Models and logics of care in youth mental health: a comparative case study of Early Support Hubs in England

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Abstract

Early Support Hubs are community-based prevention services designed to support young people's mental health and wellbeing. In England, policy interest in the model has grown rapidly, culminating in a government commitment to fund and scale a national version. Yet this expansion has outpaced conceptual clarity. Although the literature shows that hubs are accessible and valued by young people, it has not adequately explained how they organise care, what gives the model coherence across different settings, or what logics underpin their work. In this thesis, I ask what model of care Early Support Hubs enact in England, and what logics of care underpin that model?

I used comparative case study and focused ethnography to study three Early Support Hubs in England. Alongside this, I led a national evaluation to develop the co-designed Youth Access Quality Framework for hubs. The case studies provided the main empirical basis for theorising the enacted model of care, while the Quality Framework offered a sector-level account of how quality was defined and made usable for policy and practice.

I argue that Early Support Hubs have moved from a less clearly defined service category towards a more specified model of care. Across the three case studies, I identify shared logics of care: distress understood as social, relational, and material; care as unfolding over time; open access as an ethical principle; and youth voice as a defining feature of hubs. I also argue that trust is one of the mechanisms through which these logics become practice, sustained not only in relationships between workers and young people but through organisational culture, continuity, and institutional infrastructure. Finally, I argue that the politics of evidence in this field have been shaped by pressure to measure outcomes before the model expected to generate them was adequately developed and understood.

This thesis advances understanding of Early Support Hubs by clarifying the model of care they enact in England and the logics that underpin it. In doing so, it provides a foundation for service improvement, policy development, and future research aimed at improving mental health care for young people.

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Chapter 1. Introduction

Early Support Hubs are local, community-based services that offer open-access mental health and wellbeing support for young people in ways intended to be youth-friendly, flexible, and easy to reach. Usually delivered in the voluntary and community sector, they combine advice, counselling, youth work, group support, and connections to wider services in a single setting. Services of this kind have existed in England under various names since the 1970s, developing alongside, and sometimes as an alternative to, statutory provision. They now attract growing attention in research and policy as a model of community based integrated support for young people.

In this doctoral study, I ask what model of care Early Support Hubs enact in England, and what logics of care underpin that model? I examine what these services are in practice, how they organise care, and what kind of response to youth distress they make possible. I analyse hubs as organisational forms shaped by local histories, professional cultures, service configurations, and relationships with wider systems of health, education, and youth support. My aim is explanatory: to clarify what makes a hub a hub, and to identify the logics that give these services coherence.

To answer this question, I used a comparative case study design informed by health systems and focused ethnography. The thesis has two related components: fieldwork across three Early Support Hubs in England, and a national evaluation to develop the Youth Access Quality Framework for hubs. The case studies provide the primary empirical basis for the thesis' account of the enacted model of care. The Quality Framework provides a sector-level account of how quality in this emerging model was defined, debated, and translated into a practical framework for services, funders, commissioners, and policymakers. These components had distinct datasets and analytic processes, and are brought together in the final discussion.

I came to this research as a General Practitioner. Clinical practice sharpened my interest in youth-focused models of care, and in what they can offer beyond the limits of a standard general practice consultation. In primary care, it is often difficult to make the time and gather the resources needed to respond fully to the social,

relational, and psychological circumstances shaping a young person's distress. For young people who could not afford private therapy, waits for counselling and psychological support were often long, and outside of early psychosis pathways community-based psychiatric care was also difficult to access. Too often, this meant that the kind of early intervention and prevention that might have altered the course of distress was not available before mental health difficulties began to affect schooling, employment, relationships, development, and longer-term wellbeing.

As I began this research, the evidence on Early Support Hubs was growing. Studies showed that young people valued them, engaged with them, and returned to them[1]–[3]. Short-term improvements in psychological distress had been documented in English and international settings[3]–[6]. What the literature could not tell me was what kind of care these services were offering, what logics underpinned that care, and how integration occurred in practice. Those explanatory gaps are what this thesis addresses.

This thesis makes three connected arguments. First, hubs have moved from a contested boundary concept towards a more specified model of care, and this research was part of that movement. Second, trust is one of the mechanisms through which the shared logics of that model become practice. It functions as organisational infrastructure, produced through continuity, accessibility, relational boundaries, and the accumulated memory of how a service behaves over time. Third, the politics of evidence in this field have been shaped by pressure to measure outcomes before the model generating them was adequately understood. These arguments are developed across the two empirical components of the thesis: comparative ethnographic fieldwork in three Early Support Hubs and a parallel national evaluation to develop the Youth Access Quality Framework.

The problem and its moment

When I began this research, Early Support Hubs were becoming newly visible in national policy. The immediate political starting point was the Children and Young People's Mental Health Coalition's Fund the Hubs campaign[7], which brought the model to national prominence in the run-up to the 2024 general election. Labour's manifesto then committed to Young Futures Hubs, a government-funded and

nationally commissioned version of the model[8]. That sequence sharpened my interest in the thesis. A service form that had developed over decades in the voluntary sector was now being drawn into national policy at speed.

That shift brought new public and policy attention, but not greater clarity. Young Futures Hubs were framed around three objectives: early intervention for mental health support, pathways into education, training, and employment, and reducing knife crime and youth violence. These were three different policy concerns each with its own rationale. The policy also shifted attention towards a younger age range, typically 10 to 18, without addressing the transitional years into early adulthood that have long been recognised in the international hub literature as central to youth mental health service design[9].

The relationship between Early Support Hubs and Young Futures Hubs remains unclear, and the terminology in this field continued to evolve over the course of this thesis. Depending on the paper, policy context, or decade, these services have been described as Youth Information, Advice and Counselling Services, youth mental health hubs, integrated youth services, one-stop-shops, open-access drop-ins, and simply hubs. Young Futures Hubs is the most recent addition to that list. These terms are not interchangeable, and I return to their distinctions in Chapter 2 Literature Review.

That uncertainty persisted throughout this research. In February 2026, Layla Moran MP asked in Parliament how Early Support Hubs were intended to sit alongside Young Futures Hubs after visiting an Early Support Hub in south-west England, where staff had described the difficulties of planning under one-year funding cycles[10]. The Secretary of State praised the service and acknowledged the funding challenge but did not clarify the relationship between the two categories. The question remains open.

This unresolved connection is part of the wider problem the thesis addresses. Policy had already moved towards piloting sites in 'early adopter areas', and towards funding, scaling, and evaluating hubs, before the field had adequately answered a more basic question: what kind of service model was being developed in England? The literature had identified broad principles such as accessibility, youth-

friendliness, and system integration, but it could not yet specify what Early Support Hubs looked like in organisational terms. It did not offer a clear working model for England: how the workforce was configured, how safeguarding and risk were managed, how integration with other services was achieved in practice, or what gave the model coherence across different settings. These gaps are explored in Chapter 2, and this doctoral thesis works to answer some of them.

Research questions

The primary question this thesis addresses is:

what is the model of care enacted by Early Support Hubs in England, and what logics of care underpin that model?

