their health and wellbeing. Schools were also asked if it would be possible for some of their students to take part in a focus group to discuss the services. However no schools felt this was appropriate; reasons for this included concern about students feeling uncomfortable discussing health issues in a group setting, practicalities in arranging a focus group and reluctance of students to talk to a researcher. Therefore no focus groups were conducted.

The final sample included three schools. Two schools were unable to take part, one due to other commitments towards the end of term and a second did not respond to requests or return the researcher's call despite leaving messages and sending emails.

3.4.1 General Survey

The main contact at each school (usually the deputy or pastoral lead) coordinated the distribution of the questionnaires and chose which classes they would be given to. Three schools were able to distribute the general survey to a selection of their students. This general sample included students who may have attended one or more of the HSIS services and students who have never attended a HSIS service. An anonymous survey was delivered to one or two classes in each school, exact groups were chosen by the school to fit round timetabling, student availability etc. and include the years that most use the HSIS services.

Every school opted to complete the survey in paper format and they were distributed by a teacher and completed privately within a tutor group session. Students were asked not to talk or discuss answers. After the form was completed the student sealed it into an envelope and returned it to the teacher. A participant information sheet made up the first page of the questionnaire and students were informed that completing the questionnaire implied consent.

Questions in the survey asked about:

- *Publicity and awareness of services.*
- *Accessibility and appeal of the HSIS.*
- *Whether they have used a HSIS service.*
    - *For those that have used a HSIS service – what was their experience and how could it be improved.*
- *Any barriers to access and what discourages attendance.*
- *Basic demographics such as year group and gender but no identifying information.*

A gatekeeper information sheet was provided to the teacher who was distributing the questionnaires and they were asked to sign a gatekeeper consent form on behalf of their class.

3.4.2 Survey of service users

To investigate service user experience a short questionnaire was given to students who use one of the HSIS services. The questionnaire was distributed by the service providers (i.e. school nurse and youth worker) and given to students during a session. They were asked to fill it in there and then (if possible) or to take it away to complete when they had the opportunity. After the questionnaire was completed the student sealed it into an envelope and returned it to the service provider or returned it in a self-addressed envelope. A participant information sheet made up the first page of the questionnaire and students were informed that completing the questionnaire implied consent.

The questionnaire asked some simple questions about:

- *Accessing the service*
- *Their experience of the service*
- *The impact the service has had on their health and wellbeing*
- *Any improvements that could be made*
- *If they have used any of the other services*

Questionnaires included the name of the service and the school to enable us to link their experiences to a specific service and to a specific school. Questionnaire responses specifically relate to the service who distributed the questionnaire – so a questionnaire distributed by a youth worker will ask about their experiences of the youth work service.

Initially it was hoped the questionnaires could be distributed by all the HSIS providers, however, this was not appropriate as they were not all working in the schools, the timing meant it was not appropriate to hand them out or there simply was not time within an interaction to complete the questionnaire. At the three schools who had agreed to take part, the youth worker and nurse were approached and asked to distribute the questionnaires. In the end the questionnaires were distributed by youth workers at two schools and a school nurse at one school.

The service user survey also included some questions to help produce an economic evaluation of the HSIS programme. This element is being coordinated by the Research Fellow in Health Economics at Wirral Public Health and will be used as evidence to make a case for preserving interventions that work. It was hoped that the data from the service user questionnaires would feed into the economic evaluation. However, due to the small number of questionnaires returned these data will not be included in the economic evaluation.

3.5 School Nursing Service and Youth Service Activity Data

Routinely collected activity data is supplied to Public Health Wirral by the School Nursing Service and the Youth Service. This contains demographic information on each student who attends their service and what services and information was provided. The data from the academic year 2011-2012 was provided to the research team. Analysis provides insight into the activity of the two services, and corresponds with the data presented in the service mapping section (see section 4.1).

Each student is allocated a unique ID number by the two services; however, these are different so it is not possible to cross match the students. These ID numbers were used to identify duplicates in the datasets. For the demographic analysis, the duplicates were removed and the results provided as information on the individuals seen by the services. For the attendance data all duplicates were included as this represents the activity rather than the people, these are presented as attendances at the service. Analysis includes frequencies, crosstabs and means and are presented by school, where appropriate. Again, school codes have been used to maintain anonymity of the students and schools. The results are presented in section 4.5.

4. Results

4.1 Service Mapping

The data on services hosted by each school have been anonymised so that each school is represented by a code. It was decided that this information would be kept anonymous as some schools do not actively promote their services and some would not want to be identified. We were also aware that we wanted service providers and staff to speak openly and honestly about the challenges they have faced. To avoid jeopardising any professional relationships by drawing attention to challenges in service delivery we have not included any school names in this report.

The service providers sent completed email templates to the researcher in October 2012 and reported activity in schools for the 2011-2012 term. These templates were aggregated, cleaned and approximately standardised without losing the detail. The data needed to be cleaned and standardised so they could be presented alongside each other and in a comparable way (for example being able to tell that in one school uptake of AfC counselling was high but uptake of the Youth Service was poor).

This tool provides information on services provided at all schools and shows the context for the provider and school staff interviews. This information provided invaluable additional detail that enables conclusions to be drawn from the impact analysis, as level of provision is so varied we cannot view the HSIS as one single model. These data informed the student engagement section of the data collection by enabling us to approach a range of schools that host a variety of services. This information was also used to select the schools to approach for the school staff interviews. There are nine unique combinations of services provided (table 1). See the glossary for explanation of the acronyms.

Table 1. Number of schools hosting each HSIS provider, Sept 2011 – July 2012.

HSIS Provider	No. schools hosting this service
Action of Children	9
Brook	7
Merseyside Youth Association	8
School Nursing Service	28
Tranmere Community Project	3
Wirral Schools Stop Smoking Service	19
Youth Service	28

NB. Not all schools will currently host these services; these data show that they hosted the service at some point between Sept 2011 - July 2012.

The Youth Service and the School Nursing Service provide services in 28 out of 29 schools in Wirral (table 1). WSSSS is providing, or has provided, services in 19 schools and does this on a rolling programme providing services for three months in approximately 10 schools at a time. WSSSS also provide services in youth hubs and at the Youth Offending Service. In the school year 2011-2012 Brook worked in seven schools and were due to start in a new school in September 2012. Action for Children worked in nine schools and were also hoping to start in a new school in September 2012. Merseyside Youth Association have worked with eight schools and are aiming to engage more schools in September 2012. Tranmere Community Project have worked in the fewest schools (3) but have also worked in training agencies. They are hoping to work in more schools from September 2012.

Table 2. Total number and type of service hosted at each school Sept 2011 - July 2012.

School code	Total no. services	AfC	Brook	MYA	School Nursing	TCP	WSSS	Youth Service
20	7	X	X	X	X	X	X	X
***22**	7	X	X	X	X	X	X	X
†*2	6	X	X	X	X		X	X
9	6	X	X	X	X		X	X
13	5	X		X	X		X	X
18	5	X		X	X		X	X
†*6	4	X		X	X			X
***12**	4		X		X		X	X
14	4		X		X	X	X	X
†*19	4	X		X	X			X
21	4	X			X			X
23	4		X		X		X	X
3	3				X		X	X
4	3				X		X	X
5	3				X		X	X
7	3				X		X	X
8	3				X		X	X
11	3				X		X	X
24	3				X		X	X
26	3				X		X	X
27	3				X		X	X
28	3				X		X	X
1	2				X			X
10	2				X			X
15	2				X			X
16	2				X			X
17	2				X			X
25	2				X			X
Total		**9**	**7**	**8**	**28**	**3**	**19**	**28**

*Schools included in the staff focus groups
† Schools included in the student engagement

Two schools host all seven HSIS services and two host six services (table 2). Six schools host only the core offer of School Nursing and Youth Service and ten other schools only host one additional service, the WSSS. All schools have been offered all services (see section 6.2 about how the providers chose which schools to work in) so those schools which do not host many services have made a choice not to take these up. Reasons for hosting, or not hosting, services was investigated in the school staff interviews (see section 4.3). Only one school in Wirral has decided not to be involved with HSIS. Although the schools have been anonymised we can disclose that the schools which host the most services tend to be the mainstream comprehensive schools in more deprived areas. The schools hosting the fewest services are mainly special schools (for pupils with emotional and behaviour difficulties (EBD) or physical or learning disabilities (PLD)) or the faith schools. However, this is not totally clear cut; for example there are some grammar schools hosting a lot of services and some mainstream comprehensives in deprived areas hosting very few services.

4.2 Interviews with service providers

Sample

In total seven individual and group interviews were conducted with the representatives of the seven organisations providing services as part of the HSIS programme. Six of the interviews took place face to face and one, with Tranmere Community Project, took place over the telephone. The number of participants ranged from one (telephone interview) to four people and included managers and those in charge of strategic elements, as well as staff who work within the schools on a regular basis. The interviews lasted between 25 and 95 minutes.

Details about each service

Each interview started with a discussion about how each service worked within the schools and the roles of all the participants present. In the school year 2011-2012, the enhanced School Nursing Service and Youth Service worked in 28 schools, Wirral Stop Smoking Service (WSSSS) in 19 (on a rolling programme), Action for Children (AfC) in nine, Merseyside Youth Association (MYA) in eight, Brook in seven schools and Tranmere Community Project (TCP) in three. Information about what is provided by each service is detailed in the service map (section 4.1).

Recruiting schools

Each school hosts a different number and combination of services (see section 4.1). The Youth Service and School Nursing Service works within all except one secondary school on the Wirral and is part of the core offer (one school has declined to host the HSIS). The other five providers chose the schools in which they work in a number of different ways. For Brook, MYA and AfC each provider visited a Wirral Association of Secondary Heads (WASH) meeting to explain their service and asked the head teacher to contact the provider if they were interested. Each of these providers has funding to work in a set number of schools and this worked on a first come first served basis. TCP approached all schools and tried to meet with them to discuss their programme. MYA and AfC tried to ensure they were working in the same schools as the services complement each other. Two providers reported that heads emailed them asking for their service during the actual WASH meeting, indicating high demand and engagement by some schools.

WSSS was the only provider who purposefully targeted schools. The school nurses and commissioners chose the ten most deprived schools and WSSSS approached them. The most deprived schools were chosen as research shows that smoking prevalence is higher in the lower socio-economic groups (Marmot, 2010). WSSSS has since approached all other schools and are working with them on a three month rolling programme.

Differences between schools

All providers acknowledged that schools are very different, both in terms of the ethos of the school and the way their service runs in the school. AfC, MYA and Brook provide a similar service in every school. However, the other providers felt they deliver a different service within some schools.

> *"they are all the same but all different. We all offer the same sorts of things but the schools are very different and the pupils that come to see us are different." (School Nursing)*

Schools were described repeatedly by all groups as being very different; they all had different cultures, priorities and approaches to supporting the students. These differences were often put down to the ethos of the head and the governors.

"Each school is their own kingdom and they are all different. They have their own values, how they think, what they are happy with and what they are not happy with. You have to be a bit of a diplomat and [be] flexible." (Brook)

Participants commented that they had learnt that just because a service worked in one school did not mean it would be the same in other schools. However, the providers felt that their knowledge was increasing with each school and they were now able to anticipate problems and barriers.

Differences in the way services are delivered

Action for Children (AfC) provide a six week course of one-to-one counselling. Each counselling session is provided during the school day and students are excused from lessons to attend. AfC provide a very similar service in each school; where schools were unable to accommodate their needs AfC have negotiated to ensure the schools meet AfC's required conditions. AfC seemed to be the service with the least deviation from their core model.

Brook provides a second level contraception service consistently across all schools. The majority of the attendees will be signposted by the school nurse after she issues emergency hormonal contraception (EHC) or condoms. In some schools the sessions run as drop in and young women do not need to go through the school nurse to access the service. The signposting format differs slightly between schools but the service provided is the same.

Merseyside Youth Association (MYA) provide two day training to staff in schools and have been able to deliver this consistently across most schools. The follow up sessions involve producing action plans and generating evidence for the PEER (positive emotions, excellent support) school award and have been relatively similar at all schools.

The School Nursing Service delivers structured additional HSIS clinics in all schools except the two emotional and behavioural difficulty (EBD) and two physical and learning disabilities (PLD) schools. In these four schools the needs of the students mean a structured clinic would be inappropriate, so they deliver a more tailored, bespoke service with more unstructured sessions, input into classes and ad hoc support. In some schools they are only able to provide EHC and condoms to the older age groups and in faith schools they do not provide any contraception.

The Youth Service deliver drop-in clinics in most schools, structured sessions to target groups (e.g. PHSE sessions about specific health topics) and provide input into PHSE. In the EBD and PLD schools they do not provide drop in clinics but are involved in more informal sessions or input into PHSE lessons. They cannot discuss sexual health issues with students in the faith schools.

Wirral School Stop Smoking Service deliver smoking cessation clinics in the majority of schools. However they have been unable to set up cessation services in three schools. Two schools would not allow the clinic because the school did not wish WSSSS to prescribe nicotine replacement therapy in their school. The third school could not maintain confidentiality and all young people who came to the initial session were told the school would be informing their parents if they used they attended any cessation clinics. As a result of this no students signed up and the clinics were cancelled. In these three schools they deliver assemblies and input into the PHSE programme aimed at prevention rather than cessation. WSSSS are also rolling out a peer mentoring programme to reduce the uptake of smoking. This has been delivered in one school already and will be delivered in others in autumn 2012.

Tranmere Community Project (TCP) aim to deliver five one-hour peer mentoring sessions targeted at students identified as being at higher risk of teenage pregnancy . However, only one school has been able to

release students from timetable for such a long period of time. TCP have delivered a condensed one hour version of the session in two schools and in one of these schools they have delivered it more than once.

Negotiation

All services described having to negotiate and compromise with the schools to find a way to deliver their service that was acceptable to the school and themselves. In some circumstances this was simple things like covering over the word 'sex' on banners, in other circumstances this was notable changes like running condensed sessions or not providing sexual health information.

> *"We have to adapt to what they want, cos every school is different. We are like chameleons, every room is different, you get moved within the school…each week can be different sometimes." (Brook)*

All services acknowledged that there were some compromises they were willing to make, for example on venue, duration and timing of sessions, and that these compromises were acceptable if they were the only way to ensure any service was delivered in the school. These kinds of compromises were thought of as unfortunate but they would not affect the quality of the service. Many providers expressed a view that a reduced service was better than no service. However, many providers talked of elements that they would not compromise on; for example WSSSS will not deliver cessation sessions without being able to provide NRT, AfC refuse to do sessions in rooms that are not private and quiet and Brook will not compromise on anything that could break confidentiality. In an incident where AfC were moved to a different room they described a conversation with their contact at the school

> *"this cannot happen – either we cancel for today or we have a discussion now about who is going to move, but it is not suitable for me to move." (AfC)*

In this circumstance AfC asserted their needs and would not accept anything less.

For the School Nursing Service in the faith schools where they are not able to provide contraception the schools have agreed that they can deliver chlamydia and pregnancy testing. The attitude of most services, regarding where compromise will and will not be accepted, is summed up by the quote below:

> *"I think we realised after about a good year, it's not going to be ideal. There is not a purpose built room, we have to fit in with what they have got. We are guests in their school and we have just taken what we can get. There are certain things we will not have; like breaking confidentiality, so if that is happening we are going to say 'no'. Up to now what we have had to negotiate, we have negotiated and we have been ok. We've made do." (Brook)*

Assessing impact

All providers were asked what impact they felt their service was having on young people and the school as a whole. All the providers believed their service was having a substantial positive impact and this was expressed in different ways.

Most providers reported that the students were very enthusiastic and grateful for the service. Providers reported the high uptake as a sign of success and impact and some suggested the fact the students return to repeat sessions is a sign of how pleased they are with what they have received.

> *"I think we are having quite an impact on the students, the ones that we have had come back again, they tell their friends and their friends come in." (Brook)*

Other providers quoted their key performance indicators as signs of the impact they are having. For example, WSSSS were very proud of the high quit rates they had achieved, which they recognised as being particularly good given the peer pressure and need for experimentation that young people experience. WSSSS also talked about the pride young people feel the first time they get a zero reading on the CO^2 monitor after they quit - "*it shows they can set themselves a goal and achieve it".*

Other services reported examples of specific occasions where they have been able to make a dramatic difference in the life of a young person, for example Youth Service reported a time where a youth worker supported a young man and he was subsequently identified as having early stage cancer that was successfully treated.

The Youth Service and AfC both said young people talk to them about things they have never felt comfortable telling anyone else and this trust is an example of the impact they are having. MYA felt they are having an impact as they are giving teachers the confidence and skills to pick up on mental health issues.

> *"It is staff confidence and knowledge building so they can go back into school and recognise signs and symptoms within children and young people and know that there is a network of support in terms of what is available through HSIS rather than them thinking 'I don't want to pick up on that cos I know I am going to open a can of worms and have to deal with it myself'." (MYA)*

Tranmere Community Project acknowledged that there are some difficulties in identifying the impact of the peer-education programme and the real impact will only be evident in a few years. They ask all young people who attend their sessions if they would delay pregnancy until they are over 18 and 95% said they would. TCP talked about how the most dramatic impact is evident in the young mothers who act as peer educators. Delivering the sessions dramatically increases their confidence and skills and eight out of the nine peer educators have gone on to further education or employment.

The participants from the School Nursing Service felt their service and interactions had improved and this was a sign of how well they were doing. They thought this was because the nurses now have the skills and confidence to deliver sexual health services and that the young people are now more confident that the nurse will be able to help them

> *"The dialogue we have with you people has certainly changed…I think it is a much easier dialogue – they are coming because they want the service, they know what kind of service they are going to get, they know what kind of reception they are going to get – we are going to listen to them. I find it much easier to talk to them now." (School Nursing)*

Some providers reported that the positive response from the school and staff was evidence of how important their service is and the positive impact it is having on the school

> *"The school, I have not been anywhere I haven't felt like I am wanted. Most schools are receptive, the reception is great, 'come in I will call the nurse', everyone has been really helpful." (Brook)*

MYA reported being able to feel a '*culture shift*' when the head teacher of one school talked at a school wide training session and drew attention to problems with staff attitudes. MYA saw this as a big change and encouraging as they know senior managers can lead a school wide change. MYA also felt that their training was improving relationships between colleagues and creating more positive stronger relationships with the young people.

"Recognition that senior leadership, it is coming from the top, are willing to support staff." (MYA)

The way providers deliver services was thought to be an important contributor to the impact; the Youth Service suggested the fact their workers are not school staff and are called by their first name meant they are noticeably separate from the school and the young people trust them more. TCP believed having their education programme run by young people has a much bigger impact. The interviewee had stepped in when one of the peer educators was ill and believed the young people reacted differently to her as the peer educators are on the '*same wavelength'* as the young people. WSSSS believed their service was so successful because they hand the power to the young people and give them ownership of their own health

"our approach with the YP is very much...we don't force people to stop smoking that has to come from you. I think, with young people, once you hand them that power, they make a good decision."(WSSS)

Process of setting up the service

The setting up of the services was discussed in detail by most of the groups. Brook and the Youth Service initially pioneered the project and therefore made it somewhat easier for the other services. The individual who led on the setting up of the school nurse element was no longer in post and the current HSIS lead at the School Nursing Service was not involved in those early stages, so experience of setting up the Enhanced School Nursing Service could not be captured.

The Youth Service reported some difficulties getting into schools to start with as some schools had perceptions that youth workers would act in a way that did not fit with the ethos of their school.

"[they] were worried that the school's reputation could be damaged by youth workers acting unprofessionally. That this would get back to the parents…" (Youth Service)

The Youth Service worked for a long time to reassure schools that the youth workers would work within the boundaries and ethos of each school, they thought the heads had been nervous that their schools would be in the newspapers or parents would object. The Youth Service thought that over time the schools came to realise that the youth workers were consistent, reliable and kept their word and this has encouraged other schools to sign up. For a while it was a rather *'fragile relationship'* and the Youth Service were worried that it could be *"like dominoes, if one thing went wrong they would all shut the door".*

All services described many meetings and discussions with school staff (including heads, nurses, pastoral staff, PHSE leads and governors) were needed to resolve issues and concerns before the schools agreed to hosting the service. Some of the services had been surprised how difficult it was to negotiate access to the schools. They had understood from the contracts with NHS Wirral that the schools had agreed to host the service, and they would be able to *"move in and start."* One provider described their own approach and the expectations from NHS Wirral as *"naive"*. They thought the commissioners, and themselves, were unprepared for the challenges and barriers they experienced whilst trying to set up their service in some schools. Providers and NHS Wirral had both presumed once the contracts were in the place the schools would all sign up and be eager to host the service. In reality they faced many challenges trying to negotiate with schools to host the service. Another area that took a lot of time to resolve were the confidentiality issues as some schools wanted to know about who was attending services or wanted consent from parents before a young person could access a service. Schools needed reassurance from the providers about safeguarding and child protection procedures and how these were separate from the confidentiality they offered.

"they wouldn't come, young people wouldn't come, even in schools if they thought you were going to talk to anyone about what they tell you." (Brook)

When setting up their service AfC found the schools were very worried that the counselors would be encouraging sexual activity and AfC described how they had worked hard to reassure the staff that they were more concerned about relationships and young people being happy and secure in their relationships. They explained their use of Fraser Competency guidelines to determine if the young person is mature enough to give consent and take responsibility for their health. The schools were also worried about child protection issues but this was resolved once they understood that AfC planned to work within the same laws as the school and that any child protection issues would be dealt with within school policies.

AfC believed that the success of their service was due to being well set up to start with. They felt they had a solid grounding with real clarity on what they could and would deliver and what the schools wanted. They also thought their own confidence in their role and responsibilities helped the service run smoothly.

"We are quite confident why they are there, who they are engaged with, what they need to share, what to do if something goes wrong, so we are confident." (AFC)

AfC felt they were very clear from the start regarding what they could accept and what they needed. They took notes of all agreements and discussions to ensure that schools were clear on what they had agreed and the schools knew the service could not start until everything was sorted *"start as you mean to go on".* AfC themselves, and other providers, believed that the schools saw the counselling service as a priority and were more willing to agree to their requests than maybe requests by some other services. It was noted by one provider that there had been some disquiet on their team as the counselling and smoking cessation service seemed to be able to get better rooms and more cooperation from the schools because these two services were seen as more of a priority.

Brook described having to work hard to convince some of the grammar schools and high achieving schools that their students might need Brook services. One of these schools thought that as their students were 'high achievers' they would not engage in behaviours that would require the services of Brook. This grammar school will hopefully start to host the Brook service from September 2012.

"But 'high achievers' also have lives, including having sex. They could be sat in an exam worrying that they haven't come on [started their period]." (Brook)

MYA had found recruiting schools and setting up the service relatively easy in the first wave as the schools were eager for their staff to receive training about mental health. MYA changed their approach slightly and started offering a PEER school award to encourage the schools to follow through after the training. This was a suggestion that came from the schools as they were more likely to find the time to do the follow up work if they received a certificate or charter mark. However, although the schools were eager they found it difficult to release staff for two days training (see Challenges below).

A number of services reported it taking time to set up clinics in the special schools (EBD and PLD) as these needed a unique approach for each school. Some services reported trying a variety of models in these schools before finding a way that worked for the provider and the school.

Challenges

As well as the challenges experienced in setting up the service Action for Children AfC reported a number of challenges they experienced in delivering their service, with some problems with availability and appropriateness of rooms. However, AfC stated that these issues were always sorted out when raised. AfC also felt that in some schools they were not seen as important because they were an outside agency coming

in and sometimes, although not deliberate, were not seen as a priority. However, they reported that most staff at the schools were very welcoming, friendly and overall very helpful, however, at some schools they sometimes have difficulty finding a member of staff to help them.

> *"some schools you know you can go directly to someone who you know will be able to give the answer. But there are other schools where you are kind of left dangling as there is only office staff around and they're run off their feet, they haven't got time to go running round after students." (AfC)*

During the Brook interview a number of challenges and problems were discussed. The main issue they had was with the location and facilities in the room they use. They struggled to find appropriate rooms that were private but accessible and near toilet facilities. They described sometimes having to work in classrooms which was not ideal because they were often disrupted by some teachers letting the students in early for the next class

> *"I am very aware of that bell going and people coming in." (Brook)*

Brook also discussed the problems they had in providing appropriate waiting space as they also need a private area for young people to wait before the drop in clinic. They originally tried to keep all medication and files in the schools but have had to change their approach and now take a case of medicines with them to each school similar to 'clinic in a box'. They have realised: "*We have to be quite easy going to a point, without breaking confidentiality"*.

The challenges discussed by MYA mainly focused on the school staff being unable to attend the two day training course, which requires four members of staff from each school. Despite being flexible on timing, it was felt that schools struggled to release staff from teaching duties for so long. MYA also ask the staff to develop an action plan and evidence their work to support mental health (to achieve the PEER award) but some schools have found this difficult due to staffing and resources. They originally recruited eight schools and are now struggling to engage with other schools despite MYA having the resources to deliver more training.

The participants from the School Nursing Service discussed problems with venue and accessibility for the students. In a number of schools the room the nurse uses is in part of the school that is locked at lunch time and young people have to get teachers permission to enter, which is a barrier for the young people. The service felt this particularly an issue in the EBD schools

> *"The pupils in are in an environment where it is very restricted and structured and there are a lot of locked doors so it was an issue sorting out how they can access me." (School Nursing)*

The majority of these access issues have been overcome but there are still barriers in some schools. A minority of nurses also do not have any dedicated space in school and work in classrooms or store cupboards.

Tranmere Community Project have faced many challenges trying to engage with more schools to deliver the peer-education programme. They have met with and presented to other schools but they have only delivered the training at three schools. TCP felt that the main reason for this was that their full programme consists of five one-hour sessions and schools are unwilling to let students out of lessons for this amount of time. TCP have overcome this challenge by delivering a one hour condensed version in some schools. The participant from TCP also felt that they suffered from being an unknown organisation and the schools were

nervous about letting them into the school. However, the participant was confident that if they could get a *'foot in the door'* and demonstrate the power of the peer education they would be invited back.

WSSSS reported many challenges they had faced in their service, one of the biggest being time. They feel they have not got enough time within the lunch break to sign up new students and support existing quitters as there is a lot of paperwork and often lots of people in the clinic. They suggested that occasionally they would like to take students off timetable to go over more complex issues but, although it was originally hoped this would be the case, this has not been possible. In some schools they have struggled to publicise the service and feel the message is not getting out to young people that the provision is there. In some schools they have not been allowed to present in assemblies or put posters up so many students do not know about the service. WSSSS also discussed venues and rooms as a reoccurring challenge to their service; one school wanted them to work in a corridor, another suggested the busy canteen and in one school they are based in a store cupboard. They also discussed the barriers to access for young people when they are on corridors that are out of bounds to students and when the school is on 'lockdown' at lunchtime (where many areas of the school are locked and inaccessible and students are confined to specific areas such as cloakrooms).

The challenges faced by the Youth Service included access issues. In some schools, this service is delivered in parts of the school which students require permission to enter. The Youth Service felt this deterred young people from attending, due to confidentiality issues. The Youth Service felt that in some schools there was a strong focus on academic attainment, and the wellbeing of young people was not viewed as important. In these cases, the Youth Service felt they had to compromise to be allowed into a school, and did not feel as if all of the schools valued or appreciated their work. However, the discussion in this group also considered whether all schools should receive the same allotted resource of youth worker time, as some schools greatly utilise the youth workers. Some of their clinics are very busy; one of the bigger schools in a more deprived area suggested that their school should be allocated extra youth worker time as their needs are higher. There was discussion in the group about whether their resources should be focused on schools who are more welcoming and proactive. However, the group did not hold a consensus view on this issue and felt allocation of workload and hours at each school was maybe something that needed to be discussed at management level and with commissioners.

Although some barriers and challenges have only been reported by a minority of providers other challenges were common across the majority of providers. These common challenges included: inappropriate venues and accessibility, health and wellbeing not being seen as a priority for the schools and the schools not having any space within the timetable for students and staff access the services.

Overcoming barriers and working successfully

Some of the groups discussed factors that particularly helped their services run smoothly and effectively. AfC described some schools where their services work very efficiently and one of the reasons for this is having a key contact to champion the programme. Good communication was viewed as key to keeping the service running smoothly.

> *"I hate things festering…to keep good relationships we need to iron out these problems, turning a blind eye isn't going to fix it." (AfC)*

Brook described the schools that worked well as those where they have good relationships with the nurse, a suitable venue and with promotion and advertising of the service.

MYA felt the benefit of having training sessions with teachers from a variety of schools was that they get the chance to learn from each other

"it is really good cos they get to be able to be able to bounce ideas off each other, they say 'we try this, we have this approach'." (MYA)

TCP believed being able to deliver the five session programme was particularly important, stating that "*it really makes them think*". The representative from TCP felt that the programme is effective in encouraging participants to delay pregnancy, particularly the use of a video of young mothers' experiences over a 24 hour period.

The discussion at School Nursing Service around successful schools focused on venue and how schools with a well located nurse room got high uptake.

"not too public, so not everyone can see them going in but there is footfall. You don't want to be just on the staff corridor because everyone can see the young person going up to clinic. You want somewhere pupils can go through and it is allowed and accepted. But not that everyone can see. They all presume they are coming for sexual health even if they are not." (School Nursing)

WSSSS discussed circumstances where they have time to build relationships with young people and schools where the head teachers are very supportive. They talked a lot about school culture and described successful schools where teachers are enthusiastic and know about the service, they are really supportive of the young people, they are open to new ideas and approaches and focus on more than just academic achievements. They felt the attendance and quit rates tended to be higher in these schools because the young people were more supported and were not scared to be seen using a smoking cessation service.

The Youth Service felt they were building up trust of the schools and that as time has gone on the schools were more willing to let students out of lessons to see youth workers. They thought the schools that really valued the youth workers were those with a strong pastoral and holistic care approach, in these schools they feel promoted, welcomed and appreciated.

There were some elements that were specific to certain providers but the majority of providers discussed the school culture and how they had been more successful and run more efficiently in schools with a holistic approach to education. Another common theme brought up by many of the providers was the benefit of having helpful and supportive staff, especially one key champion or contact, who they know can help with any problems. The clinics and services based in more suitable rooms and well located venues were also thought to work particularly well.

Uptake and increasing uptake

In all groups there was a lot of discussion around uptake, reasons for high and low uptake and ways to improve it.

AfC reported that all their slots were filled and they were busy at all schools and they will see as many young people as the school day allowed. They have had to ask schools not to refer new students until they have a space as they do not want young people waiting on a list for six weeks. This has worked well, as schools have been respectful and can see that their time is limited. Only in one of the EBD schools have they had problems with erratic attendance, not because of reluctance to attend AfC, more because of problems with general school attendance.

The participants from Brook described some school clinics as being busier than others. In one larger school they provide two clinics but in another school the attendance is poor. Brook suggested this may be due to the school nurse not seeing many people for issues relating to sexual health, and so not signposting students on to Brook. There is a feeling that Brook *"are sure there is a need but we aren't getting them"* and feel they

need to improve the referral and signposting system and communication with the nurse. They have successfully increased uptake in some schools by promoting the service in assemblies, through the nurse talking about it in PHSE sessions and the Brook education team visiting. They continue to do the clinics at lunch times as clinics after school would have very low uptake. For a while Brook ran a satellite clinic in youth hub in Eastham but there were so few attendees they closed this clinic as it was felt this was not a good use of resources.

For the School Nursing Service the uptake is variable. In some schools the nurse is very busy, not just with HSIS but with their role generally. They described some schools where the clinics have a steady flow through and in others there are very few attendees. When they set up the clinics they purposefully organised it so the HSIS clinics in the all girls' schools took place on a Monday to ensure if young women needed EHC they could access it as soon as possible after the weekend.

EBD schools particularly struggle with low uptake and unpredictable student attendance as often the school will be on 'lockdown' (for example, if there is a violent incident, student movement around the school will be restricted to try to limit the impact of the incident and reduce subsequent disruptive behaviour in other students). The School Nursing group discussed advertising and school ethos as being factors that increase uptake

> *"It isn't just the advertising though. It is everything about the school that supports [the young people]." (School Nursing)*

The nurse to the EBD schools thought it takes a lot for the young people to trust adults and this can mean uptake is slow.

> *"In the EBD schools it takes a lot for them to trust you…so when I have been with [another HSIS provider] they sometimes don't talk to you cos they see strange faces. The best thing there is to try and get continuity and when they see the same face every time they eventually trust you. Whereas they have known me for a long time…and still they pick and choose when they want to talk to me." (School Nursing)*

For the WSSSS group the uptake also varied greatly between schools and they felt that the schools need to take some responsibility for promoting the service. Those schools that support the service and promote it have higher attendance. WSSSS also thought venue and accessibility had a big impact on whether they were busy.

> *"I'd like to see the schools being more proactive, available space, help with publicity and really try and encourage."(WSSS)*

TCP have not had the uptake they were hoping for and have struggled to engage with many schools. They suggested if they could deliver an hour peer education session to a school representative (such as the Head Teacher), the schools would see how effective the programme can be and invite them into the school. The participant stressed that the young women who deliver the mentor programme believe that professionals should not talk about young people who are at 'high risk' of teenage pregnancy as there is a chance anyone could become pregnant at a young age. Therefore TCP suggested the peer-education is delivered to general groups not just those identified as 'high risk'. They have delivered the one hour condensed session to whole year groups, one class at a time.

The discussion around uptake at the Youth Service group focused on location and timing of the clinic, promotion of the service and whether the senior leadership team (SLT) are promoting the service with the staff. They felt in some schools they work mainly with the year 10 and older groups and in other schools,

particularly those without a sexual health service, they work mainly with the younger year 7 students. This was thought to be due to who the service was promoted to by the schools, the location of the clinic and the other pastoral support that was available in the schools.

Across the providers there were differences in the way they described the uptake of their services. AfC was the only service that reported general high uptake of their service at all schools, with some minor issues at one school. All the other providers discussed how the uptake varied greatly between schools, with some very busy and full and others being very quiet despite all efforts. Some providers reported particular problems with uptake at EBD schools that needed alternative approaches to sustain these services. The majority of the services thought uptake depended on three elements; venue, promotion and attitude of the school. However, it is not possible to identify one particular element that increases uptake and makes a service successful as summed up by the quote below,

> *"It is their whole ethos and the way they work with young people.. It is everything about it [the school], not just that they advertise, it is that they are very sensitive to [needs]…education is not the only reason young people are in school, about the pastoral side…they are very supportive of young people…If they have problems educationally or academically the school will support them, if they have pastoral problems the school will support them. I think that shows, they are allowed out of class to do other things. They can see that if they are troubled by something they are probably likely not to get the best work off them. So they sort out whatever it is they are troubled by and they are more like to get a better educational experience." (School Nursing)*

Suggested improvements to HSIS

All provider groups were asked if there was anything that could be done to improve HSIS and their ability to provide their service. AfC said they would like more feedback from the schools on their opinions of the service. AfC have twice sent emails to all head teachers asking for feedback but only had two responses. They often get informal feedback in the schools but felt that some official evidence about how they are viewed would be constructive. They thought that once they started working in a school they were then left to work independently and did not know what the school thought about the service they were providing. They suggested this request could come from the commissioners and request information on all services. AfC also discussed how challenging it can be working on a short term contracts and a longer term contract would make service planning easier.

Brook discussed how having the head teachers and SLT at each school more involved could promote their service and give it more authority. Brook also want to improve their IT system to make recording notes easier. Brook described how they have been working at capacity and have surpassed what was set out in the contract, but would like more funding to be able to work in more schools.

MYA discussed the commissioning process and what will happen to the service after March 2013. Some schools have asked about additional training and other support and they want to be able to say what they will be able to deliver after then. They would also like to be able to deliver more training around specific mental health conditions or the Mental Health First Aid training as schools have asked for these.