Four secondary questions elaborate it. How do hubs relate to existing statutory services? How do they conceptualise young people's needs? How are safeguarding, risk, and clinical accountability negotiated in practice? How do organisational structures shape relational practice? These questions are developed more fully in Chapter 2 Literature Review. What they share is an orientation to the enacted rather than the structural: to what hubs do, how they do it, and why this work takes the forms it does.

This question was not fully formed at the outset of the DPhil. The study began with a broader concern about a gap in primary and preventive care for youth mental health. Through the literature review, the development of the research design, and discussion with academics in the field, my attention turned increasingly to who these services were helping, particularly young people whose needs were not well met elsewhere and who might be marginalised by existing service structures. Before I began my fieldwork, however, and after a year spent building relationships with hubs and familiarising myself with the English context, the most pressing question became more foundational. Before outcomes measurement, before implementation and scaling, and before further policy expansion, it was necessary to ask whether there was a model of care for hubs at all: what these services actually do, and what underpins how they respond to young people's mental health and distress.

In that sense, the central question of the thesis developed inductively through the early stages of the doctoral project. Through observation and interview, analytic attention shifted towards the relational and organisational conditions that made hub care possible. I found myself attending increasingly to the role of trust, to the ethics of care through which practitioners held risk and navigated the limits of their role, and to the different logics through which hubs understood what they were doing, even when the organisational forms through which they did it diverged. The secondary questions were progressively focused as these patterns became clearer.

This inductive development reflects the pragmatist orientation of the study. Jane Addams argued that knowledge is developed through situated and reflective engagement with lived social problems rather than derived from hypotheses applied in advance to a fixed design[11], [12]. That orientation shaped both the epistemological stance of the thesis and its practical form. It also shaped the use of theory. Frameworks that I had not anticipated at the outset, especially Star's account of boundary objects and infrastructure[13]–[15], and Mol's logics of care[16], [17], were applied iteratively as the empirical material generated concepts the initial framing could not fully accommodate. I develop this process further in Chapter 3 Philosophy and Theory.

The national evaluation to develop the Youth Access Quality Framework ran in parallel with the case study research. The two strands were empirically distinct. The evaluation had its own governance, users, outputs, and decision-making processes. But they were analytically related in ways that shaped both. Insights from case study fieldwork informed my understanding of Early Support Hubs and therefore shaped the evaluation process. Questions raised through national consultation, by hub staff, young people, commissioners, and government officials, clarified where deeper analytic attention was needed within the case studies. Across this doctoral study, I was conscious of a responsibility not only to academic supervisors but also to hub staff, young people, and a youth mental health non-profit sector watching government attempt to scale a service form that individual hub organisations had built, adapted, and sustained over decades. That sense of responsibility shaped both the questions I asked and the rigour with which I developed the analysis.

Structure of the thesis

Chapter 2 reviews the literature on integrated youth services in England and internationally. I examine how Early Support Hubs and related service forms have been defined and organised, what the evidence shows about their outcomes and the conditions under which they appear to work, and what remains unresolved. The central gap is explanatory. The literature identifies broad principles and reported benefits, but it does not yet offer a clear account of how hub care is enacted in practice.

Chapter 3 develops the philosophical and theoretical foundations of the study. I combine four frameworks that inform the analysis. Addams' pragmatism is the foundation of the study's epistemology[11], [12], treating inquiry as situated social practice. Tronto's ethics of care provides vocabulary for the relational, political, and ethical dimensions of care work[18], [19]. Star's boundary object theory helps explain how the category of the Early Support Hub can function coherently across groups who do not fully agree on its meaning[13], [14]. Mol's logics of care provides the main analytical lens through which variation across the three case study sites is understood[16], [17].

Chapter 4 sets out the comparative case study design and focused health systems ethnographic approach through which the research questions were pursued. I describe case selection, fieldwork design, methods of data generation and analysis, and the analytic relationship between the ethnographic case studies and the national evaluation. The chapter also addresses reflexivity, positionality, and the ethical dimensions of research in voluntary sector mental health services with young people.

Chapters 5, 6, and 7 present the findings from each of the three case study hubs in turn. Each chapter introduces one hub through its setting, history, and an opening vignette, then examines the following domains: organising care, ethics of care and youth participation, professional cultures, system integration, and logics of care. Each chapter stands as an individual case before the comparison chapter brings them together.

Chapter 8 presents the comparative analysis across the three sites. I show how hubs sharing a common orientation to young people's needs enact care through different organisational arrangements, what this variation reveals about the shared logics of care, and what the case studies suggest about the conditions required to sustain hub care in practice.

Chapter 9 presents the national evaluation of the Youth Access Quality Framework. I examine how the framework was developed through co-design with young people and hub services, how feedback and public consultation shaped its final form, and what the evaluation found, including areas of broad consensus and areas of productive disagreement about what quality in Early Support Hubs means in practice.

Chapter 10 combines the research and evaluation components of the thesis. It argues that Early Support Hubs have moved from a boundary concept towards a more specified model of care, that trust is one of the mechanisms through which shared logics of care become practice, and that the politics of evidence in this field have been shaped by a premature focus on outcomes before the model generating them was adequately understood. The chapter closes by setting out the thesis' contributions to research, policy, and services, and the directions for future work that it opens up.

The chapters that follow ask what Early Support Hubs are and how they work from the inside: across drop-in waiting rooms and staff meetings, outreach settings and youth participation, and through sustained engagement with a field that was changing as I tried to understand it.

Chapter 2. Literature review

Introduction

Youth mental health difficulties typically emerge in adolescence and early adulthood, yet the services designed to respond to them are frequently organised around the needs of adults or younger children. Internationally, rising need and worsening distress have intensified calls for models of care better fitted to the period of life in which mental ill health most often begins [9]. In England, one in five children and young people aged 8 to 25 had a probable mental health disorder in 2023[20], and the Children's Commissioner's latest analysis describes a service system under mounting strain, marked by long waits, uneven local provision[21]. The transition from CAMHS to adult services remains a point of discontinuity[22], reinforcing the case for youth-focused primary care models organised around accessibility, integration, and continuity.

Integrated youth services for mental health have emerged across multiple national contexts to respond to this need. In Australia, headspace has operated a national network of youth mental health centres for young people aged 11 to 25 years since 2007[23]. In Canada, ACCESS Open Minds redesigned services across fourteen sites spanning urban, rural, and Indigenous communities[24]. In Ireland, Jigsaw developed a community-based model explicitly organised around avoiding clinical environments[25]. In England, Early Support Hubs have grown from a long tradition of Youth Information, Advice and Counselling services[1], [3], [4], and have recently been the subject of the first government-funded, multi-site evaluation[2], [26].

This chapter reviews the evidence on these models. My aims are threefold:

1. to examine how Early Support Hubs and related hub service models have been defined and organised
2. to assess what is known about their outcomes and the conditions under which they appear to work
3. to identify what remains unresolved, particularly around how integration happens in practice, how relational care is organised and bounded, and what youth participation means beyond its formal invocation in service descriptions.