The School Nursing Service group discussed that improvements were needed in the rooms and location and they suggested they needed more modern record systems as currently it is all done by hand.

> *"Difficulty is always going to be around rooms and space. Sometimes it is the facilities and the schools that stop us offering a bit more." (School Nursing)*

WSSSS also commented on venue, publicity and more involvement from the SLT. They wanted the SLT to start seeing smoking cessation as a priority and were worried that people now think that smoking is 'solved'. They also thought the form they have to use to enrol the young people was not entirely appropriate and may need reviewing.

The Youth Service group discussed wanting to feel more valued and more of a priority to the schools. They suggested that including the HSIS in the Healthy Schools award criteria would raise the profile of the service, as schools see this as an important award. They also want clearer direction on who is leading HSIS in schools and clarification on the role of the Provider Network. Some of the representatives from the Youth Service group discussed specific things about their service that they wanted to improve, such as IT or services they would like to be able to offer, but generally the suggested improvements focused on space, venue, publicity and wanting clarification on funding post March 2013.

An issue that was discussed by a lot of groups related to wanting the schools to see student health, and therefore the work done by the providers, as more of a priority within school.

> *"In an ideal world the schools would value us being in there, the nurse would utilize us fully, the schools would give us a decent room to work in and the HSIS was at the forefront of the 'what is going on in the school' as a valid piece of work alongside all the other stuff that they are getting." (Youth Service)*

One service provider described how the lack of strategic lead for school nursing has resulted in a lack of clarity regarding overall responsibility for the HSIS programme.

Working with other HSIS providers

All providers believed they worked well with the other HSIS providers and many groups talked about the success of these relationships and the Provider Network. All service providers said they signpost to other HSIS services and have had referrals from other HSIS providers. The WSSSS and Youth Service work particularly closely as they share an office. MYA particularly praised the relationships between the providers and put this down to the way the service is commissioned. They believed that the exact role of each service was clear and everyone knew where they fit in. The commissioning process made it clear that no extra services would be purchased and this reduced the competition between the providers. They thought it was a relief to not feel like they were competing for the same funding and because all providers knew where they stand they could work together without feeling like they were rivals.

Targeted and accessible service

All providers who worked directly with young people were asked '*if the young people didn't access your service where, if anywhere, do you think they would go?'*

AfC thought that the young people would not go somewhere else, and indeed some students reported to AfC that they had been signposted to other services but had not attended. They did not think young people would go to their GP about these issues and they felt that young people value the service because it is in school

> "[school] *is where they feel the safest and securest – therefore more likely to access a counsellor in school, because that is where they know." (AfC)*

Brook suggested that students who attended schools outside of Birkenhead may not come to the main Brook clinic and that the GP is the *'last place they would go, they often still go with their mum at 14"*

The discussion in the School Nursing Service concluded that a lot of young people would not go to family planning clinics as they worry they will see relatives, it is busy and the hours are difficult for young people. By providing service in schools they are promoting the main Brook clinic as well as providing a service where they want it in a convenient location. This group believed the immediate accessible nature of the school nurse meant that young people could access it very quickly which is important to young people.

> *"Young people want to ask a question there and then. It is not worth making an appointment or going miles to ask a 5 minute question. They just want to ask something and get a response, they may go away and mull it over and maybe come back in a few months. It is almost not worth going to Brook for a short response so they will come to the nurse." (School Nursing)*

> *"It is very immediate 'I have thought about it and I need something sorted out right now - not next week'." (School Nursing)*

TCP believed what they were providing is unique and that peer education messages would not reach young people otherwise.

The WSSSS group discussed how young people are reluctant to visit adult stop smoking services and those that do are not welcomed, and adult services do not know how to support young people. They believed very few young people would visit their GP and that often other services do not believe or understand that people as young as 12 can be addicted to smoking. It can be very intimidating for a young person to go to a service for the first time and providing it in school makes it less daunting.

The Youth Service discussed different types of young people; some already access youth centres or similar services but some never attend any services. The value of the HSIS is that it is accessible to everyone and attracts young people who may not attend any other services. This group thought HSIS had created a ripple effect and young people now know a lot more about other local service such as Brook and Response – whereas before the young person may have only gone to these organisations in crisis now they are more likely to go before they reach crisis point.

The conclusion of all the groups was that the majority of people who attend HSIS services would not go anywhere else for this issue. The school venue is safe, convenient, accessible and immediate for the young people.

4.3 School staff focus groups

Sample

Focus groups were conducted with staff at five schools. Each focus group involved different types of staff and ranged from three to five participants. Staff roles and job titles varied widely between schools; each school had a slightly different management and pastoral system and therefore the staff who linked in with HSIS differed between the schools. Staff involved in the interviews included head teachers, deputy head teachers, heads of sixth form, heads of year (years 9, 10 and 11), pastoral and wellbeing leads, inclusion and home liaison leads, learning mentors and one school nurse. At all but one of the focus groups there was a mix of teaching and non-teaching staff. The types of school and the different services they host are detailed in table 3. In this section opinions will be referred to as the opinion of the school, because the participants in the focus group were taken to speak as the voice of the school.

Table 3. Description of schools included in focus groups

School code	Type of school	Services hosted*
School 2	Girls comprehensive school Academy No 6th form Not faith 700-1000 students	AfC Brook MYA Nurse WSSSS Youth Worker
School 6	Girls grammar school Academy 6th form Not faith 1000-1300 students	AfC MYA Nurse Youth Worker
School 12	Mixed comprehensive school Academy Mixed 6th form Not faith 700-1000 students	Brook Nurse WSSSS Youth Worker
School 19	Girls comprehensive school Academy 6th form Not faith 700-100 pupils	AfC MYA Nurse Youth Worker
School 22	Girls comprehensive school Academy Mixed 6th form Not faith 1300-1600 students	AfC Brook MYA Nurse TCP WSSSS Youth Worker

*not all schools will currently host these services; they have hosted them at some time in 2011-2012.
N.b. this information has been kept purposefully vague to ensure anonymity of schools
Source: Department of Education 2013

Reasons for taking up HSIS services

All groups were asked the reasons for taking up the variety of services. Three schools discussed that they were aware of gaps in their skills and knowledge and lacked time to offer support to the students. They felt there were areas of health, especially related to sexual and mental health, which teachers were not confident to offer support in. These staff felt that other agencies and professionals could provide this more specific expert advice to students.

> [There is a gap between] "*the support we can offer from learning mentor and teacher level…and there is CAMHS at the other end…we were finding that there were students in the middle for whom a CAMHS referral wasn't being made, wasn't deemed to be appropriate but we felt they needed some more help." (School 6)*

School 6 felt their students needed extra support because of the stress and pressure students felt, and support around mental health was particularly important. This group also felt there was a gap in the services that were available to their students, especially in relation to mental health.

> *"There was a perceived need for the services, we needed support in the school because of the stresses and strains the girls experience in and outside of school. They needed more help than we could give them, more professional help than we could give them." (School 6)*

School 12 also discussed this and hoped that the HSIS services would enable them to deliver more low level prevention and support and not focus on 'fire fighting' the issues that were not resolved early

> *"what we hoped with this initiative is that there will be less fire fighting….we are definitely helping their health and wellbeing."* (*School 12)*

School 19 discussed how this had already happened at their school.

> *"[before] we were dealing with the aftermath, whereas now we are almost nipping it in the bud because they feel they can come and raise these issues." (School 19)*

School 12 described the deprived community in which their schools is based as having generally low health and how some of their students' families do not understand or promote healthy behaviour.

> *"We felt that many of our children may not be getting the type of advice that we would want them to receive, from their parents." (School 12)*

School 2 felt the HSIS service fitted in well with the changing face of schools and how they now provide more pastoral service to the students. They felt parents of their students expected more from the school than just education and that the services available through HSIS enhanced their pastoral system

> *"the concept of schools just providing an education has completely shifted, I don't whether or not [that is just here] but here, the pastoral system is so deeply imbedded we link into lots of other services, extend our knowledge and liaise with them. We bring that support into school." (School 2)*

School 2 also discussed how the HSIS services, especially the sexual health services, empowered their students. School 19 discussed taking up the other HSIS services as their nurse was extremely busy, previous to the HSIS programme she was the only person who could deal with a lot of these health issues and they described how there was often a long queue outside the nurse's room. They described that now the youth worker can offer more low level support, the nurse is able to focus on the more major issues.

Process of setting up the HSIS programme

Some of the groups discussed that, when they were initially planning the enhanced sexual health service, they were concerned about the reputation of the school. School 2 was particularly worried about how the parents would react

> *"What worried us more, not senior managers but certainly governors, was at one point we were asked to take part in the pilot and our name was trumpeted. And as a girls school we didn't want to get a reputation that maybe we needed HSIS, people would equate it with abortions and contraceptive pills and all that sort of stuff. So that stopped. And then all the schools went together and that was fine. The governors were fine with that. And the parents on the governors were saying 'we might not want to think about our girls needing advice but at some point they will and we would rather have it in school'." (School 2)*

> *"I think there was an issue we had was girls accessing things like the morning after pill I don't think we run a full contraceptive clinic. I think that came from governors, it was almost like encouraging girls to go out and be promiscuous and know they had a backup plan in school so to speak. They can access that service, it is much more confidential and we don't advertise it as a contraceptive service." (School 2)*

One group talked about how they had had an open meeting for the parents to come and learn about the HSIS and to try to build trust between the parents and the providers. Other schools talked about writing to the parents or including information about HSIS in the school brochure.

School 6 discussed how they had made a conscious decision not to host the Brook clinic and for the nurse to only offer contraception to year ten and older.

> *"we made a conscious decision not to have that much contraceptive advice because of the reaction of parents. I know the girls are offered the morning after pill but that is as far as we took it. …Now, once it is embedded we may want to go a little bit further I don't know, but when we wanted to introduce it, to make sure that parents were on side, we only took it so far. And that was the year ten, the morning after pill, we had to write to parents to say this would be offered. But that is as far as we took it." (School 6)*

School 12 and School 6 discussed how they had found it generally straightforward to set up HSIS in their school. There were some practical issues with referral pathways and signposting and rooms but generally it had run smoothly.

> *"other than space it worked really well. We talked about how we were going to run the referral process and work together, then how the confidentiality would work…things like that. And all those elements were all very smoothly done." (School 6)*

School 12 felt it was particularly straightforward because the HSIS providers built on activities they were already doing in their school and it built on their existing multiagency working

> *"[The HSIS] has built upon the multiagency working that we were already doing, which is why it has been more successful in this school than perhaps in others, it was building on something that already existed rather than introducing something brand new." (School 12)*

Parents' reaction

Some groups discussed how worries about parent reactions limited which services they agreed to host and which services they offered to which age groups. School 6 discussed the challenge of balancing the needs of the students with the wishes of the parents

"I mean you want to help the children but you also want the parents to be supportive and understand what is going on within the school. You've got to work with the parents, we have some parents who still withdraw their children from sex ed…and cultural differences as well. You've got to walk a line thinking this is what we are offering to the girls and this is what the parents will accept." (School 6)

School 22 discussed the challenge of not telling the parents when students accessed the services; sometimes the students tell their parents, but because it is a confidential service it is up to them

"the only thing that has been raised as a concern, they can get the confidential counselling but the parents want to know but don't find out...just one or two where things have come to a head, parents have discovered they have been going to counselling and they didn't know about it, because it is confidential." (School 22)

Once services were set up some schools reported that they had had some issues with parents however these had mainly been resolved.

"[parents] thought anyone, like a year 7, could get the morning after pills, were they going to be offered contraceptives in school, condoms by the quarter etc. It was good to be able to reassure them, no, it is only year 10. In an area like this we always get phone calls." (School 6)

"now it is embedded and they realise condoms aren't being given out like boiled sweets every break time then I think they see it as positive. I think probably the parents have forgotten about it, which is fine." (School 6)

"this is what we can offer in school and they bite our hand off 'I'd love my daughter to have some support'. It has been really positive." (School 6)

School 2 discussed that the HSIS was a strength and enhanced their relationship with the parents as previously they had not been able to offer more support and information to parents when they approached the school.

"school very much not only focused on academic side…but parents, when they have a problem with the child their first port of call is school so it is nice for us, as school, to put in our own package of care. Having those HSIS to be able to signpost parent and young people direct rather than just sitting on the problem, or saying 'you go away and deal with it'. That is again about home school working we have created a partnership between home and school cos we have that access to support for young people." (School 2)

Factors that have been successful

Participants at the schools were asked what they thought had worked well. One of the main positive elements that was mentioned was the relationships that had been built between the providers and the school. The schools all talked very highly of their school nurse and the communication, support and trust that existed between the nurse and the senior school staff. Some schools talked about particular providers with whom they felt they also had good relationships. However, this was not the case for all schools and providers.

Most schools talked positively about the continuity of care and how useful it was to be able to signpost a student to a service that was based within school. This helped encourage the student to attend but also meant the school staff were updated, as far as confidentiality policies would allow, on the progress and any other issues with their student. School 6 discussed their experiences before HSIS was introduced, describing

that when they signposted a student to an outside agency they were not always updated on if the student had attended or if things had improved. With the dialogue between the providers and the school this information was now being passed on and the school felt confident that issues were being dealt with, even if they did not know all the details.

> *"It doesn't matter that I don't know, I know there is support that is enough. [The nurse] knows, she refers and something is happening. It used to be that you didn't know who was working with the kids out of school."* (*School 6)*

This was highlighted when groups talked about the good communication they felt they had with the providers. School 22 and School 12 thought this was particularly important and they discussed successful multiagency working and information sharing. School 12 felt this was something they had already been doing, but that HSIS just enhanced this, and attributed the success in their school to building on what they already delivered.

School 19 and School 2 discussed how well they now communicated with their school nurse and how they struck the balance between openness and discussion of issues but did not compromise the confidentiality of the nurse-student relationship.

> *"it is far smoother this year and more transparent. [The school nurse] feels more confident to say to us 'I'm seeing her' and we don't need to know why, but we know that there is an issue. She might say 'it is home' or 'it is stress'. And so it does seem to be far more transparent this year and I think the girls are really benefitting from that. They have a place they can go and they feel it is confidential and it is secure, and they are using it." (School 19)*

> *"as a school we always thought it was a good thing, we had a good relationship with our nurse, we trusted her. A lot of the things that were being offered, [the nurse] was already offering, with an extra layer of confidentiality we could take [a student], sit her down and talk to [the school nurse]. So that wasn't such a shock." (School 2)*

All of the schools discussed the benefits of the students talking to someone who was external and not a member of the school staff.

> "*sometimes it helps some young people to talk to someone outside of the school system. They don't want it to be in school, sometimes it isn't about school, it isn't so much that it is a barrier to learning…which is our job to break down these barriers so in the classroom they are achieving better. There are some issues that we could deal with bit it takes a lot of our time." (School 2)*

School 22 thought that talking to people who were external to the school was particularly important for students when trying to change behaviour. They spoke particularly positively of the peer mentors from TCP and thought it had more of an impact when the message came from them as opposed to teachers

> *"kids respond to people who are knowledgeable and talk about personal experiences…They need to know that the person that is telling them this info actually knows what they are talking about…sometimes they might look at their art teacher, for example, and think 'what do you know about being a teenage mum?' They like to hear it from somebody who they perceive as on their level. They take it in much better than school telling you what to do…it is someone who is not school, who doesn't have a vested interest in telling you not to have a baby at 16…they believe that message far more." (School 22)*

School 2 talked positively of the group work conducted by the Youth Worker and the groups of students that formed because of attendance at the WSSSS. They also talk about how parents were trying to give up smoking as a result of students engaging with the WSSSS.

Issues and Challenges

An issue and challenge that was mentioned by all the schools was a problem finding appropriate spare rooms and spaces to host the providers. All schools felt that they were short on space and discussed how rooms were used for clubs or other activities and that certain areas were closed off at lunch time. Some groups discussed how they had had to move providers around into different rooms or changed the times.

> *"Always lack of space in a school, because [smoking cessation worker] had to share a room with [the nurse] a set group that come in and could be quite loud and take over. So a lot of new people don't tend to want to come in. If we had another space it would help." (School 22)*

Two schools discussed recent building work and reconfigurations which had caused disruption and reduced the amount of offices available. One of these schools mentioned how, since becoming an academy, they had had to take on more finance staff and this meant some spare rooms had to be converted into offices. However the schools felt that although there were some issues with location these did not discourage students from attending.

The school staff acknowledged the problems with space and rooms but did not focus on it as much as the discussion in the providers groups. For school staff lack of space within school seemed to be common place and just part of everyday issues and they seemed more resigned to it and tried to make the best of it. For the providers this was a major issue that they really struggled to overcome.

> *"we managed to find space and everyone [has been] very flexible. [The nurse] gave up her office when Action for Children came in…we've just been flexible about it really....we are so keen to have them [HSIS providers] we will work round it and try and give them somewhere decent to operate from." (School 19)*

Some schools mentioned a problem with lack of continuity, especially due to staff changes within the Youth Service. Youth Workers had changed at a number of the schools, at one they had had three different youth workers and the groups felt this caused some disruption to communication and to the relationships with students. However, it was felt that once Youth Workers had been there a while the students adjusted and learnt to trust the new person.

> *"Our kids take a while before they trust you. Once they trust you they are fantastic, but because they are from chaotic backgrounds where partners come and go, they don't like that change." (School 12)*

Two of the schools reported a lack of communication and concerns around information sharing between the providers and the school. For School 2 they found this a big challenge and they would have preferred the information given by the students to the Youth Worker and AfC counsellors to be passed back to the school.