I approach this review as an Australian GP and early-career researcher with some direct clinical experience of the kinds of systems these hubs sit alongside. My positioning shapes what I identify as missing in the literature. The evidence on access, acceptability, and short-term outcomes is reasonably consistent. What is much less visible is the everyday work of integrated care: how practitioners from different disciplinary traditions work across organisational and professional boundaries, how hubs hold and respond to risk, and what model of care is enacted when a young person walks through the door.

Methods for the literature review

This review combined four strands of literature identification and interpretive synthesis. For reviews of complex evidence, protocol-led database searching alone is often both ineffective and inefficient, since key word searches generate vast numbers of hits but may fail to locate all key sources (which are often more readily identified through citation chasing, snowballing, and expert knowledge)[27].

The first strand was a structured academic search through the University of Oxford's SOLO Bodleian library and linked databases, using terms including early support hubs, one-stop shops, youth mental health hubs, integrated youth services, and Youth Information Advice and Counselling Services, with additional terms identified iteratively. Searches were not restricted by date but were limited to peer-reviewed publications and substantive grey literature.

The second strand was a targeted review of literature cited by the Lancet Psychiatry Commission on Youth Mental Health[9], which played a consolidating role in international advocacy around integrated youth mental health care. Because it drew selectively on a large international literature, I reviewed its cited sources in full as an additional route into the field.

The third strand involved expert dialogue with senior international researchers directly involved in major hub models in Australia and Canada. This included email exchanges and online meetings to discuss the literature field, clarify how major international models had developed, and situate the English Early Support Hub

model within wider debates on integrated youth mental health services. Youth Access, the national membership organisation for hub services in England, was also consulted to identify evaluations or practice-based evidence that formal searching might not have captured.

The fourth strand was interpretive co-review with three Youth Engagement Co-designers involved in the Youth Access Quality Framework project. The Quality Framework was a separate but related national evaluation project, commissioned by Youth Access and led by me during the DPhil, to define quality in youth hub services and develop a practical framework for services, funders and commissioners. The three Youth Engagement Co-designers were young people aged 18 to 25 with lived experience of hub services, recruited and paid through Youth Access to support youth consultation, analysis, review and communication of the framework. Their role is described in detail in Chapter 4. In this literature review, their responses helped shape the emphases of the chapter, particularly around what young people valued in hub settings and what they considered meaningful indicators of quality.

The synthesis across these four strands followed a hermeneutic rather than systematic approach to literature review. Boell and Cecez-Kecmanovic describe the hermeneutic literature review process as constituted by iterative cycles of searching, classifying and mapping, critical assessment, and argument development, with understanding deepening through each pass rather than being established once and fixed[28]. A small number of anchoring texts established an initial account of the field[9], [29], [30], and are explored in the next section. This account was then tested and revised as my reading widened. Sources that appeared to complicate or contradict the emerging picture were treated as productive rather than anomalous.

Smythe and Spence describe literature as an essential dialogical partner from which scholarly thinking and new insights emerge, and the quality of this literature was improved by the range of interlocutors involved in the process[31]: conversations with international researchers, supervisory dialogue, engagement with the Youth Access Quality Framework Co-designers, and sustained discussion with young people whose experience of hub services did not always map onto how those services were described in the academic literature. The review has been written and rewritten across the course of the DPhil, with sources returned to and re-evaluated

as the research questions developed inductively through fieldwork, as the Quality Framework work surfaced new questions about practice, and as each conversation shifted the interpretive frame. What is presented here reflects that cumulative process of meaning-making rather than the application of fixed inclusion and exclusion criteria to a stable body of literature.

Defining the field

There is no common term in the academic literature for integrated youth mental health services. Depending on the paper, location, or decade, I encountered integrated youth mental health care, one-stop shops, integrated community-based youth service hubs, Youth Information Advice and Counselling Services, youth mental health hubs, and, more recently in England, Early Support Hubs. This variation reflects heterogeneity in the origins, philosophies, funding structures, and clinical orientations of services that have developed independently in response to similar problems in different national contexts. In this review, when referring specifically to English services, which are the subject of this thesis, I use the term Early Support Hubs, or where the context is clear, simply "hubs". For all other situations, I refer either to the name of the country specific programme or to the broader term integrated youth mental health services.

The earliest substantial attempt to map this field was Hetrick et al.'s 2017 review[30], which examined evaluations of services across multiple countries, including among others: headspace in Australia[32]–[35], ACCESS Open Minds in Canada[24], [36]–[38], Jigsaw in Ireland[6], Youth One Stop Shops in New Zealand[39], Maisons des Adolescents in France[40], Foundry in Canada[41], and CHAT in Singapore[42], [43]. Hetrick et al. define integrated care as joining up physical health, mental health, and social care services, organised around the needs of the young person rather than the logic of the system[30]. What these services share, despite their considerable variation in clinical orientation and organisational design, is a commitment to overcoming the access barriers, fragmentation, and poor developmental fit that have historically prevented many young people from receiving timely care.

A subsequent detailed scoping review by Settipani et al.[29] examined 110 documents and identified five common principles across integrated youth mental

health services: rapid access and early intervention; youth and family engagement in service design; youth-friendly environments and service cultures; evidence-informed approaches; and cross-sector partnerships and collaboration. These principles recur consistently across the international literature. The Lancet Psychiatry Commission lists similar essential features of integrated youth primary mental healthcare, including early intervention, rapid access, youth-friendly care, youth and family participation, multidisciplinary support and cross-sector integration[9]. This convergence across three major reviews suggests that the broad principles of hub-based care are relatively settled, even if the organisational forms through which they are delivered remain diverse.

Integration in hub models exists on a spectrum, yet this distinction does not appear to have been adequately explored in the literature. Hetrick et al. argue that it ranges from formalised agreements and shared referral pathways at one end and collaborative multidisciplinary working with a common culture of care at the other. Co-location, they state explicitly, does not ensure coordinated care: services may be housed under one roof and continue to operate in silos. Settipani et al. reach the same conclusion, noting that although integration was frequently mentioned as an aim, there was little explanation of how services are integrated on a structural level beyond the role of care coordinators[29]. Two independent reviews arrive at the same finding: the literature describes the aspiration of integration but not its mechanics. This gap shapes the inquiry of this thesis.

In England, the services most relevant to this review sit within an evolving model of care that predates the international integrated youth mental health services literature. Youth Information Advice and Counselling Services, commonly known as YIACS, have existed since the 1970s[44]. YIACS offer community-based counselling, advice, and practical support to young people outside statutory systems. What are now referred to as Early Support Hubs are best understood as one of the contemporary forms of this YIACS tradition: the organisational principles are continuous, even as the terminology has shifted.

YIACS appeared in the academic literature for the first time in Duncan et al.[4], though the services themselves long predate that publication. Early Support Hubs[2], [26] retain the voluntary and community sector character of YIACS,

including an emphasis on non-clinical environments, low-threshold access, and practitioner relationships built on trust rather than diagnosis, while increasingly organising around the common principles identified by Settipani et al.[29]. Many English hubs are less clinically focused than their Australian or Canadian counterparts: where headspace explicitly provides medical, mental health, substance use, and vocational services through a multidisciplinary team, a typical Early Support Hub is more likely to centre counselling, youth work, peer support, and advice, with NHS services accessed through referral rather than co-location.

Alongside YIACS, the English literature includes several earlier models that anticipated features now associated with Early Support Hubs without identifying as hubs themselves. Multi-agency services such as the Isle of Wight intensive support team[45] co-located health, education, social care, and substance misuse staff, but targeted young people at very high risk of residential placement rather than the broader early support population hubs serve, and may represent an organisational predecessor of the current Isle of Wight Youth Trust. The Junction[46] closely resembles later hub approaches in its voluntary-sector ethos and holistic orientation, but is best understood as a precursor: smaller in scope, narrower in age range, and developed before the one-stop-shop model had been articulated as a distinct service form. Youthspace in Birmingham[47] was a time-limited pilot programme focused specifically on improving transition for sixteen to twenty-five year olds, and did not offer the breadth of holistic support that characterises hub models. The Well Centre in Lambeth[48] integrated general practice, nursing, and youth work in a single setting, though its clinical infrastructure and funding model are distinct from the voluntary and community sector hubs that are the focus of this review. Forward Thinking Birmingham[49] extended this trajectory into a city-wide zero to twenty-five service redesign, but was a structural reform of the statutory mental health system rather than a community hub model, and its evaluation showed how difficult it is to operationalise partnership working and timely access at that scale.

These services share a commitment to accessible, relational, and integrated responses for young people rather than a common model of care. Despite variation in clinical orientation, resource base, and organisational design, the defining features recur: open access, low thresholds, youth-friendly environments, and an explicit orientation toward young people not well served by statutory systems. Youth

participation is invoked as a core principle across all of them, though it is more often stated than examined, and the literature rarely describes in sufficient detail what influence young people actually have. The international literature was largely generated by models with stronger clinical infrastructure and greater government funding than most English Early Support Hubs, which limits direct comparability. They belong to the same service family, but it is a family with considerable internal diversity, variable terminology, and an unresolved question at its centre: what distinguishes full integration from the mere assembly of services under one roof.

What the evidence shows

Evidence from England

The English evidence base is relatively small and recent compared with other international integrated youth mental health services. Three peer-reviewed studies and the early outputs of the Shared Outcomes Fund evaluation are developing a coherent picture of services that are accessible, valued by young people, and associated with short-term improvements in distress and wellbeing, while also holding persistent uncertainty about their reach and effectiveness for young people with more complex needs.

Hassan et al[1], in a qualitative service evaluation, explored what features of a voluntary-sector YIAC in a disadvantaged North West city supported access and engagement. This evaluation drew on semi-structured interviews and focus groups with 24 young people, 5 parents and carers, and 7 professionals who referred to or worked alongside the service. They found that self-referral, flexible appointments, and a non-clinical environment supported engagement among young people who had avoided or been turned away from statutory services.

Wright et al., in a qualitative multi-hub site study as part of the Shared Outcomes Fund evaluation conducted semi-structured interviews with 20 young people aged 16 to 25 across twenty Early Support Hubs. They found that young people consistently described hubs as easy to enter, easy to return to, and meaningfully different from NHS services in their orientation toward the whole person[2]. Both Hassan[1] and Wright[2] suggest that accessibility is a service ethos that extends beyond the specifics of geography or opening hours.

The quality of the practitioner-young person relationship emerges across all English studies as the most consistently valued feature. Parry et al.[3] conducted the first mixed-methods evaluation of a hub model in England in 2023, examining an Early Support Hub in a socio-economically deprived area and to assess whether it was associated with improved outcomes and how it was experienced by young people and families. Clinical data from 2,384 young people were analysed using pre-post comparisons on the YP-CORE10 and SCORE-15, alongside survey responses from 35 service users, including 21 young people and 14 parents and carers, and interviews with four children aged 12 and under and one parent. The study found statistically significant reductions in psychological distress, with scores moving from the moderate to the mild range with a medium effect size, and significant improvements in family functioning. Qualitatively, participants emphasised trusting relationships with staff above the type of intervention delivered: neither presenting problem nor number of sessions attended predicted positive outcomes as strongly as the relational and environmental conditions of care. By comparison, Wright et al. found that young people valued continuity and the possibility of long-term informal contact, with some describing sustained engagement over several years[2]. These findings converge on a picture of hubs as relational environments built on trust and continuity of care rather than intervention delivery mechanisms.

Duncan et al., examining whether voluntary and community sector counselling services were reaching a distinctive client group and achieving measurable change, analysed routine pre-post outcome and satisfaction data from 2,144 young people aged 11 to 25 across nine services(10). They found significant reductions in distress with medium to large effect sizes, reliable improvement in just over half the sample, and clinically significant recovery in around one third, broadly comparable to outcomes in NHS youth services and school-based counselling. Duncan et al. also show that these services reached more older young people, a higher proportion from Black and minority ethnic backgrounds, and a notable proportion with Youth Justice System contact than CAMHS comparators, suggesting that voluntary sector hubs may be reaching groups systematically underserved elsewhere.

The English literature also points to the complexity, limits, and evaluative difficulties of hub models. None of the studies includes a comparison group, long-term follow-

up, or linked administrative data with NHS or other statutory services. Parry et al. note that routine outcome measures were not well suited to capturing the value of the holistic and responsive nature of hub-based care[3].

Couchman et al., in a qualitative multi-site study conducted as part of the Shared Outcomes Fund evaluation examining how staff understood and enacted practice across eight English hubs, drew on semi-structured individual interviews with 24 staff members and used codebook thematic analysis to identify five themes around holistic support, supported signposting, accessibility, embedded values, and unmet need[26]. They identify a structural tension that none of the other studies captures directly: hubs routinely hold young people whose needs are more complex or acute than the service was designed to manage, because those same young people do not meet thresholds for specialist services. This reflects a pattern well-documented in the international literature as the *missing middle*: a systemic care gap in which individuals are too unwell for primary care but not unwell enough for tertiary services[50], [51]. Menssink et al., drawing on a Delphi consensus process across clinician, researcher, and lived experience groups, repositions the *missing middle* as a systems-level problem rather than a characteristic of patients, describing it as a gap in care where existing mental health services are not meeting needs in any meaningful way[50].

Open-access services attract the full range of need, and Early Support Hubs are no exception. Designed for early intervention, the relational continuity and low thresholds mean they routinely hold considerably more complexity and risk than their model formally implies. This is a consequence of the system surrounding them: when statutory thresholds are high and waiting lists long, hubs become the de facto point of containment for young people who fall between primary and specialist care. The implications for workforce, clinical safety, and model sustainability remain insufficiently addressed in the current English evidence base; the international literature, with its longer track record and more varied service contexts, attends to some of these questions.

International evidence: headspace and ACCESS Open Minds

The international literature is more extensive, but it also raises important comparative challenges for Early Support Hubs. Many of the largest government-

funded youth mental health models are more clinical in orientation than the English hub services considered in this thesis. Headspace, for example, is explicitly organised around co-located clinical and allied health provision, including GPs, mental health clinicians, and visiting psychiatrists, alongside other streams of support. More broadly, large-scale international models often sit in health systems with different funding structures, workforce compositions, and relationships to statutory care.