> "*It makes more sense to centralise the information, just so the people who have that information can share it. Because quite often we each have different bits of information about a child or family we might be working with and if you put all those bits of information together then you have a whole picture of what is happening and it is not helpful to have pieces of information that aren't linking together." (School 2)*

"there is a bit of an issue as we don't know what is being said. Students will come out of a counselling session maybe more upset than they were before they went in, and we don't know why." (School 2)

School 2 also discussed an example of when a student was having a problem at home and told the Youth Worker. In this incident the Youth Worker dealt with it without telling the school, but the problem escalated. The staff at this school felt the lack of information sharing caused a problem, and that the parents expect this type of information to be shared amongst all staff who see their child at school. They also felt it was difficult when they don't know if an issue has been resolved. They discussed a specific example:

"… sharing information about successes…for example a young person who has been referred to the youth worker who is misusing alcohol and we're not getting feedback and we're six months down the line and we have a case open for TAC [Team Around the Child] and we're not knowing whether this is an advantage. Frustrating for us as professionals, should we be signposting to another agency or where we are at." (School 2)

School 2 did describe how they felt they have a different relationship with their students compared to other schools and this is why they had more concerns with the lack of communication

"our girls tend to tell us most things…but I am guessing in other schools, the students wouldn't talk openly to members of the school they would only talk to counsellors. And counsellors have been going into other schools but they don't understand how open the students are with us...and how much they are prepared to trust us. Actually most of the things they would talk to a counsellor about they have already talked to [school staff] about. It isn't something new." (School 2)

School 19 discussed how they were not sure how much the contraception service was used because their students did not discuss it with them. When the service was initially set up the school staff had some issues with the nurse not communicating information to them, but they were happy they had now reached a balance on this

"we were saying we need to know who is going [to see HSIS providers] cos we need to know how it is going to impact on their learning because what is going on externally has an effect. So there was a bit of tension and friction but it has [worked out]." (School 19)

School 6 also felt they needed to reassure their staff and ensure they anticipated that information would not be shared between the providers and the school, however they felt this was resolved easily

"There has been a bit of a need to educate staff, especially when the mental health service came in...Particularly pastoral staff to who are used to sharing information with each other. They need to understand 'I am going to refer to a counsellor and I am going to get nothing back, and I need to understand I am going to get nothing back. What was the root of the problem and how are they moving forward, I am not going to know that'. That didn't create any problems but there was a bit of thinking it through, but it is all ok now." (School 6)

School 6 talked very positively about the HSIS programme and described the only challenge they faced was about communicating the confidentiality to the students, and how confidentiality policies differ between school and the providers. They described how students often asked *"is this confidential?"* as this was very important to the students. This was an issue that they particularly had to work to communicate with the parents. They had a parents evening to introduce the HSIS programme and presented it as:

"it is like a GP coming into school. It is confidential, we wouldn't know and no one else would know…had to explain that the NHS was a confidential service and we wouldn't

know what was going on and what was being said. This calmed them [parents] down, they liked the idea it was totally confidential that nobody would know." (School 6)

Confidentiality

The issue of confidentiality was mentioned by all groups and discussed as both a positive element of the service and as something that had caused tension. As mentioned above, School 2 struggled with the strict confidentially and the lack of information that was passed back to the school.

However, for most schools the confidentiality of the externally provided services was discussed as a real strength of the programme. Groups discussed how important this is to students.

"the confidentiality is so huge at that age. They have it know you are not immediately going to report back. Even though they know the rules about safeguarding, but it is so important to them that they can come and just speak without it being reported all the time." (School 22)

"I think it has worked really well. I don't think the girls would go if they thought we [school staff] were being told. I really don't." (School 19)

For School 12 they did not feel that the confidentiality of the information given to the providers was something to be concerned about because they have a good relationship with the providers and trust them and their safeguarding policies.

Gaps in provision

All groups were asked if there were any gaps in the services available as part of the HSIS programme. The most common issues mentioned by the groups were around mental health issues, specifically eating disorders and self-harm. The groups felt they and their school nurses were not skilled or equipped to support students with eating disorders and they worried they would do more harm than good. Two schools discussed how they get clusters of problems with eating disorders and they did not know how to address it. Schools wanted more training for staff around eating disorders and a specific service that they could signpost to or host within the school.

"This is very hard to deal with, at a lower level something to deal with would be good, to stop it escalating. Cos we feel frankly out of our depth. Talking to girls with a potential eating disorder, it is hard to know what to say and if you are actually supporting them or encouraging." (School 6)

"when we had that problem with the girls in that year group with eating disorders…we had a heck of a job getting a specialist to come in and talk to them. [The nurse] was able to talk to them generally but she is not a specialist on how to deal with it. It would be nice to have someone who could come in and do a bit of training or help her, or deliver something to the girls." (*School 19)*

School 22 discussed how they don't know who they can ring to ask for advice and how they would like to be able to suggest a service or some support to parents who have a child with an eating disorder.

Self-harming was also mentioned as an issue by two schools, they felt the school staff and nurses were not confident to deal with it

"Self-harming – it almost has a life of its own really. And [the nurse] doesn't feel qualified to always give the right information….Self-harming is the biggest thing after eating disorders, it has just surged." *(School 19)*

Some specific outreach or training from CAMHS was suggested by School 22 and School 12 wanted to be able to bring in specialists such as psychologists and counsellors. At the time of the focus group School 12 did not host the AfC counselling service; the reason for this was unclear to the researcher.

> "*There are things they don't want to talk about with staff – they want someone with good counselling skills, good understanding of education, psychology and so forth would be helpful." (School 12)*

Mental health support in general was discussed by some groups. They really appreciated the AfC service but felt that more mental health support was needed as AfC was working at full capacity and they would like to be able to refer more students for counselling. Two groups discussed how long it took to get a referral to CAMHS and one school discussed how the CAMHS service had been cut and therefore CAMHS could not always accept their referrals.

School 2 discussed how bereavement was a big issue, reflecting the social background of their students. They acknowledged the AfC service could address some of these issues but they were hoping to get some funding for a specific bereavement counselling service.

Publicising the services

Groups were asked how the HSIS services were publicised within their schools. The majority of schools did not widely publicise the HSIS but talked about subtle advertising. Methods of publicity relied on word of mouth or targeted promotion of the services, especially in relation to sexual health services. Some schools held an assembly at the beginning of the year or PHSE lessons where students were told about the service.

Most groups said their school had a poster up outside the nurse's office describing what services were offered and in School 19 they have posters up in the sixth form building. Three of the schools described how they felt it was important to strike a balance between advertising the service but not being too obvious about it

> *"it's not a secret but it's not advertised either, I think it is on a needs basis, as we feel the girls are in need, or [the nurse] feels the girls are in need then they are directed. I think the girls are aware the services are there but it's just...I don't think there is a need for the posters." (School 19)*

> *"I think word of mouth worked so well, it is not aggressive marketing...but it works and they all know...friends bring friends." (School 22)*

For School 2 they were considering advertising the service so students were more aware, but only with posters in learning mentor offices, they did not feel posters in the corridors were necessary.

School 6 felt that the service shouldn't be too intrusive and if the service was too visible or invasive the head teacher would have concerns; as it was, the head teacher felt the service was subtly embedded into the school.

> *"I think the staff know but it is not intrusive, and that is what it should be. We're hosting it, it should go on, but if they need to refer girls they can do to [deputy head] but basically it goes on and we go on. Isn't that how it is supposed to be?... If staff were coming in and telling me all about it every day I would think lets abandon it, it is becoming too intrusive." (School 6)*

Improvements

The most common improvement suggested by the groups was more time for the school nurse to work in their school as the time she could spend with students now was not enough.

"we could benefit from more of school nurse time in school, but obviously we have to share her." (*School 2)*

"more – just more hours. The drop in sessions at lunch time and breaks can get full up." (School 19)

School 6 discussed problems they had with their nurse spending a lot of their allocated school time at child protection meetings. The school felt that these meetings were not a constructive use of the school nurses' time, as often the nurse was not directly involved with the child because it was not a health issue. The school felt that the nurse's time would be better used seeing students or just providing a briefing for these meetings.

"If they only have 2 hours a week and their meeting lasts 1 hour plus travel, then basically that is their week gone. Generally they [the students] don't have health issues, some sometimes they aren't even known but the school nurse. Well…she is going to these meetings, not because there has been a need [but because she has to]." (School 6)

School 22 wanted more smoking cessation resources for their nurse; this school had had the stop smoking service in the past and had decided against the ASSIST programme, and at the time of the evaluation felt they were not able to support students to stop smoking. The school described how the number of forms and the time taken to complete them for every student to get nicotine replacement therapy was seen as a barrier.

School 6 also discussed wanting a more formal review process where they could meet up with providers and discuss how things are going. This school felt there was good information communication between providers and general school staff but that this did not always feed into their senior management team, especially from the youth worker.

Health services based within school

All groups were asked '*if the students didn't go to these services where else, if anywhere, would they go?*' All groups felt that the majority of students would not access other services and would not go to other mental health or sexual health providers who were based in the community. Two schools mentioned that some of their students, especially the older ones, used Brook or other youth services but the majority would not go anywhere else.

"I am very confident that they would not be accessing many of these services independently...they wouldn't take the time and trouble." (School 12)

"A lot would go without." (*School 19)*

"…some of the girls use Brook independently…especially the older ones…they know about the clinics there are outside of schools at St Caths etc. They do use them. For the more general questions they might have they appreciate they can access for that in school without having to go somewhere like Brook. That that service is actually here." (School 2)

The main reason given for students not using external services was the difficulty in accessing them without their parents finding out. Attending other sexual health services meant going at a time when their parents would expect them to be at home and they would have to explain this absence.

"They like that they can go in school, parents don't have to know, they don't have to be away from school, there are no absences to worry about." (School 5)

"Family Planning are only open a few hours in evening and a lot of them can't get out in the evening...they have revision or mum is expecting them home." (School 22)

"They find it really difficult to make the time and then they feel like they are lying to lots of people to go. So in school is it more open and honest." (School 22)

"I think it depends on their relationship with their parents doesn't it, if they feel confident to talk to their parents. It is difficult...cos we are offering a service that is great cos it is giving girls the access. For some girls that is great cos they couldn't talk to their parents and they wouldn't get referrals." (School 19)

Two schools discussed how a referral to CAMHS needed parental consent and involvement and often the students did not want their parent to know, especially if it was an issue with their family relationships.

Other benefits of the service being in school included the security and familiar school environment, the immediate and instant access to support, the lack of a waiting list and the young person friendly providers.

"I think it is the thing of having the security of being in school. They are comfortable here, they feel secure, it is all happening in school, and so they are more willing to take it on." (School 19)

"I think the problem is the waiting list isn't it? I mean six months to get counselling, if they go through their GP they have come back and said 'its 6 months wait to get anything' so I think very few would actually [get help somewhere else]." (School 19)

"sit in a waiting room with lots of people, and some of them are middle aged women, they feel like they are being judged….it's not the [staff] it is sitting in the waiting room and registering and all of that, or seeing someone they know." (School 22)

"they have to have everything so instantly and they are quite selfish. If it is not handed to them on a plate they won't do it…" (School 22)

"it is the convenience...the girls feel supported, the moment they get out of the gates they get a bit lost, I haven't got somebody…some of them do crumble a little bit." (School 19)

Two groups discussed that young people do not like to discuss mental health or sexual health issues with their GP, either because of the reaction or because their parents attend their GP appointment with them. School 19 talked about students who had used Response before but not liked the service

"I have one girl who has an eating problem and when she went to her GP. He basically said 'well you either eat or you don't, this is what is going to happen', he didn't even suggest referrals." (School 19)

"[the nurse] has taken girls down to Response, in the past, and I think the girls haven't felt it was the place for them. It is obviously quite a diverse group of people that go to Response and I think for some that has put some of them off, they almost scurried away. By having [HSIS in school] I think that has helped and supported them. Some of those girls that did initially go to Response are now being supported in school, and having that support. Whereas they might not have had it, or it may have taken a longer time. And sometimes they didn't want to go to their GP." (School 19)

Two schools felt the service being based within the school building had had a positive impact on attendance rates, stopped students from staying off or from leaving school to attend other services.

"We would look at more student absences if they had to attend services outside of school, which would obviously have an impact." (School 6)

"I think if [the nurse] wasn't here I think they would stay off, they may go to Brook, but they would sit at home worrying about it rather than coming into school and seeing [the nurse]…the most vulnerable come in." (School 22)

"I think it has helped [attendance]. We used to have girls not coming in cos they had to go to the Brook, or they wouldn't say where they were. Attendance used to be tricky if they disappeared…not just sexual health but maybe emotional issues, they were getting drunk all the time…other things that the youth worker now does. It is so much more multi-agency working than it ever was. There is always someone to refer to or speak to." (School 22)

School 22 discussed how even though the students are aware of other services sometimes they would not go even, if they needed them

"I do have to remind them [students]. They will come in after the Easter holidays and say 'I had unprotected sex the first week' and I say 'did you go to Brook? Did you go to Family Planning? Did you go any of the places we talked about?' and they will say 'no I was waiting for you Miss'. I have to remind them there are all these places to go to. I give all the times of the clinics…they know what is available here to go to." (School 22)

School 2 discussed the good links they have with local youth services and how many of their students used these services; however they were concerned that council cuts would mean they would lose the services they rely on.

School 19 discussed how in-school services were especially important for younger students who were not always aware of what they needed and school staff could easily signpost them to in school services and know they were being looked after

"the younger ones don't have the self-awareness, they might just know they don't feel very happy, They are less likely to know about all these services...so I think they need someone in school...it is crucial it is in school because staff pick up on things and nudge them towards services, the younger ones especially haven't got that awareness." (School 19)

Impact

All groups were asked what impact the HSIS programme had had on their students and on the school. Although they agree the impact had been positive, most groups struggled to articulate this and talked quite vaguely about the positive elements of the programme rather than about actual impacts and outcomes.

It was felt that students had improved knowledge and were empowered, especially around contraceptive choices.

"it empowers them rather than keep them in the dark, about contraception and all those things… it's not that we encourage it, it is just that they have the knowledge." (School 2)

For some groups the impact of the service was seen in how busy the clinics were and how much the services on offer were being taken up. It was suggested that busy clinics meant the services were working as students were recommending it to their friends and wanted to return to the services themselves.

"It seems to be working as people are using it. If there were people (staff) sitting in rooms and nobody was knocking on their door then it would be a waste of time. But since we know we are referring girls and girls are referring themselves to all the services therefore it must be valuable and working. Whether it can work between that is the difficult question to answer." (School 6)

"there is more collective knowledge about the counsellor which can only come from them talking amongst themselves. They know where to go." (School 6)

Two schools discussed the impact of the HSIS programme on their teenage pregnancy rates. School 12 felt teenage pregnancies were much less likely because of the support that was available to the students within their school.

"I always feel a failure when I hear of someone getting pregnant. There is all this information and they're in this situation now…there is access to the morning after pill…the message is getting across." (School 12)

School 22 talked very highly of the positive impact that HSIS has had in their school and discussed in detail the impact the HSIS package has had on their teenage pregnancy rates. They discussed how they now have fewer pregnancies and attributed this in a large part to the HSIS programme; they also discussed their improved PHSE programme but acknowledge this was influenced by and built upon the HSIS services that were available

"Teenage pregnancy generally within our school it had gone down, a lot. It is hard to pinpoint which bit of the [HSIS] service makes the reduction but I think, I have been here over 5 years, and over that time since HSIS has been introduced our teenage pregnancy rate has definitely dropped. It's not something that is as on our radar anymore, we aren't waiting for another pregnancy…we feel it helps." (School 22)

"Used to be lots of concealed pregnancies in all schools but we don't see this as much as they don't need to conceal it. If we do a test and it has been positive, I tend to give them so long to tell somebody and if they don't and I think they are concealing it I have to tell someone and they know that." (School 22, nurse speaking)

The nurse from School 22 was present in the focus group and discussed what would happen if the School Nursing Service was withdrawn and she was no long able to prescribe the emergency hormonal contraception

"I think our numbers would rise again, if I had to turn people away and say 'I can't prescribe EHC, I can't give you those condoms, I can't do your chlamydia you have to go to family planning…they would just go home and worry about it and hope that they weren't unlucky. It would be a real step back as a school." (School 22, nurse speaking)

The school staff from School 22 also discussed the positive impact of HSIS programme on the general wellbeing of their students and highlighted how important it was in their school.

"I think HSIS has made a massive difference to our school, to the wellbeing of our students it has made a real impact. Things come and things go and I think this is the one thing that has made a real difference...it is not something that we undertook lightly...the head gave it a lot of thought…it has really embedded itself in our school and it is as important to some of our students as their lessons are." (School 22)

At the end of the focus group at School 22 the participants discussed the possibility that the HSIS programme might be stopped or reduced. They were very worried about this and felt that losing the HSIS services would have a very negative effect on their school.

"taking away HSIS would be catastrophic in some ways, it is there, they need it and they use it. If we had to turn those students away what would they do instead?" (School 22)

"[students] assume it is there, it is part of the school and they know where to go. For that suddenly to lose, it would be dramatic, I think it would be drastic. Please please please don't take it away; keep the funding…put that in quotes!" (School 22)

School 2 discussed that if they did not have the School Nursing Service they would have a big problem, they felt the nurse was known and trusted by their students and also gives the staff a lot of advice on how to support the students. This school also discussed situations where they have seen the HSIS have an impact on the wider family when older siblings change their lifestyles and this filtered down to their younger siblings.

School 6 struggled to quantify the impact they had seen in their school as they did not routinely monitor this. This group felt that they had a hands-off approach with the services and after they had signposted girls into an HSIS service they did not necessarily know the outcome. However they did feel the students were keen to take up the offer of service and that the services were helping. So although they could not necessarily say for sure the exact impact of the services, they felt it was generally overall having a positive impact.

"We don't do any follow up or 'how was it for you?'. Not much discussion after using it really…anecdotally students who presented with problems and then go to Action for Children are presenting with fewer problems…we aren't thinking 'we need to get some more support'." (School 6)

School 19 discussed the very positive impact of AfC and how they could see the changes in the students who had been to AfC counselling.

"Action for Children is brilliant, the counselling is just fantastic….The girls are far more confident once they have been [to AfC] they feel their issues have been resolved or some go, stop and think 'I shouldn't have stopped I will go back'. You can see it within them; the girls are far more settled and far more content." (School 19)

School 19 felt that uptake and numbers being seen for sexual health support had highlighted areas that they did not know were an issue and led them to look at their PHSE programme. They also felt they were more aware of issues with self-esteem, self-harming and eating disorders that they now know they have to address.

"… it highlights that we need to do something in school about risky behaviour. [The school nurse's] feeling is that the behaviour of a particular group is actually quite risky. So we need to put something in place, some PHSE type stuff, get some external agencies in to work with them…" (School 19)

School 19 also felt that, although they could not quantify it, the AfC service was preventing issues escalating and addressing mental health problems earlier.

"can't measure it but I feel some girls haven't got to the self-harm stage, because they have been able to talk it through. They have the counsellors and I think we might have pre-empted some of the bigger issues cos they girls have had, you know, some of the intervention [from nurse and AfC] we have prevented some [self-harming]. Previously the girls were coming to us and it had already escalated into a bigger issue. Whereas now we are getting them earlier." (School 19)

School 12 felt overall that the HSIS programme had been very successful in their school because it built on the aims and pastoral system already in place within their school.

"[HSIS] complemented and supported what our genuine pastoral aims for the kids are…It enhances exactly what we want to achieve for ourselves. It has been, in my view, a very successful partnership that has synergy." (School 12)

Assessing impact - whole HSIS package or the individual services?

All groups struggled to identify whether it was particular services within HSIS or the whole package that was having an impact on the health and wellbeing of their students. They acknowledged they could not always identify the impact of each particular part, especially the services like Wirral School Stop Smoking Service, Tranmere Community Project and Merseyside Youth Association. The majority of the discussions focused on the busier services that were common to nearly all the schools – the enhanced nursing service, the youth workers and AfC.

To capture points not necessarily covered in the themes above, the general impression and key issues of each service is summarised below:

- **Action for Children** – The four schools that hosted AfC spoke extremely highly of their work and the positive impact it had on student health. A lot of time was spent talking about the AfC service and the impact and importance of it. Some of the schools talked about the long waiting list because the service was so needed and how desperately they wanted to keep providing the AfC service. The AfC counselling was thought to fill a vital gap in mental health provision that was not available anywhere else. Two schools hinted that if the AfC service was withdrawn they would consider funding it themselves; that is how eagerly they wanted to continue the service. Overall, AfC was the service that was talked about consistently highly, mostly in terms of need and impact.

- **Brook** – Three out of the five schools included within these focus groups hosted the Brook contraception clinic and all spoke highly of the service and the impact on student health. The Brook nurses and the school nurse had a successful working relationship and the schools felt Brook built on the nurse's enhanced sexual health service. One school discussed how being able to signpost to Brook for contraception had reduced the number of repeat EHC that was being prescribed by the school nurse.

- **Merseyside Youth Association** - There was a general lack of awareness of the service provided by MYA, for one school it took a lot of explaining before the participants understood which programme the interviewer was referring to. It was felt that this element was something only a minority of staff were involved with and it didn't appear to have filtered through the rest of the staff. However, those staff who were involved with the training or gathering evidence for the award spoke positively of the MYA staff. This lack of awareness may have been because the work was still on-going and the programme is designed to involve a minority of staff who then cascade the training to the other staff. This was only mid-way through and the cascading may not have started yet.

- **School Nursing Service** – all groups talked very highly of their nurses, the service she provided and the trusting relationship they had with their nurse. Some schools reported that there had been some initial issues with communication and confidentiality and which students could access contraception but once these had been resolved they felt things worked very well. So much of the discussions focused on the role of the nurse that the interviewer sometimes struggled to guide the groups to discuss the other HSIS providers. It seemed for the schools that HSIS effectively equated to the enhanced School Nursing Service and they tended to forget about the other services. This may reflect the strength of the relationship and the success of this element of the programme.

- **Tranmere Community Project** – Only one school had engaged with the peer mentoring programme delivered by TCP; however they were incredibly positive about the programme and the impact of peer mentoring. They felt having young women who had the experience of motherhood at a young age had a strong impact compared to any lessons the school staff could have tried to teach to discourage teenage pregnancy.

- **Wirral School Stop Smoking Service** – Three of the schools included in the data collection had hosted the WSSSS and these had all been over six months previously, therefore few could talk about the impact or their experience of the service. Those that had hosted the service spoke positively about the smoking cessation worker and the relationship they had built up with the students but weren't sure how much of an impact it had had on smoking rates in their school. One school discussed how they felt the 12 week period wasn't long enough for them to recruit students, develop a relationship and move towards quitting.

- **Youth Service** – All schools thought the Youth Worker was having a positive impact on their students but many mentioned problems with communication and many described how they were not clear on exactly what the youth worker did as they tended not to communicate information back to the school. Changes in worker had caused disruption at some schools and schools described wanting more consistency with the same worker. Schools felt that what the youth worker did was good but the management were not able to fully explain the impact the work was having.

4.4 Student engagement

4.4.1 General Survey

Sample

Surveys were collected from three schools on the Wirral. School names have been anonomysied and schools are identified by the school code (this list is not available publically but will be available to the commissioner). In total 108 participants completed the survey; 44% (48/108) of these were from 'School 6', 35% (38/108) of these were from 'School 19' and 20% (22/108) were from 'School 2'. The three schools in the sample were schools for girls (see table 4). Ninety eight per cent (106/108) of participants were female with the remaining 2% not responding to this question, though all were students who attended a girls' school. Seventy three per cent (77/108) of participants were in year 10 and 26% (28/108) were in year 9.

Table 4. Description of schools included in student surveys

School code	Type of school	Services hosted*
School 2	Girls comprehensive school Academy No 6th form Not faith 700-1000 students	AfC Brook MYA Nurse WSSSS Youth Worker
School 6	Girls grammar school Academy 6th form Not faith 1000-1300 students	AfC MYA Nurse Youth Worker
School 19	Girls comprehensive school Academy 6th form Not faith 700-100 pupils	AfC MYA Nurse Youth Worker

*not all schools will currently host these services; they have hosted them at some time in 2011-2012 academic year

Awareness of health services in their school

When participants were asked if they had heard of any of the list of health services in their school 98% (106/108) said they had heard of at least one of the services with just 2% (2/108) of participants stating that they had not heard of any of the health services in their schools (table 5). The health service that participants had most frequently heard of was Brook sexual health/contraception clinic (76%, 81/106). The health service that participants were least aware of in their school was peer monitoring delivered by teenage mums from Tranmere Community Project (6%, 6/106). However, at the time of evaluation, Brook only had a contraceptive clinic in School 2 but did provide outreach and education work in most schools in Wirral. Therefore it is likely that most participants were aware of Brook's non-HSIS programmes.

Table 5. Awareness of the health services in school

	Frequency
Brook sexual health /contraception clinic	81
Sexual health service provided by school nurse	66
Stop smoking service	49
Action for Children one to one counselling	30
Youth service	24
Peer mentoring delivered by teenage mums from Tranmere Community Project	6

When participants were asked if they had used any of the listed HSIS services in their school, 62% (61/98) stated that they had never been to any of these services and 22% (22/98) stated they had used the Brook sexual health/contraception clinic. Only 10 students had heard of the Youth Service despite this being part of the core offer and available in all schools (table 6).

Table 6. Participants who have used a health service in school

	Frequency
I have never been to any of these services	61
Brook sexual health/contraception clinic	22
Youth service	10
Sexual health provided by your school nurse	9
Peer mentoring delivered by teenage mums from Tranmere Community Project	5
Action for Children one to one counselling	4
Stop smoking service	2

Participants were asked if they had ever used any of the services, and how did they find out about the service(s). Over half (54%, 42/78) of participants stated that they had never been to any of the services listed below. Students had most often found out about the HSIS service from the school nurse, teachers or learning mentors and friends (table 7).

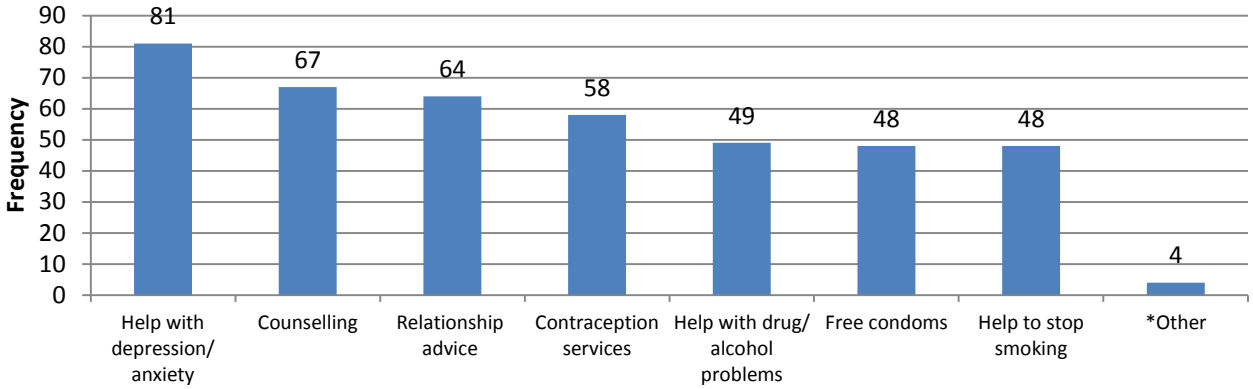
Table 7. How students found out about the service they used

	Frequency
I have never been to any of these services	42
School nurse told me about it	15
Teacher/learning mentor told me about it	14
Friend/another student told me about it	11
I saw a poster/leaflet in school	7
Someone talked to us about it in assembly	7
*Other	6
Youth worker told me about it	3

*Other responses included the school environment including people coming into the school to talk to the students, family and one participant stated that they had always known about health services.

Participants were asked what kind of health services they would like to have in their school. Support for a variety of mental health issues was the most frequently mentioned type of service needed (figure 1). Eighty one per cent (81/100) stated that they would like help with depression/anxiety, 67% (67/100) indicated counselling and 64% (64/100) stated relationship advice.

Figure 1. Health services students would like to see in school

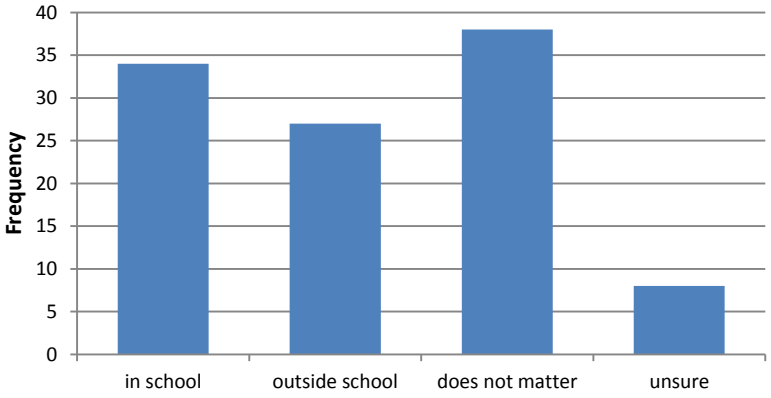


*Other responses included the 'use of 'electronic babies'.

Location of health services

Participants were asked whether they would prefer to attend health services in school or outside of school. Thirty six per cent (38/107) stated that it did not matter where they attended health services, 32% (34/107) felt that they would prefer to attend in school and 25% (27/107) stated outside of school would be better (figure 2). Seven per cent (n=8) said they did not know if they would prefer to attend health services within school or outside of school. Participants were asked why they preferred health services to be provided in this location. Reasons for preferring health services to be hosted in school are presented in Box 2 and reasons for them being provided outside of school in Box 3.

Figure 2. Where students would prefer to attend health services



Box 2. Reasons participants would prefer health services to be provided in schools

Reasons provided by participants for preferring for health services to be provided within the school have been categorised during thematic analysis into the following; feelings about people running the service, characteristics of the service and participant feelings.

Feelings about people running the service

- Students know the school nurse (n=3)

Service

- Confidential, people such as parents and carers not knowing they attended (n=10)
- Convenience (n=12) including it not taking up their free time (n=2) and missing lessons (n=1)
- More people show up (n=2)
- People come to them (n=1)

Participant feelings

- Know friends and other students that go; trustworthy (n=3)
- Less scary (n=1)
- Less embarrassing (n=1)
- Leave problems in school (n=1)
- Don't have to walk into place and see people they do not know (n=1)
- Easier to speak about problems with no parents (n=1)

Box 3. Reasons participants would prefer health services to be provided outside of schools

Reasons provided by participants for preferring health services being provided outside of school have been categorised by the researcher during thematic analysis into the following; general thoughts and views about the service and general feelings of participants.

Service

- Nobody knowing they attended (n=18)
- The school not being involved (n=3)
- More professional (n=1)

Participant feelings

- Knowing people in school; less awkward (n=3), too public, embarrassed or fear of being judged (n=3)

Reasons given for it not mattering whether the health service was provided in school or outside of school included as long there was a service available, it was the way the service was provided which was important not the location, and that all health services were important and helpful. Another participant stated that it did not matter if the health service was provided in school or outside as the services would be the same; however one participant stated that it depended on the service being provided if they were to attend inside or outside of school. When talking about the health service being provided in school they highlighted both advantages and disadvantages such as people seeing them attend in school (disadvantage) and advice from

people they knew (advantage). Furthermore two participants stated that sometimes they may wish to speak to someone in school and at other times they may wish to talk to someone outside of school.

Encouraging attendance at school health services

When participants were asked what would encourage them to attend a health service in their school, if they needed support, 88% (95/108) provided reasons. These free text responses have been categorised into four main themes; the people running the service, the nature of the service, the environment/set up of the service, and who would encourage them to attend the service.

Students that responded to this question highlighted being friendly as the thing that would most encourage them to attend a health service in school if they needed support (table 8).

Table 8. Desired characteristics of people in the service

	Frequency
Friendly	14
Experienced	4
Understanding	3
Helpful	3
Easy to talk to	3
Trustworthy	2
Know the person before speaking to them	2
Not judgmental	1
Young	1
Same sex	1

The service being confidential was the most important thing that would encourage them to attend a health service in school if they needed support (table 9).

Table 9. Desired nature of the service

	Frequency
Confidential	32
More information about the services	9
More services	4
Support – from friends or nurse	2
Useful	1

Students highlighted a relaxed environment and having food and beverages as something that would encourage them to attend a health service in school if they needed support. Some respondents interpreted this question as asking about the people who would encourage them to attend. Six people said friends would encourage them to attend, three said teachers and one said they would be encouraged by parents.

Barriers to accessing school based health services

When participants were asked what would put them off attending a health service in their school, if they needed support, 93% (n=100) provided reasons. These have been categorised into four main themes regarding; the personal attributes of the people running the service, the setup of the service, the nature of the service and the people that would discourage them to attend. The biggest barrier mentioned by 33 respondents was the service not being confidential and 25 students mentioned that people knowing they had attended would also discourage them from attending (table 10). Personal attributes of the people who work in the services were highlighted as being important; students suggested that staff being mean, not jolly, nasty and unwelcoming would discourage them from attending a health service in school if they needed

support. People they did not trust or who were judgemental were also highlighted as people that would discourage them to attend (table 11)

Table 10. Elements that would discourage them from attending

	Frequency
Not confidential	33
People knowing they attended the service	25
Being embarrassed to attend the service	10
Awkward conversation or questions whilst attending the service	4
Talking about something really personal	2
Not liking meeting new people	1

Other elements that were mentioned by two or fewer people included the service running after school, teachers being present, no freebies, going along, bad environment, friends saying not to go, a group session, not knowing what happens at the service and not knowing how to book an appointment.

Table 11. Personal attributes of the service staff that would discourage them from attending

	Frequency
Someone who was not nice – mean, not jolly, nasty, unwelcoming	8
Someone they did not trust – Not trustworthy	5
Someone who was judgemental	5
Someone who was patronising	4
Opposite sex person	4
Someone who did not listen to what they wanted - uninterested	2
Someone who was too serious	1
Someone who provided negative feedback	1
Someone who did not explain things clearly	1
Someone who was old	1

Publicising services in school

When participants were asked to write what would be the best way to publicise the health services which were available to them in their school, 88% (n=95) answered this question. The responses have been themed and are detailed in table 12. The most common suggested publicity methods were posters, assemblies and talks. These are methods that are already used in some schools. Other ideas suggested by participant included freebies, notes in register, school TV, diary notifications, daily information through teachers, fun stuff, daily notices and fun stuff.

Table 12. Ways the HSIS could be publicised

	Frequency
Posters	49
Assembly	31
Talks –from nurses, services, teachers, Brook – experiences, real	22
Leaflets	9
Demonstrations – including activities and presentations	7
Social media - Facebook/Twitter and www	5
Creative arts – including videos, music, play and pictures	4
Lessons – including PSHE	3
Adverts – including television and radio	3
Letters	2
More inviting – including making students feel comfortable	2

4.4.2 Service User Survey

Service user surveys were distributed by the youth worker and nurse in two schools. Only six surveys were returned, four from School 19 and two from School 2. Due to the low response rate it would not be appropriate to combine the responses and try to draw out trends. The majority of the questions were open text boxes that allowed the participant to write as much information as they wanted. Therefore analysis is presented as each survey representing a case study of an individual student; this provides examples of the experiences of a small number of students.

The first respondent was a female year 8 student who attended School 2 and had come to see the youth worker about relationship problems and to stop smoking. She thought the youth worker was '*good*' and liked that the service '*helps you*'. She suggested that the service could be improved if you could '*talk about things more*' and if they could '*make sessions longer*'. She thought the Youth Service had '*helped a lot*' and had also attended the AfC counselling service.

When asked what other service she thought should be provided at her school she suggested a '*school nurse on site all the time – always here*' and '*general time out and support*'. She indicated she would prefer to attend health services within school rather than outside of school and this was because '*parents don't need to know*' and '*keeps time free out of school*'. When asked for any other comments she wrote '*you do a number of sessions and it's great. Been useful to have stuff in school*'

The second respondent was a year 9 female student who attended School 2 and had been to see the youth worker for family problems. She thought the youth worker was '*very nice and kind. I liked working with them and they helped me and always understood*'. To improve the service she suggested '*ask the students more about what they want to know*'.