A recent systematic review and meta-analysis by McHugh et al.[52] examined integrated youth mental healthcare models that link primary and community mental health care with more specialist or tertiary services, and found a small but statistically significant improvement in depressive symptoms relative to treatment as usual, alongside consistently higher rates of access and engagement. Common components included multidisciplinary teams, shared treatment planning, and care coordination. This is useful supporting evidence that integrated care arrangements can improve access and some outcomes, and it offers a more granular account of integration mechanisms than is typically available in the integrated youth mental health services literature.

This section focuses on the two most well documented examples of integrated youth mental health services in the literature: headspace in Australia and ACCESS Open Minds in Canada. These were selected because they are the most substantial and influential models in the international evidence base, with the clearest published literature on service design, implementation, evaluation, and system reform.

The Australian headspace model is the most extensively evaluated integrated youth mental health service in the literature and differs from Early Support Hubs in being a nationally funded and standardised service model. It is described as an enhanced primary care model for young people aged 12 to 25, organised through 16 core components, including youth and family participation, enhanced access, early intervention, evidence-informed practice, service integration, supported transitions, and four core streams: mental health, physical and sexual health, alcohol and other drugs, and work and study support[32]. The model has also been framed as a ‘soft entry’ into youth mental health care, while studies of community awareness and service use show how headspace functions as a visible national network with large-

scale routine data infrastructure[34], [53], [54]. Independent evaluation by KPMG identified headspace as accessible and acceptable while highlighting workforce, funding, consistency and integration challenges[55], and more recent work has shown persistent structural barriers between headspace and state-funded specialist mental health systems[56].

Early national studies showed that headspace was reaching young people with substantial levels of need, including groups often underserved by mainstream care, and that many young people were seen quickly after presentation[35], [57]. An independent evaluation by the Social Policy Research Centre found the programme highly accessible and acceptable, but characterised its overall effect as positive and modest rather than transformative[58]. More recent routine outcomes data suggest improvements in psychological distress, psychosocial functioning and quality of life[5], while session-by-session feedback indicates generally positive experiences of participation in care[59]. At the same time, Australian debate has questioned both the model's capacity and the strength of claims made for its impact. Hickie et al., writing from a broadly supportive position as contributors to the wider headspace reform agenda, argue that many young people presenting to headspace now have greater clinical complexity, suicidality, comorbidity and functional impairment than an enhanced primary care model can easily manage, suggesting the need for stronger links with specialist care and greater service intensity[60].

By contrast, Kisely and colleagues, a group of Australian academic psychiatrists, have been more direct critics of the model, questioning the consistency of demonstrated clinical benefit, the adequacy of comparisons with general practice and other primary care services, and the cost-effectiveness claims made in the KPMG evaluation[61], [62]. Related critiques have raised concerns about parallel governance, duplication and coordination with existing public mental health services, the high cost of the headspace early psychosis programme, and the extent to which a model developed and evaluated in a WEIRD (Western, Educated, Industrialised, Rich and Democratic) context can be generalised beyond Australia[63]–[65]. These critiques do not negate the positive evidence on accessibility, acceptability and routine outcomes, but they suggest that integrated youth mental health services should be evaluated not only by whether young people access services and show improvement, but also by whether the model provides

sufficient value, equity, and system integration compared with alternative ways of organising primary and specialist youth mental health care.

In Canada, integrated youth mental health service reform has developed through several related models: Foundry, Youth Wellness Hubs Ontario, and ACCESS Open Minds. Foundry in British Columbia has built a network of community services with strong emphasis on youth-friendly design and peer support[41], [66]. Youth Wellness Hubs Ontario has contributed learning on implementation and measurement-based care across twenty-five sites[67], [68]. Both demonstrate that integrated youth mental health services can be adapted to different provincial contexts while retaining a common architecture of open access and cross-sector collaboration.

ACCESS Open Minds is the most extensively studied integrated youth mental health service in Canada and is a useful second international comparator for this review. Established as a pan-Canadian initiative in 2014, it sought to transform existing primary and community services for young people aged 11 to 25 around five principles: early identification, rapid access, appropriate and culturally relevant care, continuity across age-based service transitions, and youth and family engagement[69]. Unlike headspace, ACCESS Open Minds was not implemented as a single nationally branded service platform, but as a principles-based transformation adapted across urban, rural, remote and Indigenous settings[24].

Early ACCESS Open Minds papers are most useful for describing the model of care, including shared decision-making processes, local adaptation, youth and family involvement, and cross-sector service redesign[24], [38], [70]. More recent studies provide stronger outcome evidence, showing increased referrals and improved timeliness to first assessment and service contact across 11 sites[69], high youth satisfaction[71], and site-specific improvements in clinician-rated outcomes in Edmonton compared with matched non-ACCESS community mental health services[72]. However, young people with moderate to severe problems still experienced longer delays[69], and variation in services received across sites suggests an ongoing need to balance local adaptation with clearer minimum core service offers, adequate service intensity, and equity for young people with higher levels of need[73]. A protocol for economic evaluation was published in 2023, setting

out plans to assess whether ACCESS Open Minds shifts care upstream and offsets increased community costs through reduced acute, emergency, hospital or specialist service use, but the evaluation findings have not yet been published[74].

Gaps in the literature

The literature reviewed here is sufficient to establish Early Support Hubs and related integrated youth mental health services as a credible and established form of mental healthcare provision for young people. It shows that these services are typically low-threshold, youth-friendly, relational, and holistic, and that they are valued by young people and associated with short-term improvements in distress and functioning. The main literature gap is no longer descriptive but explanatory. The literature can describe what hubs look like from the outside, but not yet how their model of care is enacted in practice. It remains unclear how integration is achieved beyond co-location, how relational and ethical aspects of care are organised and bounded, how workforce cultures sustain the model, and how hubs respond when young people's needs exceed what early support can safely provide. These unresolved issues provide the rationale for the questions that follow:

1. **Service target populations and eligibility criteria**
    a. Who is being served by Early Support Hubs in England, and how is the intended population defined in practice?
    b. How are young people with complex or high-need profiles accommodated within a low-threshold, open-access model, and what happens when their needs exceed what the hub can safely provide?
2. **Staff roles, skills, and integrated practice culture**
    a. What workforce structures, role boundaries, and organisational cultures support youth-centred integrated care in Early Support Hubs?
    b. How is the hub workforce recruited, developed, and sustained, and how are the relational and values-based capacities the model depends on supported through supervision, training, and organisational practice?
3. **Depth and impact of youth participation**
    a. How is youth participation integrated into Early Support Hubs, how is it resourced, and how does it operate in the design and delivery of care?

b. What level of influence do young people have on service decision-making, and how are tensions between young people's preferences and service constraints navigated in practice?

4. **Physical and social environment**
    a. How do the physical and social environments of Early Support Hubs support or hinder engagement, and how are these environments experienced by young people and staff?
    b. Are hub environments, access points, and opening hours co-designed with young people, and if so, what forms does that co-design take in practice?
5. **Evaluation methods and outcome metrics**
    a. What outcomes are being measured in Early Support Hubs, how are they being measured, and how well do current tools capture the holistic and relational dimensions of hub-based care?
    b. Are there consistent, validated approaches to outcome measurement being used across hubs, and what would a more adequate evaluation framework for this service form need to include?
6. **Mechanisms of integration beyond co-location**
    a. How do Early Support Hubs coordinate care across disciplines and organisations in practice, and what distinguishes full integration from co-location without meaningful exchange?
    b. What formal structures, including memoranda of understanding, multidisciplinary team meetings, shared care planning, and joint casework, and what informal structures, including the time and relational investment required to build and sustain working relationships across services, are in place to support integration?
7. **Formal pathways to specialist care**
    a. How do Early Support Hubs connect to secondary and tertiary specialist services, and how are those connections maintained under the pressures of high demand, workforce turnover, and funding instability?
    b. How do hubs hold risk while young people wait for higher-tier services, and what are the consequences for young people, staff, and the service when that pathway is blocked or delayed?
8. **Relational care and professional ethics**

a. How are ongoing relationships with young people initiated, maintained, and appropriately bounded within Early Support Hubs, and how do practitioners navigate the tension between accessibility and professional limit?
b. How are the ethical dimensions of hub-based care, including confidentiality, safeguarding, shared decision-making, and the management of power in practitioner-client relationships, enacted in everyday practice rather than stated in policy?

These eight questions map the territory the literature leaves unresolved, and they point toward a broader research agenda that will require further researcher collaborations to address. This thesis focuses on the primary research question, with attention to the secondary questions most amenable to focused ethnography and comparative case study: how integration is enacted in everyday practice, how relational care is organised and bounded, how workforce cultures sustain the values the model depends on, and how hubs hold and respond to risk at the boundaries of statutory systems.

The aim is to articulate the model of care that underpins Early Support Hubs and the logics through which it operates, providing a foundation from which future research and evaluation questions can be formulated and pursued. I hope that questions about who hubs best serve, how outcomes should be measured, and how youth participation is formally governed can inform future stages of inquiry, and build on this account of what an Early Support Hub is, and how it enacts care in practice.

Conclusion

The literature reviewed in this chapter establishes Early Support Hubs and related integrated youth mental health services as a credible and increasingly well-evidenced form of care. These services are consistently accessible to young people who do not engage with statutory provision, are experienced as welcoming and non-stigmatising, and are associated with short-term reductions in psychological distress across English and international settings. The English evidence from Hassan et al.[1], Parry et al.[3], and Duncan et al.[4] suggests that hub-based voluntary sector services reach groups systematically underserved by CAMHS, including young people above

the age of 18, those from Black and minority ethnic backgrounds, and those with previous or current Youth Justice System involvement. The international literature, particularly from headspace[5], [23], [32] and ACCESS Open Minds[24], [36], [69], adds a longer track record and more systematic outcome data, though the models it describes are more clinically resourced and nationally governed than most English hubs, which limits direct comparability.

The limits of the evidence are equally clear. Short-term improvements in distress are documented; long-term outcomes are not. System-level effects, including whether hub engagement reduces demand on emergency and specialist services over time, remain almost entirely unmeasured. Economic claims, where they exist, are methodologically contested[55], [62], [64]. Crucially, the evidence base is much stronger on what hubs look like from the outside than on how they function from the inside. The consistent finding, across Hetrick et al.[30], Settipani et al.[29], and the Lancet Psychiatry Commission[9], is that integration is one of the defining aspirations of hub models and yet it is an inadequately described feature in the literature. The English qualitative evidence from Couchman et al.[26] gives the closest account of what integration requires in practice: not a formal governance arrangement but effortful daily relational work, conducted by practitioners who hold continuity across a fragmented system through relationships rather than formal protocol. That this finding comes from a single qualitative study of English hubs, rather than from the accumulated international literature, speaks to how much remains unexamined.

The eight research questions formulated in the preceding section follow directly from this. Questions about service populations and eligibility arise because the literature shows that hubs routinely hold young people whose needs exceed what early support was designed to manage but offers no account of how those boundaries are negotiated in practice. Questions about workforce, role boundaries, and practice culture arise because the literature invokes the right values and relational capacities without describing how they are recruited for, developed, or protected. Questions about youth participation arise because it is universally claimed and valued but rarely examined in detail. Questions about integration mechanisms, pathways to specialist care, and relational ethics arise because the

central feature of hub models, the enacted model of care, remains a descriptive gap in an otherwise growing literature.

Answering these questions requires a methodological approach and a theoretical framework capable of making sense of what is found. The gaps the literature identifies are not simply empirical; they concern the ethical and relational dimensions of practice, the logics through which care is organised and justified, and the boundaries across which practitioners work. Chapter 3 develops the philosophical and theoretical foundations the thesis draws on, combining pragmatism, an ethics of care, Mol's logics of care, and the concept of boundary objects to examine how integrated care is constituted in everyday practice. Chapter 4 then sets out the comparative case study design and focused ethnographic approach through which those questions are pursued empirically.

Chapter 3. Philosophy and Theory

My doctoral research is informed by four theoretical traditions that constitute a practical ethical framework: the pragmatism and social ethics of Jane Addams, Joan Tronto's ethics of care, Susan Leigh Star's boundary object theory, and Annemarie Mol's logics of care. Theory shaped the design of the study, guided the analytic process, and oriented the ethical commitments that structured fieldwork and interpretation. Addams's pragmatism grounds the ontological and epistemological orientation of the study, treating knowledge as developed through situated inquiry and reflective participation. Tronto provides a vocabulary for the relational and ethical dimensions of care work. Star's boundary object theory accounts for how a category like the Early Support Hub varies across service practice, policy, and research while remaining meaningful in each context. Mol offers a way of understanding how care is enacted differently across settings without treating variation as inconsistency or error.

These frameworks were not fixed in advance. Addams and Tronto shaped the design from the outset; boundary object theory and Mol's logics of care were iteratively applied through sustained movement between fieldwork, interviews, documentary material, data analysis and reflection. That inductive process is consistent with the pragmatist orientation the study takes: theoretical frameworks are tools for making sense of the world, judged through what they allow the analysis to illuminate. Because this orientation cannot be separated from methodological design, I address those connections briefly here before exploring them fully in the following methods chapter.

Philosophy

Addams' pragmatism and social ethics

Jane Addams was part of the American pragmatist movement that emerged in the late nineteenth century. Associated with thinkers including Charles Sanders Peirce, William James, and John Dewey, pragmatism treated ideas as shaped through experience, inquiry, and action in the world[75]. Addams worked within this tradition but developed it in a distinctively social and ethical direction, locating knowledge in shared life and in engagement with concrete social problems.

Addams locates the development of knowledge in praxis, treating ideas as formed, tested, and revised through engagement with lived social problems rather than derived from detached abstraction. Two texts were especially important as guiding works for this study: *Twenty Years at Hull House*[11], which shows inquiry emerging through everyday settlement life at Hull House in Chicago, where living alongside immigrant and working-class neighbours generated reciprocal encounter, social observation, and practical experimentation, and *Democracy and Social Ethics*[12], which articulates her account of social ethics in action and pragmatic philosophy.