When asked if and how this service has changed her health, wellbeing or happiness she stated '*it has made me realise more things and made me more aware*' and she indicated if she had not attended this service in the school today she would not have gone anywhere else for help. As well as the Youth Service she had also attended the AfC counselling service. She stated that she doesn't mind if she attends health services in school or outside of school.

The third respondent was a year 9 female student who attended School 19. She had come to see the youth worker about bullying, drug problems, stopping smoking, alcohol problems and '*future career aspirations*'. She thought that the youth worker '*was very efficient with addressing our problems. She also offered many solutions*' and she liked that the service '*was indepent [sic] from our school*'. She suggested '*we could make the service better by coming 2 days per week instead of one*'.

She said '*I do not mind where the health services are, just if they are effective*' and thought that as a result of attending the Youth Service '*my happiness in our school environment had increased*'

The fourth respondent was a female student in year 7 and saw the youth worker and nurse. She had quite a number of issues with which she wanted support because to the question 'why have you come to the service today?' she had ticked bullying, mental health problems, to get contraception or advice about contraception, emotional issues and family problems and also written in '*self-esteem'*. She was very positive about the staff and described them as:

"[youth worker]: she gives me good advice on what to do next whether it's friendship problem.
Nurse: I haven't talked about friendship problems with the nurse but she helps me when I am ill"

She listed some things she liked about the service and they were '*venue, staff, good advice, posters displayed, confidentiality',* the only suggestion to improve the service was '*timing could be better'.* She felt that the service had '*helped me to realise that only I can do something about the situation and make a decision'.* When asked if she would have gone to another service she ticked the school nurse but also ticked that she would not have gone anywhere else. She suggested other services that should be provided in her school should be '*one on self-esteem and just friendship'.* She also suggested longer appointments and that the youth worker comes in three days a week. She preferred to attend services with school '*because I can go at lunchtimes'*

The fifth respondent was also a female year 9 student from School 19. She was very positive about the youth worked and wrote *'[the youth worker] is amazing. She is really helpful and she's really easy to talk to. She has amazing advice and I don't know if I could get through my week without talking to her'.* She liked that the service is '*confidential and that there are very few occasions in which confidentiality is breached*'. She did not think the service could be improved '*it's perfect already'.*

She had come to the service to get help with mental health problems, stop smoking, emotional problems, alcohol problems, family problems and for '*pregnancy ethics'.* As a result of the service she said '*I feel happier around school and my general wellbeing had improved since I started to see [the youth worker]'.*

If she had not been to see the youth worker that day she indicated she would have been to see the school nurse or talked to friends and she had never been to any other HSIS services. She preferred to attend health services in school because '*I don't like to go to places on my own and if it's in school it is more accessable [sic]'*

The sixth respondent was a female year seven student who attended School 19. She had come to the service that day for support with bullying, mental health problems, emotional issues, family problems and friend advice. She had much more mixed feelings about some of the providers within the service, stating that she felt she did not always receive the support that she required, and described that she felt she was often told off and judged by some providers. The service user described her experience and feelings towards one of the providers within her school: '*I think the [provider] has a problem with me, she constently [sic] tell me off for being ill and I have bearly [sic] any respect from her*'

However what this student liked about the service was that '*it gives me an escape and someone to talk to*'. She suggested the service could be made better if you had a choice between some of the service providers that you were able to see, such as a choice of youth workers or school nurses.

This student didn't feel the service had impacted on her health, wellbeing or happiness: '*there was no difference because I have mixed feeling about [the provider]. [This person] often judges me*'

If she had not attended the service the student indicated she would have gone to a different HSIS within the school, talked to friends or talked to family, and stated that she did not know if she would prefer these services to be provided in school or out of school.

4.5. School Nursing and Youth Service Activity Data

4.5.1 School Nursing Service Activity Data

Data recorded by the school nurses is routinely provided to Public Health Wirral. To fit with service mapping data and to ensure a whole school year was included data from September 2011 to July 2012 were analysed. Data were provided for 26 out of the 29 schools.

Individuals seen by the School Nursing Service

Each individual in the dataset is allocated a unique identifying code when entered onto the database. The dataset includes information on each separate time each student attended the School Nursing Service within their school. To identify the types of students who are attending services at each school duplicates were removed so each individual is only shown once. In the 2011-2012 school year a total of 1,132 students were seen by school nurses across the 26 schools.

Table 13. Deprivation and numbers of students attending the School Nursing Service, by school

School Code	Mean IMD	No. students attending*
2	2.77	26
3	1.62	16
4	2.08	61
5	3.25	12
6	4.37	27
7	2.09	23
8	2.38	13
9	2.14	119
10	2.22	18
11	2.11	45
12	1.81	57
13	3.46	13
14	1.28	116
15	4.25	16
16	2	6
17	2.09	11
18	2	14
19	4.57	7
20	2.02	86
21	3.5	20
22	2.38	160
23	3.76	55
24	2.08	13
26	3.41	32
27	4.2	20
28	3.4	15
Total	**2.41**	**1001**

*Does not include students for whom no postcode was recorded

Ninety four per cent of those for whom ethnicity was provided (1053/1122) were of white British ethnicity, with the most common other ethnic groups being White Irish (15; 1.3%) and Asian Bangladeshi (9; 0.8%). Of the 1,119 individuals for whom looked after status was recorded 4.4% (49) were recorded as looked after children. Only 0.2% (2/1108) were recorded as having a disability.

A postcode was provided for 88% (1001/1132) students and these records also included an Index of Multiple Deprivation (IMD) score quintile that was generated from the postcode. IMD quintiles divide areas into five sections dependent on level of deprivation. Quintile 1 includes the households that are in the most deprived areas and quintile 5 are the least deprived. To work out a proxy indicator of deprivation for the students attending the School Nursing Service the mean IMD quintile for students attending the service at each school was calculated and is presented in table 13. The IMD scores vary depending on where the schools are located and the type of catchment area they include. The schools seeing the most deprived students included school 14, school 3 and school 12. The least deprived were school 19, school 6 and school 15.

Table 14. Sex of students attending the School Nursing Service, by school

School Code	Female	Male	Sex not reported	Total
2	29 (93.5%)		2 (6.5%)	31
3	4 (22.2%)	13 (72.2%)	1 (5.6%)	18
4	39 (59.1%)	24 (36.4%)	3 (4.5%)	66
5	1 (4.5%)	21 (95.5%)		22
6	29 (100%)			29
7	19 (70.4%)	6 (22.2%)	2 (7.4%)	27
8		12 (85.7%)	2 (14.3%)	14
9	76 (60.8%)	46 (36.8%)	3 (2.4%)	125
10	1 (4.2%)	22 (91.7%)	1 (4.2%)	24
11	32 (59.3%)	19 (35.2%)	3 (5.6%)	54
12	44 (73.3%)	16 (26.7%)		60
13		15 (100%)		15
14	78 (59.1%)	53 (40.2%)	1 (0.8%)	132
15		19 (95%)	1 (5%)	20
16	7 (100%)			7
17	4 (33.3%)	8 (66.7%)		12
18	12 (70.6%)	4 (23.5%)	1 (5.9%)	17
19	6 (85.7%)		1 (14.3%)	7
20	49 (50%)	49 (50%)		98
21	24 (96%)	1 (4%)		25
22	172 (98.9%)		2 (1.1%)	174
23	60 (96.8%)	1 (1.6%)	1 (1.6%)	62
24	9 (56.2%)	7 (43.8%)		16
26	12 (33.3%)	24 (66.7%)		36
27		21 (87.5%)	3 (12.5%)	24
28	17 (100%)			17
Total	**724 (64%)**	**381 (33.7%)**	**27 (2.4%)**	**1132**

The majority (724; 64%) of students who attended the School Nursing Service were female (table 14). The distribution of gender by school reflects the type of school (i.e. single sex schools), with some schools seeing

only males or females. At mixed sex schools the majority of attendees were female, which reflects the types of services the nurse provides, for example emergency hormonal contraception and pregnancy testing.

The year group of the students who most access the School Nursing Service varied by school (table 15). Overall the service was used by more pupils from year 11 (323; 29% of attendees) and year 11 (316; 28%). Although the service was used by students in year 12 (9% of individuals accessing the service were in year 12) relatively few from year 13 use the service. In some schools the service is only available to older students (e.g. school 6, see section 4.3 for discussion of why the school took this decision) and some schools do not have a sixth form.

Table 15. Year group of students attending the School Nursing Service, by school

School Code	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Total*
2	1 (3.2%)	1 (3.2%)	4 (12.9%)	3 (9.7%)	22 (71%)			31
3	3 (16.7%)	7 (38.9%)	3 (16.7%)	4 (22.2%)	1 (5.6%)			18
4	9 (13.6%)	11 (16.7%)	15 (22.7%)	10 (15.2%)	21 (31.8%)			66
5			1 (4.5%)	2 (9.1%)	14 (63.6%)		5 (22.7%)	22
6			4 (14.3%)	2 (7.1%)	5 (17.9%)	15 (53.6%)	2 (7.1%)	28
7	11 (40.7%)	2 (7.4%)	7 (25.9%)	2 (7.4%)	2 (7.4%)	1 (3.7%)	2 (7.4%)	27
8				9 (64.3%)	2 (14.3%)	2 (14.3%)	1 (7.1%)	14
9	13 (10.4%)	14 (11.2%)	21 (16.8%)	20 (16%)	28 (22.4%)	27 (21.6%)	2 (1.6%)	125
10	10 (41.7%)		7 (29.2%)	4 (16.7%)	3 (12.5%)			24
11		5 (9.4%)	6 (11.3%)	25 (47.2%)	14 (26.4%)	3 (5.7%)		53
12		3 (5%)	16 (26.7%)	15 (25%)	24 (40%)	2 (3.3%)		60
13	2 (13.3%)	1 (6.7%)	4 (26.7%)	3 (20%)	4 (26.7%)	1 (6.7%)		15
14	5 (3.8%)	19 (14.4%)	47 (35.6%)	36 (27.3%)	25 (18.9%)			132
15			1 (5%)	8 (40%)	3 (15%)	4 (20%)	4 (20%)	20
16				4 (57.1%)	1 (14.3%)	2 (28.6%)		7
17	1 (8.3%)		1 (8.3%)	3 (25%)	7 (58.3%)			12
18		4 (23.5%)	3 (17.6%)	6 (35.3%)	3 (17.6%)	1 (5.9%)		17
19				4 (57.1%)		3 (42.9%)		7
20	1 (1%)	8 (8.2%)	15 (15.3%)	43 (43.9%)	31 (31.6%)			98
21		5 (20%)	2 (8%)	4 (16%)	8 (32%)	5 (20%)	1 (4%)	25
22		7 (4%)	27 (15.5%)	56 (32.2%)	50 (28.7%)	26 (14.9%)	8 (4.6%)	174
23		2 (3.2%)	3 (4.8%)	30 (48.4%)	18 (29%)	6 (9.7%)	3 (4.8%)	62
24	1 (6.2%)			6 (37.5%)	6 (37.5%)	2 (12.5%)	1 (6.2%)	16
26		2 (5.6%)	7 (19.4%)	11 (30.6%)	16 (44.4%)			36
27	1 (4.2%)	1 (4.2%)	6 (25%)	4 (16.7%)	10 (41.7%)	1 (4.2%)	1 (4.2%)	24
28	2 (11.8%)	6 (35.3%)	2 (11.8%)	2 (11.8%)	5 (29.4%)			17
Total	**60 (5.3%)**	**98 (8.7%)**	**202 (17.9%)**	**316 (28%)**	**323 (28.6%)**	**101 (8.9%)**	**30 (2.7%)**	**1130**

*does not include students for whom no year group was recorded

Attendances at School Nursing Service

This section presents the data on all attendances at the School Nursing Service and thus includes duplicate people (e.g. the same person who attended a number of times within the school year). Therefore all data presented in this section should be interpreted with caution as the individual attendances cannot be seen as independent episodes of care but may be part of a longer on-going relationship between the nurse and student.

The number of attendances varied across the school year. As expected there were fewer attendances in months that include longer holidays (i.e. March or Aug). The months that were busiest for the school nurses were January (with 344 separate attendances) and April (319; table 16).

Table 16. Attendances at the School Nursing Service by month, all schools.

	Frequency	Per cent
Sept	184	8.1
Oct	238	10.5
Nov	298	13.1
Dec	127	5.6
Jan	344	15.2
Feb	209	9.2
Mar	32	1.4
Apr	319	14.1
May	263	11.6
Jun	141	6.2
Jul	113	5
Aug	1	0
Total	**2269**	**100**

Table 17. All attendances by type of School Nursing Clinic, all schools

Type of clinic	Frequency	Per cent
Clinic	825	36.4
Drop in	1399	61.7
Not recorded	45	2
Total	**2269**	**100**

Overall there were 2,269 attendances at a school nurse service within the academic year and most attendances with school nurses took place within drop in sessions (1399/2269; 62%, table 17). The mean number of attendances for each student who attended the School Nursing Service is presented in table 18. This only shows the mean for those who attend the service, not the mean for all students within the school. Overall, across all the schools the students who attend the School Nursing Service attended an average of two times in the school year. This varied across schools, with the mean number of attendances being the highest at School 12 (2.83 times in the school year) and lowest at school 8 (1.43). Across all schools the number of attendances per individual attendees ranged from one to twenty two and the majority of attendees (58%) attended once.

A total of 196 pregnancy tests were performed during the academic year and 11 of these showed a positive result (180 were recorded as negative and 5 no result was recorded). There were 10 students with positive

pregnancy test results (one student had two positive results four months apart) and they came from only five schools.

Table 18. Total and mean number of attendances at School Nursing Service, by school

School Code	Total no. individuals	Total no. attendances	Mean per individual
2	31	51	1.65
3	18	39	2.17
4	66	103	1.56
5	22	47	2.14
6	29	44	1.52
7	27	58	2.15
8	14	20	1.43
9	125	281	2.25
10	24	37	1.54
11	54	117	2.17
12	60	170	2.83
13	15	23	1.53
14	132	210	1.59
15	20	43	2.15
16	7	9	1.29
17	12	21	1.75
18	17	30	1.76
19	7	11	1.57
20	98	177	1.81
21	25	38	1.52
22	174	411	2.36
23	62	147	2.37
24	16	45	2.81
26	36	64	1.78
27	24	42	1.75
28	17	31	1.82
Total	**1132**	**2269**	**2.00**

Emergency hormonal contraception (EHC) was provided a total of 166 times to 134 individuals. The majority (82%) of the 134 individuals who received EHC only had it once in the academic year. However 20 individuals (15%) received it twice and four individuals received it more than three times (table 19).

Table 19. Frequency of EHC provision at School Nursing Service, by number of individuals

Frequency of receiving EHC	No. of Individuals
1	110
2	20
3	1
4	2
5	1
Total	**134**

A total of 232 Chlamydia screening tests were taken by 197 individuals and 179 (77%) of the tests were done by females (table 20). The majority of these people only did one test (168; 85%), 24 individuals (12%) did two tests, four people tested three times and one took four chlamydia tests. The tests were performed at 20 schools with the majority of tests (58%) performed in just four schools (28% of all tests at school 22; 11% at school 23; 10% at school 11 and 10% at school 12). The School Nursing Service received 236 requests for first line contraception and gave condoms out at 787 attendances. This provision of condoms means that at over a third (34%) of the times the nurse saw a student they were given free condoms.

Table 20. Chlamydia tests performed by School Nursing Service, by school

School Code	Frequency of tests	Per cent
2	5	2.2
4	11	4.7
5	6	2.6
6	10	4.3
8	5	2.2
9	13	5.6
11	22	9.5
12	23	9.9
14	7	3
15	6	2.6
16	3	1.3
17	3	1.3
19	1	0.4
20	11	4.7
21	4	1.7
22	64	27.6
23	25	10.8
26	6	2.6
27	4	1.7
28	3	1.3
Total	**232**	**100**

For each attendance the school nurse records what issues were discussed with the student (the options are provided in the database as set items and tick boxes for the nurse to select). These are presented in table 21. The most common issue discussed was sexual risk behaviour with this being discussed at 1,314 (58%) of attendances. Other common topics of discussion were emotional wellbeing (589; 26%) and relationship issues (316; 14%). At 12% (269/2269) of attendances the nurse signposted the student to another service; this includes other HSIS services and external health and support services. Only 50 Teen MOTs were conducted in the year and substance misuse was the topic that was discussed least frequently (39; 2%). However, these figures must be interpreted with caution as the data include duplicates (students who have attended more than once) and it could be that issues were not discussed at one attendance because they were discussed at another recent attendance.

Table 21. Issues discussed by School Nurses, all schools

Issue	Frequency*	Per cent*
Sexual health risk behaviour	1314	57.9
Emotional wellbeing	589	26
Relationship issues	316	13.9
Student referred to another service	269	11.9
Smoking	197	8.7
Alcohol misuse	162	7.1
Weight	117	5.2
Teen MOT	50	2.2
Substance misuse	39	1.7

*n.b figures are number of attendances not individuals and will include duplicate students who attended more than once. Frequency should not be totalled as some records included more than one issue so will be counted twice

Table 22. Additional issues discussed by School Nurses, all schools (as indicated in free text space)

Issue discussed	Frequency*
Physical health/first aid	117
Referral to another agency	29
Puberty/periods	28
Sexual health	19
Mental health	14
Eating behaviour/weight	12
Pregnancy advice and support	11
Behaviour Issues	8
Relationship/family/friends	7
Bereavement	3
Smoking/drugs/alcohol	2
Other	21

*n.b. frequency should not be totalled as some records included more than one issue so will be counted twice

In addition to the options provided an open text field allowed the nurses to add additional details about the interaction with the student. Additional information was provided for 264/2269 attendances. These have been coded into broad categories and are presented in table 22. The most common additional information included details about physical health problems and first aid (117 attendances), and included problems like injuries, rashes, medication advice, minor illnesses, concerns about lumps, infected piercings, advice about chronic health conditions, allergies etc. Other records included information about referrals to other services (29), puberty and periods (28), sexual health (19) and mental health (14). The lower numbers of records that indicate other issues should not be interpreted as a lack of discussion of these issues, as many of these were included in the tick boxes (see table 21); this field was provided to give details of issues that were not provided as a tick box. There were six attendances where it was indicated that self-harm was discussed, however this does not mean these were the only discussions about self-harm. The category of emotional wellbeing (table 21) could include self-harm and it would depend how the different nurses recorded the information.

4.5.2 Youth Service Activity Data

Data recorded by the youth workers is routinely provided to Wirral Public Health. To fit with service mapping data and to ensure a whole school year was included data from September 2011 to July 2012 were analysed. Data were provided for 26 out of the 29 schools; these 26 schools differed slightly from the schools for which School Nursing Service data was provided.

Individuals seen by the Youth Service

Each individual is allocated a unique identifying code when entered onto the database. The dataset includes information on each who attends a Youth Service clinic or drop in. However, unlike the School Nursing Service data, the Youth Service data does not record every time the students attend. There are some duplicates in the dataset (where students have been recorded as attending more than once) but only 22 students are recorded more than once. This section will examine the demographics of the students who have attended so the duplicates (identified by ID code) have been excluded at this stage. Because numbers of students at some schools are small, percentages will not always be presented as they will not be useful as they may distort the data. Overall 368 individuals attended a Youth Service session in the 2011-2012 academic year.

Table 23. Sex of students attending Youth Service, by school

School Code	Female	Male	Total*
1	3	2	5
2	1	0	1
3	3	12	15
4	6	4	10
5	0	1	1
6	18	0	18
7	8	4	12
8	1	29	30
9	2	1	3
10	0	3	3
11	13	23	36
12	3	0	3
13	0	18	18
14	30	9	39
15	0	1	1
17	2	2	4
18	10	21	31
19	27	0	27
20	16	17	33
22	14	0	14
23	8	0	8
24	1	2	3
25	5	13	18
26	9	15	24
27	0	5	5
28	4	0	4
Total	**184 (50.3%)**	**182 (49.7%)**	**366**

*does not include individuals where school name was not recorded

Half (184/366; 50%) of all attendees were female while no gender was recorded for two students (table 23). The distribution of gender by school reflects the type of school (i.e. single sex schools), with some schools seeing only males or females. However, in the mixed schools the split is more even and suggests the service is used by both male and female students, in contrast to the School Nursing Service which was mainly used by female students. Across all the schools the year group who access the Youth Service most is Year 10 (127 students; 39% of attendees) followed by Year 9 (71; 20%) and Year 11 (64; 18% table 24). The Youth Service is rarely used by students in Year 7 or Year 13. In most schools the Youth Service is available to all students and not restricted by year. Year group was not recorded for five students.

Table 24. Year group of students attending Youth Service, by school

School Code	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Total
1	0	0	0	0	0	5	0	5
2	0	0	1	0	0	0	0	1
3	3	7	1	4	0	0	0	15
4	0	0	4	3	3	0	0	10
5	0	0	0	0	1	0	0	1
6	0	0	1	3	5	9	0	18
7	0	3	6	3	0	0	0	12
8	0	0	0	23	3	4	0	30
9	1	0	1	0	1	0	0	3
10	2	0	0	0	1	0	0	3
11	1	1	4	9	1	18	0	34
12	0	0	0	0	3	0	0	3
13	1	1	5	4	7	0	0	18
14	0	4	20	8	1	6	0	39
15	0	0	0	0	1	0	0	1
17	0	0	0	3	1	0	0	4
18	4	5	10	10	2	0	0	31
19	1	3	9	10	2	1	1	27
20	0	7	2	16	7	1	0	33
22	0	0	6	6	0	0	1	13
23	0	0	1	7	0	0	0	8
24	0	0	0	1	2	0	0	3
25	0	8	0	8	2	0	0	18
26	0	1	0	8	15	0	0	24
27	0	2	0	1	2	0	0	5
28	0	0	0	0	4	0	0	4
Total	**13**	**42**	**71**	**127**	**64**	**44**	**2**	**363**
Total %	**3.6%**	**11.6%**	**19.6%**	**35.0%**	**17.6%**	**12.1%**	**0.6%**	

Ethnicity and Looked after Child status was recorded for all students. Ninety seven per cent (357/368) of students were White British and only 9 students (2%) were recorded as being Looked After Children. Twenty seven per cent (90/331) of students were recorded as having a disability.

Attendances at the Youth Service

This section presents the data of all attendances at the Youth Service and thus includes duplicate people (e.g. the same person could have attended a number of times within the school year; there are 22 duplicates). Therefore all data presented in this section should be interpreted with caution as the individual attendances cannot necessarily be seen as independent episodes of care but may be part of a longer on-going relationship between the youth worker and student.

The number of students attending the Youth Service varied across the academic year (table 25). Across all the schools the Youth Service had the most attendees in September (62; 16%), March (60; 15%) and May (57; 15%). The service was quietest in June and July, which coincides with the exam period and the end of term.

Table 25. Attendances by Youth Service by month, all schools

Month of Attendance	Frequency	Per cent
Sept	62	15.9
Oct	33	8.5
Nov	30	7.7
Dec	30	7.7
Jan	25	6.4
Feb	44	11.3
Mar	60	15.4
Apr	20	5.1
May	57	14.6
Jun	15	3.8
Jul	14	3.6
Total	**390**	**100**

For each attendance the youth worker records what issues were discussed with the student (the options are provided in the database as set items and tick boxes for the youth worker to select). These are presented in table 26. The most common issues discussed with students was emotional health and wellbeing (184; 47% of attendances), other common issues discussed included alcohol misuse (106; 27%), sexual health (93; 24%) and Twist Screening (82; 21%). Smoking and healthy eating were the least regularly discussed issues.

Table 26. Issues discussed with Youth Workers, all schools

	Frequency	Per cent
Emotional Health & Wellbeing	184	47.2
Alcohol Misuse	106	27.2
Sexual Health	93	23.8
Screened Twist	82	21.0
Substance Misuse	35	9.0
Relationship Issues	32	8.2
Alcohol Related Harm	31	7.9
Smoking	17	4.4
Healthy Eating & Weight	6	1.5
Total	**390**	**100.0**

5. Discussion

5.1 Service delivery and implementation

The service mapping exercise collated information about which services were delivered in each school. As well as informing the subsequent sampling and methodology this information provides an overview of how the services and the elements of the programme were distributed at each school. In the 2011-2012 academic year 28 schools hosted the core offer of the Youth Service and the Enhanced School Nursing Service and most schools hosted at least one other service, the most common of these being the Wirral School Stop Smoking Service (WSSSS; 19 schools). Two schools took up all seven services and Tranmere Community Service had only worked in three schools. One school on Wirral chose not to host any services. Although the school names have been anonymised, the schools that hosted the most services tended to be mainstream comprehensive schools in more deprived areas, and those which hosted fewer services were either special school or faith schools. However, this is not totally clear cut; for example there were some grammar schools who hosted a lot of services and some mainstream comprehensives in deprived areas hosting very few services. Evidence has shown that students who attend schools in the more deprived areas, and therefore live in more deprived areas, are likely to have worse health. Many health and social issues are more prevalent in areas of higher deprivation including teenage pregnancy, STIs, obesity, smoking, alcohol and drug use, mental health and low educational attainment, and are likely to affect adolescents as well their parents (Marmot, 2010). Therefore it is important that schools in more deprived areas are encouraged to host as many HSIS services as possible to help reduce these health inequalities.

During the school staff focus groups the participants were asked why their school had decided not to host the other services on offer. The most common reason for this was that they did not think they needed the service, for example the peer mentoring programme to reduce teenage pregnancy was discussed as not needed in a grammar school with very low teenage pregnancy rates. Another reason often stated was that the staff thought the service was too controversial for their school, for example the Brook contraception service would be seen to encourage promiscuity.

Another common reason described by schools for not having taken up all the services was that they were not aware that some services were available and stated that they had not been offered the service. During the roll out of HSIS, the smoking service was initially targeted at the more deprived schools but most of the other services were offered on a first come first served basis. During focus groups, a couple of the schools discussed how they would like to host some of the other services but they had not known they were available. The reason for this lack of knowledge was not entirely clear but the service providers described how they had presented at a WASH meeting and the head teachers then took up the service if they were interested. Therefore it is possible that if the head teacher was absent from the meeting or did not pass this information back to other school staff, then schools would not always be aware about what was available. If there is scope to extend the existing services into more schools or providers feel they want to get more schools on board but are struggling, it might be worth the providers attending another WASH meeting to promote their service further as some schools may be happy to host additional services.

Some providers described unforeseen challenges in engaging with schools and setting up their services. Providers described the challenges they had faced in negotiating with schools to organise service delivery, and how they had not anticipated such problems. One provider described how they felt it had been more difficult to deliver HSIS in schools than first thought, and described how schools were not as keen to host the service as both they and the commissioners had perhaps expected. Those services which required taking groups of students or staff ‘off timetable’ had found it particularly difficult to recruit schools to host their service. However, this was not a problem for AfC who saw individual students within lesson time; this may

be because they do not see a large number of students, or because the work they do is very intense and the schools can see the impact within the classroom.

5.2 Service use and uptake

The service use and uptake varied across schools. Routinely collected Enhanced School Nursing Service and the Youth Service data were analysed to understand more about the students attending these core services and to identify the types of issues that are dealt with by the nurse and youth worker. These data are presented separately in section 4.5.1 and 4.5.2 but will be discussed together in this section. It is not possible to identify which students attended both the Youth and the School Nursing Service because they are anonymised and include two different ID numbers. However it is likely that there is some crossover of students between the two services as school nursing and youth clinics are often held jointly, at the same time or in the same room.

The School Nursing Service dataset for the academic year 2011-2012 included 1,132 individual students who were seen a total of 2,269 times. The mean number of attendances per individual student was twice, and this varied between schools (range 2.83-1.43). The Youth Service dataset for the academic year 2011-2012 included 368 individuals with 390 recorded attendances. Unlike the School Nursing Service data the Youth Service data do not record all attendances by every individual and there are fewer fields on the Youth Service dataset. Nearly two thirds of the students who attended the School Nursing Service were female, which reflects the early intervention sexual health and wellbeing clinical service provided by the nurses. However, half of the attendees at the Youth Service were male. This reflects the more general wellbeing focus of the youth workers, as opposed to the clinical provision of the nurses.

The vast majority of students seen by the Youth Service and School Nursing Service were white British and there were few looked after children. The School Nursing Service recorded only 1% as having a disability whereas 27% of the students seen by the Youth Service had a disability. This could be due to differences in the way disability is classified or recorded or it could be differences in the types of students who are being supported.

Across the schools, both the School Nursing and Youth Services were accessed by students from every year group, however the most common in the School Nursing Service was year 10 and year 11 and for the Youth Service was year 9 and year 10. Very few attendees at either service were from year 7 or year 13. The distribution of attendees across the year groups varied by school and can, in some way, be attributed to some schools not having sixth forms and some not making the service available to the younger year groups. However, the types and location of publicity and the school staff who signpost will also account for some of these differences.

From the school staff interviews we noted that schools targeted their services differently. Some only allowed the older students to access the nurse contraception service, for some schools this was a very purposeful decision and they had decided not to make some services available to younger students. However, in some schools the promotion of services to students was more subtle than this; although they didn't prevent or discourage younger students from attending it was more actively promoted to older students and the staff who worked with older students were more likely to signpost them. Some schools discussed only having posters and promotional material on display in areas accessed by older students, for example in sixth form buildings. This element of HSIS was left to the discretion of the individual schools and was often negotiated as the service was being set up. If the schools would like a wider selection of students to attend the services they could increase promotion aimed at younger students or encourage learning mentors and heads of year who work with younger students to signpost more. At the time of the evaluation, some schools allowed students to self-refer to the services, sometimes the signposting needed to come through a member of staff, and some of the referrals had to go through the nurse. Each school had worked out their own system for

how the students were signposted to and accessed the services, and each school involved in the focus groups seemed happy with the signposting and referral pathways. The most common suggestions from students of ways to best advertise a school based service was posters, assemblies and talks from service providers. From the student engagement we saw that although students were very aware of the nurse and Brook services only 23% were aware of the Youth Service clinics. So although the school staff groups believed that the students were aware of the services, either through word of mouth or signposting, it is clear not many of them would know they were able to access support from a youth worker unless they approached a teacher and were signposted. This signposting will work for some students but for those who do not want to reveal their problems to a teacher or their friend they are unlikely to find out about the support available to them. Without wider and open publicity students may remain ignorant of the services that they can access in their school. Those who are unlikely to talk to a teacher, learning mentor or other students may be the most vulnerable or isolated and are even less likely to hear about the HSIS services if they are not widely publicised.

The attendances at the School Nursing Service varied across the schools with the busiest months being January and November. For the Youth Service their busiest months were September and March, however they do not record all repeat attendances so these should be understood as the months when the most students attended for the first time. The providers all reported that the uptake and demand for their services varied and sometimes they knew the reasons for this, for example one nurse said after a day of teacher's strikes they had a high demand for EHC, but sometimes the services were quieter and they did not know why. During the service provider interviews AfC were the only provider that reported consistently high uptake for their service. AfC attendees are agreed in collaboration with pastoral staff and prioritised based on need. This high uptake of AfC may be because school staff are very involved with the process of signposting students to AfC. For all other providers uptake varied greatly between schools, with some very busy and others being very quiet despite all efforts. Uptake at EBD schools was consistently reported as low by all providers. The majority of the providers thought uptake depended on three elements; venue of their service within the school; promotion and publicity of their service; and the ethos and attitude of the school.

As uptake was poor at some schools and providers had not been allowed to publicise their services too openly in school, uptake may not increase further if this does not change. One school and one provider discussed the idea that services should be increased in schools where uptake and demand is high, rather than use resources in schools where the clinics are not utilised. This is obviously a complicated issue and commissioners need to ensure equity of access and provision, however this might be worth further discussion.

The School Nursing Service data show high uptake of the enhanced contraception provision. Across all schools a total of 196 pregnancy tests were performed during the school year and 11 of these showed a positive result. There were 10 students with positive pregnancy test results (one student had two positive results four months apart). These positive results came from only five schools, however we will not be identifying these schools to ensure no confidentiality is breached. Students who have a positive test result are supported by the school nurse and signposted into further services such as Brook or abortion services, all of this remains confidential. We cannot know whether these ten girls who received positive pregnancy tests would have accessed testing in a service out of school or whether these pregnancies would have remained unnoticed. However the enhanced contraception service enables the nurse to support these girls more than she could have done before the roll out of HSIS.

Emergency hormonal contraception was provided a total of 166 times to 134 individuals. The majority (82%) of these individuals received EHC once, however 20 individuals (15%) received it twice and four individuals received it more than three times. This shows that students do not seem to be 'relying' on EHC as few used it more than once. Previous research has shown that providing emergency hormonal contraception to adolescents is not associated with more unprotected intercourse or less condom or hormonal contraception

use (Marston et al., 2005 and Gold et al., 2004). However, more work is needed to reduce the risk taking behaviour and promote longer term contraception use in this minority of students who repeatedly use EHC. The nurse is ideally placed to provide this support and because she sees students regularly is likely to be aware and able to work with the students to reduce risk taking and to signpost them to other HSIS services. If these students were accessing repeat EHC at other services, for example at a CaSH clinic, the staff there are unlikely to be able to work with them as regularly or know them as well. The school nurse is physically close to these students and can almost 'keep an eye on them' and work with the other HSIS providers to offer other support. The school staff and the providers discussed good communication and strong working relationships between the schools and the providers, and between the different providers. These links mean that students with complex needs or engaging in risky behaviour can be cross signposted and receive a comprehensive package of care from a variety of providers.

The School Nursing Service also provided other contraception. Across all the schools they received 236 requests for first line contraception and gave condoms out at 787 attendances. This high provision of condoms means that at over a third (34%) of attendances the nurse gave students free condoms. Although some of these young people may have accessed condoms in other ways this high coverage of condom distribution should have reduced risk of STIs and unplanned pregnancies in students at these schools. Chlamydia screening varied between schools. A total of 232 tests were conducted in 197 individuals, 179 (77%) of the tests were done by females. The majority of people (85%) only did one test, 24 individuals (12%) did two tests, four people tested three times and one took four chlamydia tests. The chlamydia tests were performed at 20 schools with school 22 being particularly proactive, performing 28% of all tests. Other schools that performed high numbers of chlamydia tests included school 23 (11%), school 11 (10%) and school 12 (10%). For students who test positive the nurse is able to provide treatment within school ensuring that infections are treated quickly and without the students having to go to a clinic out of school, which may not happen. For any sexual partners within school the nurse could also easily do partner notification and testing.

A questionnaire consisting of closed and open questions was distributed to students in three schools in Wirral and a total of 108 responses were collected. Awareness of services was high; with 98% students having heard of at least one HSIS provider, and 38% of respondents had attended one or more of the HSIS services. These schools did not have the busiest youth or nursing clinics (see section 4.5), yet over a third of students questioned had attended at least one service. We would expect the proportion attending to be higher in schools with the busiest clinics. However, awareness of the Youth Service was low, despite it being part of the core offer and youth workers being based in schools since the outset of the programme. As discussed above this most likely links in with publicity and the amount of promotion that the schools allow. The most common ways students had found out about the HSIS programme was through the school nurse, school staff or friends showing that the services are promoted through interactions with school staff, between HSIS services and informally through word of mouth. Few found out about services through posters or formal publicity.

Mental health and wellbeing services are an important and much needed resource within schools. When asked which services they would most like to see in their school the most common response from the students surveyed related to mental health with 81% saying they would like a service that helped with depression or anxiety and 67% suggesting counselling. Mental health is clearly an important issue for the students, and they would like services around this in their school. This was also stated during the school staff interviews when most schools viewed AfC very favourably and saw their counselling service as a priority and invaluable service. When school staff were asked about gaps in services or what else health related support they would like in their school the two main issues were around eating disorders and self-harm. School staff felt they did not have the training to support students with these issues and struggled to know where to signpost them to, especially for the more low level cases. AfC do work with some young people with these kind of mental health problems, however their resources are limited and AfC have waiting lists.