Addams' work highlights several concerns central to this thesis: inquiry grounded in lived problems rather than abstraction, ethics as process to be explored through practice, youth participation as a social and relational accomplishment, and sympathetic understanding as both an ethical and epistemic stance. She offers a form of pragmatism that is experimental and iterative, alongside an applied social ethics in which action, rather than detached philosophical speculation, is the medium through which ethical life is expressed and progressed. For a thesis concerned with how Early Support Hubs operate in practice, and with how their value is assembled through relationships, judgement, and institutional work, this orientation shaped the methodological design of the study and the process of analysis.

Addams shaped the epistemological orientation of this thesis. Her pragmatism begins with problems encountered in the world rather than with abstract doctrine, and understands knowledge as developed through engagement, experiment, and reflective participation in social life. William James captured this quality in a letter to Addams on 13 December 1909 when he wrote, "You are not like the rest of us, who seek the truth and try to express it. You inhabit reality ; and when you open your mouth truth can't help being uttered."[76, p. 1].

Like other classical pragmatists, Addams understood knowledge as produced through participation in the world and judged through its consequences in its application, rather than as a detached and wholly objective analysis of fixed truths. She translated this philosophical orientation into her methods. In Twenty Years at Hull-House, she described the settlement as a place in which one might seek "to learn of life from life itself"[11, p. 32]. Shields emphasises Addams's scientific

attitude, by which she means an approach distinct from positivism, the view that valid knowledge derives from objective measurement and value-free observation of an external world[77]. For Addams, scientific inquiry meant open-minded observation, fallibilism, and a willingness to test ideas in lived circumstances rather than apply fixed methods to produce detached conclusions[78]. Hull House was itself a place of inquiry, where social knowledge was generated through contact with urban poverty, labour conflict, migration, gendered inequality, and everyday forms of social interdependence. Addams's work guided my orientation to what we can know through research, what methods are used to produce that knowledge, and how research outcomes should be applicable to real-world experience.

Addams extended this pragmatist orientation beyond epistemology and into ethics. In *Democracy and Social Ethics* she wrote that "action is indeed the sole medium of expression for ethics" [12, p. 74]. Addams' pragmatism applies to how knowledge is produced and to how ethical life is understood. As Villadsen notes, for Addams questions of morality cannot be answered through abstract philosophical or theological debate alone, but must be worked out through action in concrete situations [79]. Whipps extends this argument by showing that, for Addams, ethical life is always interdependent: persons are constituted in relation with others, and community is remade through engagement with diverse voices and experiences rather than through isolated reflection or fixed doctrine[80]. This does not require a false equivalence between researcher and participant, nor does it dissolve imbalances of power for Addams. It suggests that to attempt to know what is true for a person, one must be with them closely enough for relationship to generate insight through sympathetic care, generative difficulty, and ethical engagement.

That was especially resonant for me both as a researcher and as a GP, because ethical practice in clinical work is not fixed or external to action. It is a live and continuous reflective practice, negotiated in relation to particular people, histories, constraints, and obligations. In this thesis, that orientation shaped not only the design of the case study methods and the inductive, theory-informed analysis, but also my stance as an interdisciplinary health systems researcher. It drew the study design away from detached modes of academic inquiry collecting data from a desk in the University of Oxford, and towards a more embedded approach developed in close proximity to hub practice and alongside the young people seeking care.

Addams' work sets the foundations for what would later emerge as the feminist ethics of care. Hamington argues that for Addams, pragmatism and care are inseparable: her philosophy joins relational attention, social inquiry, and political action rather than treating ethics as a set of rules applied from a distance[81]. In *Democracy and Social Ethics*, Addams argues that it is difficult to sustain democracy as "a social expression and not a mere governmental contrivance, unless we take pains to keep common ground in our human experiences"[12, p. 221]. Ethically, she asks for sympathetic engagement with others rather than abstract judgement from afar. Epistemologically, she suggests that understanding is deepened through remaining in touch with the lived realities of other people rather than retreating into doctrine or institutional abstraction.

Addams' commitment to sympathetic care is enacted through practices such as active listening, participation, connected leadership, and activism rather than through the application of inflexible moral rules. Hamington located Addams' work alongside contemporary feminist care ethicists such as Carol Gilligan, Nel Noddings, and Joan Tronto, and argues that her work anticipates a public and political ethics of care[81]. These practices closely resemble the relational qualities that later appeared repeatedly in the hub fieldwork data, where staff described listening carefully to young people, building youth participation into service design, and leading through presence, trust, and responsiveness. In this way, Addams formed the overarching philosophical approach to the doctoral study, while the later feminist ethics of care tradition, discussed in the following section through Joan Tronto's work, complemented this orientation by providing a more explicit vocabulary for analysing the relational and moral practices through which care was enacted.

Theory

Tronto and the ethics of care

Ethics of care provides a framework for making visible what is often valued but rarely measured in primary and community-based care. The field of care ethics posits that ethical reasoning cannot be reduced to the application of abstract principles by autonomous individuals. It emerged as a field from Carol Gilligan's In a Different Voice (1982), developed against Kohlberg's account of hierarchical moral

development, which privileged universal principles and detached objective reasoning. Gilligan argued that moral life could also be organised through relationship, particularity, and responsibility within a web of human connection. Persons are already entangled in relationships, dependencies, and vulnerabilities, many of which are not freely chosen. Ethical action therefore requires sustained attention to the particular other and their circumstances.

Joan Tronto's contribution was to move beyond a general language of compassion or empathy and provide a structured account of the phases and ethical qualities of care. In Moral Boundaries[18], Tronto identifies four phases: caring about, taking care of, care-giving, and care-receiving, each associated with an ethical quality: attentiveness, responsibility, competence, and responsiveness. She later adds a fifth phase, caring with, to capture the democratic and political dimensions of care[19]. These categories allow care to be assessed in terms of how need is perceived, who assumes responsibility, whether action is skilful and adequate, whether the response of the cared-for person is taken seriously, and whether caring relations are embedded within broader commitments to justice and collective life. I chose this framework over more broad vocabularies such as compassion, kindness, or empathy because those terms, while also present in the health research field, risked reducing care to private disposition or interpersonal feeling. Tronto's categories could hold together and synthesise the ethical, relational, and organisational dimensions of practice simultaneously.

Marian Barnes's account of how these principles translate into practice was especially useful on two points. The first is trust. Barnes argues that attentiveness requires active listening, attending to what is said, how it is said, and what is not said. Carrying out an assessment schedule while failing to listen can itself be a form of inattentiveness, amounting to "wilful ignorance" when it is the worker's role to provide help[82, p. 161]. Trust is the condition that makes attentiveness possible: young people often disclosed, returned, or engaged differently when they believed someone would stay, listen, and follow through. The second is Barnes's use of Tronto's distinction between taking care of, meaning the putting in place of systems intended to meet a need, and care-giving, meaning the actual process of meeting that need[82, p. 163]. Services could have pathways, referral criteria, and recorded

safeguarding systems in place yet still struggle with the relational work of care. In hub practice, the gap between these two was often where the ethical work happened.