Both school staff and service providers thought it was very important to have health services located within school because of the secure and familiar school environment, the immediate and instant access to support, the lack of a waiting list and the young person friendly providers. School staff believed that if the service was not available in school the majority of students were unlikely to access similar services outside of school. The reasons for this included practical access and transport problems, having to tell their parents where they were going, fear of the unknown and lack of motivation. The school staff felt that the students did not like talking about mental or sexual health issues with their GP. However, this was not as unanimous for the students themselves. When asked about the best location for health services opinion was reasonably evenly split; 32% of students said that they would prefer to attend services in school, 25% said they prefer to attend outside of school and 36% stated they did not mind. Reasons for preferring school based services included confidentiality, convenience, trusting the providers and less stressful or embarrassing. Reasons for preferring services to be outside of school included privacy, people not knowing they were attending and the school not being involved. It is important for young people to have a choice in the types of service that they can access; outside of school they can access CaSH clinics, Brook, Response and GPs for some of these issues. However, for those who do not feel confident or able to go to mainstream services providing services within school could mean some young people are supported who would otherwise not attend any service.

Students were asked what would encourage them to attend a school based service. The most common responses were friendly and helpful staff, a confidential service and more information about what was available. The main barriers to attending a service in school were lack of confidentiality, people finding out they had attended the service, embarrassment and unfriendly staff. The provider groups discussed problems with the location of rooms, particularly rooms in secure areas of schools where students have to ask permission to enter. If students are worried about confidentiality and the embarrassment of attending services having to ask a teacher for permission to visit a HSIS service, even if they do not have to explain the reasons, is likely to act as a major barrier to accessing services. To encourage usage and reduce discomfort for students HSIS services need to be located in areas of school where students can access them as subtly as possible without having to draw further attention to their attendance.

5.3 Experiences and perceptions of the service

The way the services were delivered in 2011-2012 differed greatly between schools, with the majority of providers having to adapt and compromise on the service they delivered in each school. These changes were made to fit in with the wishes, ethos and expectations of each school; for example at some schools, especially faith schools, the nurses did not provide contraception, at some special schools the youth workers delivered PHSE lessons rather than a drop-in clinic, or the WSSSS provided smoking prevention assemblies but did not run cessation sessions. All providers described schools as very dissimilar to each other with different cultures and approaches to supporting their students. The schools where service providers thought the HSIS worked best were the schools described as providing 'holistic' support; where they did not only focus on academic achievement. During the school staff interviews it was clear that each school had a different ethos and aims, with some focused more on attainment and academic success and some having a more holistic and pastoral role.

All providers stated they had to negotiate and compromise on the service they delivered in schools. Because of the concerns and the restrictions put on them by the school, some providers were not able to deliver certain elements or had to reduce the duration of the intervention. Providers were clear on which elements they were happy to compromise (i.e. venue) and which they could not compromise (i.e. confidentiality). The only provider that had not changed any of their service and had been able to be steadfast in their delivery model was AfC. In all of the school staff groups, participants described their initial concerns about the HSIS programme, especially relating to the sexual health elements, and how they were worried about the

reputation of the school and the response of parents. The school staff described how their governors voiced concern that the sexual health services would be seen to be encouraging promiscuity. As a result some schools had chosen to provide the sexual health elements only to older students. However, school staff described that now the programme was imbedded and most schools reported no adverse reactions from parents, they felt more confident that the service could be developed or possibly extended.

Linking in with the issues of uptake discussed in section 5.2, publicity was discussed in detail by the providers and was seen as strongly affecting how busy their services were. More publicity and more openness about services was seen as a key area for improvement by the providers. However, generally, schools reported that they did not widely publicise the HSIS services and relied on mainly word of mouth, a one off assembly at the start of term and staff signposting the students. The schools felt it was important to strike a balance between the people who need the service knowing it is available but not being too obvious or intrusive. More publicity would mean there are fewer empty clinics and a better use of resources; however some schools will not be eager to promote the services further.

The main concern and problem faced by the providers was that of rooms, location and space to deliver their service in the manner they needed. All providers talked about the challenges they had faced finding rooms that were appropriate size and location, few used rooms that were ideally suited to their needs and more than one provider reported delivering their service in a store cupboard. The location of the room was of particular concern as some schools have areas which are not accessible during lunch time and mean the students had to ask a teacher to be allowed in. The providers saw this as a big barrier as having to tell a teacher that they were using any service discouraged students from attending, even if they did not have to give a reason for their attendance. Students also indicated that lack of confidentiality and embarrassment were major barriers to access for them. Interestingly, this was only ever briefly discussed by the school staff; the researcher asked about rooms and possible challenges and all school staff groups acknowledged it was a problem but spoke about it without much concern and quickly moved on the discussion. School staff talked about rooms always being a problem within school and how they were often unable to find suitable spaces, they were used to this challenge and seemed to take it in their stride and not appeared resigned to it. However, the providers who do not solely work in schools rooms described how this had caused a lot of problems. Providers described how this difference in experience and priorities between them and the schools had caused some friction and difficulty in setting up the services, and some providers still felt they were delivering services in unsuitable locations; however this was the only option.

From the perspective of the providers, they felt school culture was very important and that services worked best in schools with a holistic approach to education, those who focused on pastoral care and not just academic attainment. Some of the school staff groups discussed how much they focused on pastoral care and multiagency working and felt this was a key value in their school. Schools reported they had good working relationships with the providers, especially the school nurses, and that the multiagency working element was mainly successful. Many providers also stated they found it particularly good to have one key champion or contact as this ensured any issues could be sorted out quickly and easily. For school staff they valued being able to signpost to another agency within the school as this meant there was a continuity of care and they knew the students were being supported. They talked highly of the importance to students of the confidentiality and that having an external individual who was not employed by the school increased the student's trust.

Perceptions of parents and their reaction and involvement was discussed by both the school staff and the providers. Schools reported that either parents had expressed concern or that the school had anticipated concern from the parents, especially around the sexual health elements of the programme. Initially the provision of EHC was a big concern as it was thought it might encourage promiscuity and risk taking behaviour. However this does not seem to be the case as 82% of students who accessed EHC in the academic year accessed it only once. Schools felt that parents now saw the HSIS programme as a strength

and a valuable resource for their children. Some schools mentioned that the parents had probably forgotten about the service and the quietly bedding in was a positive element of the programme. Some of the providers felt that that schools had been very cautious when taking up the programme and had cited parents as a reason for concern; they were worried how parents would react to providers talking to the students about sex. Some of the providers had issues negotiating the confidentiality agreements as some schools had initially wanted to obtain parental consent for their students to access the services. For most services they had negotiated this and the schools had understood that informing parents would stop students using the service. However, at one school the WSSSS had not been able to deliver a service as the school insisted on parental consent before the students received any nicotine replacement therapy. From the student engagement we saw that parents not being informed about their attendance was a key strength of a school based service and that confidentiality was the most important factor that would encourage attendance and lack of it discourage attendance.

Confidentially was also a very important issue for both the school staff and the providers and came up regularly in discussions. For most of the services the schools know who is attending, either because they signposted them or because this information is passed back (with consent), however they do not know any details about why a student attends a service, what is discussed or if they are provided with anything (e.g. condoms, NRT, EHC). The schools acknowledged that they had been initially concerned about the confidentiality and how little information would be passed back to the school, but as they had worked with the service and began to trust them this had eased and they were confident in the skills and professionalism of the providers. Most providers reported how they had good working relationships with the schools and they were open about some of the information they shared but that the school respected their confidentiality clauses. All but one school felt it was important that the students felt that the details of their interaction with the provider remained confidential, without this assurance of confidentiality the students would not use the services. However, for one school they still had concerns about the strict confidentiality of the services and how little information was passed back to the school, especially from the youth worker, and thought the providers should share more details with them. Communication and openness (within the confines of confidentiality agreements) is very important and where communication had not been easy this had caused problems between the schools and providers. However, the strict confidentiality agreements can also mean that schools are not always aware of the uptake and impact of the services as providers cannot necessarily communicate this back without breaking confidentiality. Finding a way to communicate the uptake and impact without breaching this confidentiality may enable the schools to feel more included and help them see the impact of the HSIS programme.

Providers, schools and students struggled to articulate the impact of the service. All providers believed their service was having a substantial positive impact though some acknowledged it was difficult to demonstrate this. Providers and schools thought the HSIS programme was having a positive impact but struggled to see the difference between activities (i.e. people attending) and the impact (i.e. improvements in health). They often described activities such as repeat attendances and recommendations from friends as a sign of the positive impact. Some services reported excelling on their KPIs and some reported high uptake of services and positive comments from school staff. Although all the schools felt the programme had had a positive impact on their students and the school as a whole they struggled to articulate how they knew this or quantify the impact it had had. Generally they felt the programme had empowered and improved knowledge and the busy clinics were seen as proof that the programme was successful. The provision of EHC was seen as particularly important and two schools felt the sexual health elements had reduced their teenage pregnancy rates. They felt the programme had made the school aware of issues they had not previously known about and that the services prevented problems from escalating. The schools felt that losing the services, especially the sexual health and counselling services, would have a dramatic negative impact on their students. The schools also struggled to isolate the impact of individual services, as opposed to the whole programme. However, the services schools spoke most positively about were the enhanced School Nursing Service and AfC. For most schools the discussion focused around their nurse and the

interviewer had to steer them back to more general conversation. For a lot of school staff it seemed that they equated the HSIS programme with the school nurse.

5.4 Limitations of the evaluation

During the process of this evaluation there have been some challenges and difficulties in recruiting schools to take part. Originally, the evaluation intended to include a larger sample of schools within both the school staff focus groups and student engagement activities. However, it was not possible to engage with some schools, mainly due to how busy the schools were and how they struggled to find time to accommodate activities outside of the curriculum. This also influences the ability of the school to engage with evaluation activities. Schools face competing pressures on their time, the competitive league tables of academic achievement and the variety of additional pastoral care needs all need to be taken into account. Therefore additional activities such as health promotion and evaluations have to be compromised. We had originally planned to conduct some focus groups with student groups within schools however no schools could accommodate this; therefore the voice of the students is limited to the surveys undertaken in three schools and the studies from two of these schools.

Although we attempted to recruit schools based on a sampling frame developed from the service mapping issues, not all of these agreed to take part. It may be that those involved in the evaluation were those that were more proactive and interested in the HSIS and possibly those that had either a better experience of HSIS or those who are generally more proactive in relation to student health. Both of these options may have biased the results.

6. Recommendations

1. In 2011-2012, the uptake of HSIS services in some schools was low and without more publicity this may not improve. Schools with low uptake of providers should increase promotion for these services using more open and visible publicity methods such as posters, assemblies and discussion in PHSE.

2. Schools need to make all attempts to host HSIS providers in discrete rooms that are accessible to all students without the need to ask teachers permission. Rooms located in areas that are on 'lockdown' at lunch time or where a written permission is needed to allow access create additional barriers that discourage students from attending. Even if the teachers never ask the reason for the attendance at a service, the act of having to tell a teacher they want to go to the service was found to be a major issue for young people.

3. A regular review and feedback process would encourage communication between providers and schools and would ensure:
    a) there is open and honest communication between schools and providers which will improve relationships and trust and hopefully promote uptake in school;
    b) schools are more aware of the impact and uptake of the various services they host, allowing them to see the value; and
    c) any problems can be resolved early for both the schools and providers.

    This review process could take the form of a formal yearly meeting between each provider and school or be more informal email updates from providers to the school informing them of the work they have done in the school (aggregated numbers or case studies, not details that would break confidentiality). However, due to the difficulty in schools finding time to have meetings it should be anticipated that some schools will not accept the invitation to meet providers.

4. Schools consistently report that AfC were having a strong positive impact on student wellbeing, the service was highly utilised and had long waiting lists. Enabling AfC to work with more students and in more schools would be a positive approach.

5. Ensure schools are fully committed to hosting the HSIS providers. A Memorandum of Understanding could be developed between the schools and providers to establish what is expected and required of all parties to HSIS services. This would enable a more localised project and giving the service a higher profile within the school community and could include local agreement with regard to outcomes for pupils.

6. A number of gaps in the types of service that are available were identified by the school staff. Eating disorders and self-harm were felt to be beyond the expertise of HSIS providers unless identified at very early stages. Special consideration should be paid to this in any future review of services. Training for school staff and nurses would enable them to confidently support students who were showing signs or low-level problems. A specially designed service would ensure students with more complex eating disorders and self-harming could be supported effectively. Any development of training or a service should be done in consultation with schools and HSIS providers.

7. The core skills of the youth workers around alcohol awareness, prevention and intervention and risk-taking behaviour are not clear to schools. The role of the youth worker, what they do and who they support should be clarified and clearly communicated to the schools. A higher profile is needed for the drop-in service which includes befriending, supporting and signposting young people to a range of services.

8. There was particularly low uptake of services, including School Nursing and Youth Services, in special schools for young people with physical or emotional and behavioural difficulties. There is also disparity in the services provided within faith schools with some hosting a significantly reduced version of the core offer. The commissioners should revisit the offer and models of delivery to these schools.

9. For any further developments in services it is important to try to reduce the instances where groups of students or staff need to be removed from lessons or taken off timetable. This evaluation found that services that removed groups of students or staff have struggled to work in schools and use time and resources that could be used focusing their services in other ways.

10. Discussions between WASH, the HSIS Provider Network and Public Health commissioners need to examine where resources should be focused. Some schools have very low uptake and are reluctant to further promote the services, it could be an option that these resources would be better utilised in schools that have high uptake and actively promote and engage with the providers.

7. Glossary

AfC	Action for Children
CaSH clinic	Contraceptive and sexual health clinic
EBD	Emotional and behavioural disorders
EHC	Emergency hormonal contraception
KPI	Key performance indicator
MYA	Merseyside Youth Association
NRT	Nicotine replacement therapy
PEER	Positive emotions, excellent support award
PHSE	Personal, health and social education
PLD	Physical and learning disabilities
SLT	Senior leadership team (within schools)
TCP	Tranmere Community Project
WASH	Wirral Association of Secondary Heads
WSSSS	Wirral School Stop Smoking Service

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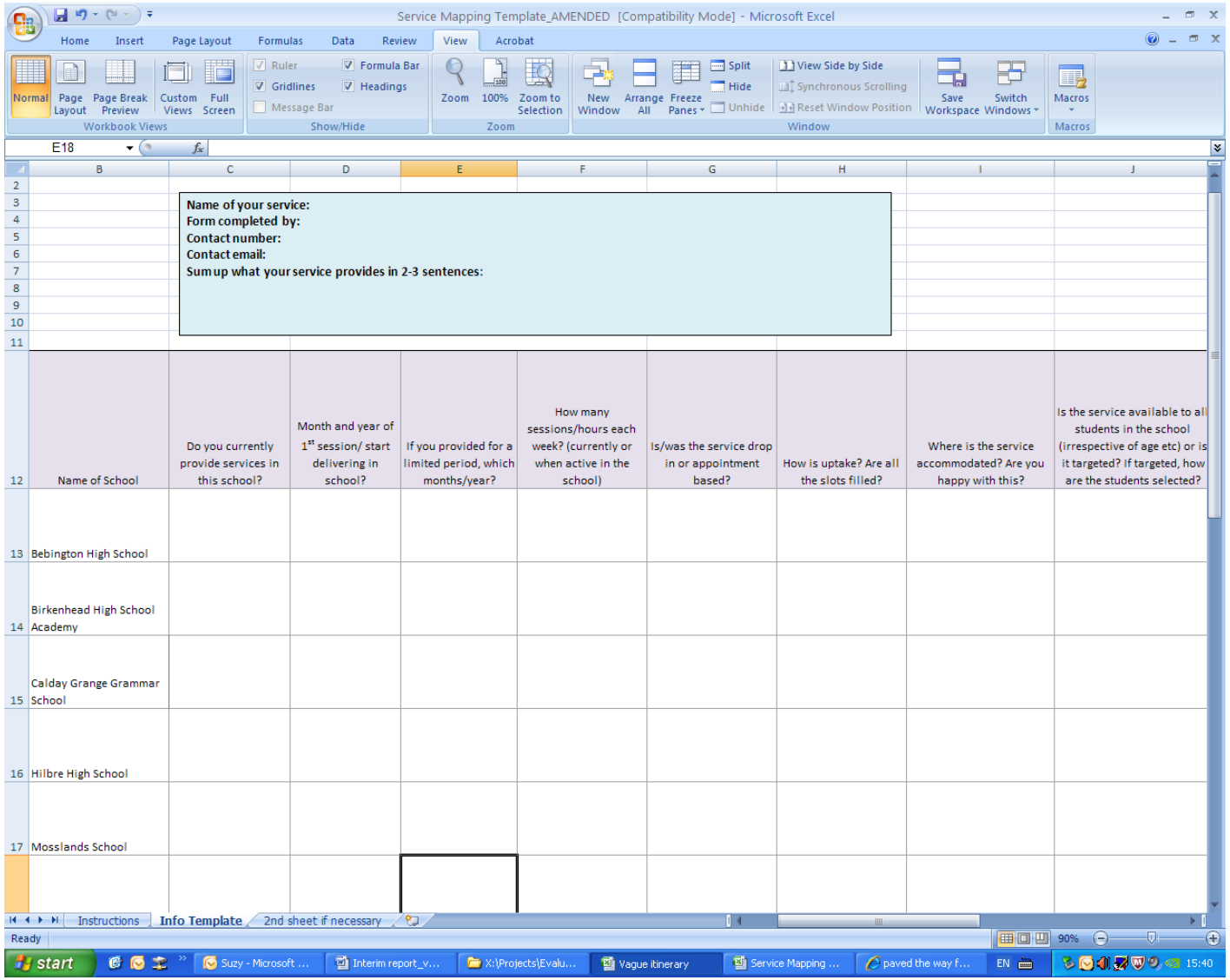
9. Appendix

Appendix A – service mapping template completed by all service providers



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