Ethics of care made visible the ordinary but demanding relational work through which hubs sought to support young people. Continuity mattered because repeated contact altered what could be said and what kind of judgement became possible. Participation mattered because care was shaped with young people, not only delivered to them. Relational labour mattered because much of what made hubs valuable was work done through presence, conversation, noticing, remembering, and responding, even when that work resisted conventional service metrics. Tronto and Barnes provided a framework precise enough to name that work, and grounded enough to remain in contact with what staff and young people actually described and did day to day in Early Support Hubs.

Star on boundary objects and infrastructure

Boundary objects, as Star and Griesemer defined them, are objects plastic enough to adapt to local needs while remaining robust enough to maintain a common identity across different social worlds[14, p. 393]. They organise coordination between groups who do not share identical goals or understandings, without requiring those groups to resolve their differences first. Early Support Hubs have functioned precisely in this way. The category has been coherent enough to organise service development, advocacy, funding claims, and policy discussion, while remaining sufficiently open to accommodate substantially different service configurations, workforce compositions, and organisational identities.

As discussed in the introductory chapter, a model of care in health systems research refers to an overarching design specifying core elements, guiding principles, intended users, and implementation structures. Early Support Hubs do not meet that level of specification. They do not share one fixed workforce configuration, implementation pathway, or settled set of minimum components. During development of the Quality Framework, it became clear that services identifying with the hub movement held a strong shared sense of what hubs were for alongside a much less settled account of their operational minimum. Some had counselling and youth participation but no formal advice offer; others had youth work and advice

but no counselling strand. The boundary object concept explains this precisely. Because hubs had functioned as a shared category without fixed membership criteria, services could identify with the term without meeting a defined threshold. That interpretive flexibility was both the source of the category's political reach and the source of its practical ambiguity.

As I will go on to demonstrate, the three case study sites resembled one another through shared logics of care, similar non-profit histories, and a common orientation to young people's needs, all enacted differently across sites. All three offered combinations of advice, counselling, youth work, and wellbeing support. All operated as community-based settings where young people could seek help without first meeting the referral thresholds or diagnostic criteria of statutory mental health services. All attempted to connect forms of support that are commonly separated elsewhere, responding to distress as entangled with housing, education, family relationships, identity, peer dynamics, and social exclusion. The resemblance lay in a shared attempt to respond to that convergence, not in identical service offerings.

Star later argued that boundary objects require more than interpretive flexibility to do analytical work. They must have sufficient internal structure to actually coordinate activity across social worlds, and their boundaries are always subject to renegotiation as different groups pull the category towards their own purposes[15]. Boundary objects are under pressure from two directions simultaneously. Standardisation attempts to fix the category, resolving its productive ambiguity into a well-structured object with defined components and governance requirements. Against this, boundary objects generate residual categories: the services and practices that do not quite fit the emerging standard and may coalesce into new alliances or new boundary objects of their own. Early Support Hubs have been subject to these pressures throughout the period this thesis covers. The Quality Framework and the Young Futures Hub programme each represent distinct standardising moves, attempting to give the category more definite shape.

In policy the term hub has been applied far more broadly than the Early Support Hub category. Family hubs within children's policy, employment and education hubs, women's health hubs, and interagency safeguarding hubs all use the same term for substantially different purposes. For clarity, this thesis uses Early Support

Hubs and hubs interchangeably throughout. The Young Futures Hub programme, where relevant, is referred to by its full name. Other hub models are not analytically relevant to this study and are not discussed further.

The adoption of the Quality Framework by funders and services represents a shift towards converting hubs from a boundary object into something closer to a model of care. The framework articulated quality standards that could still be locally interpreted but established minimum expectations across service components, workforce requirements, and integration with surrounding services. It gave more stable form to a category that had been widely applied but conceptually unstable, addressing a question the sector had not previously resolved: what must a hub include for the term to retain meaning, and what level of organisational and relational coherence does quality hub care require? That process of specification is constitutive rather than merely descriptive. The framework helped define the model it purported to evaluate.

This thesis contributes to the same process through a different route. Comparative ethnographic analysis of three mature hubs, combined with analysis of the Quality Framework process, identifies the shared logics of care that underpin Early Support Hubs, how those logics are enacted differently across sites, and where the conditions that sustain or erode them lie. As I go on to show in the findings chapters, hubs are value-laden institutions that shape which needs become visible, which forms of support become legitimate. In the absence of a single specifiable model, Mol's concept of logics of care, introduced in the following section, proved more analytically productive: it offered a way of understanding what hubs share and how they differ without treating variation as failure.

Star also developed a concept of infrastructure that is analytically distinct from boundary objects but addresses a connected problem: how the organisational conditions that make coordination possible tend to disappear from view precisely when they are functioning well. Infrastructure, in Star and Ruhleder's account, is not a fixed thing but a relation: embedded in organised practice, learned as part of membership in a community, linked to conventions and standards, and noticed most clearly when it breaks down[83]. Star's ethnographic writing extends this point by showing that infrastructure is often mundane and backgrounded, which is exactly

why it is so easy to overlook analytically. Star and Strauss's work on visible and invisible labour surfaces a further tension: efforts to make tacit work visible may legitimate it, but they may also expose it to managerial scrutiny, standardisation, and loss of discretion[13], [84]. How trust in organisations can itself become part of infrastructure, sedimented in routines, relationships, and institutional memory, is explored further in the discussion chapter.

Mol and the logics of care

Annemarie Mol's logic of care holds that what counts as good care cannot be determined in advance, in the abstract, or from outside the situation in which care is being given. Mol writes in *The Logic of Care: Health and the problem and patient choice* that a logic:

> invites exploration of what it is appropriate or logical to do in some site or situation, and what is not. It seeks a local, fragile and yet pertinent coherence. This coherence is not necessarily obvious to the people involved. It need not be verbally available to them. It may be implicit: embedded in practices, buildings, habits, and machines. [16, pp. 9–10]

Logics, in this sense, are situated patterns of coherence that must be traced by rendering practice into language. They are found through close empirical attention to what people do, how spaces are arranged, what routines persist, and what adjustments are made when things do not go as expected.

This philosophical position is developed across two of Mol's major works. In *The Body Multiple: Ontology in Medical Practice*, Mol undertakes what she calls an exercise in "empirical philosophy" through the study of atherosclerosis in clinical practice[17, p. 4]. Her concern is not what disease is in the abstract, but to conduct an ethnography of disease: how it is enacted, by whom, and under what circumstances. Disease, in Mol's account, is something multiple, enacted differently in the pathology laboratory, the consulting room, the operating theatre, and the patient's own body and experience.

The Logic of Care extends this argument through its case study of diabetes care, asking how care practices are assembled and made coherent in specific sites. Mol's work offered a way of understanding Early Support Hubs as practical accomplishments whose coherence had to be traced in action, through the particular roles, relationships, routines, and material arrangements through which care was made possible.

Mol distinguishes between a logic of choice and a logic of care, and the distinction matters for understanding how hubs work. In a logic of choice, facts and values are separated, options are presented to an autonomous individual, and that individual selects between them. Where a logic of choice asks what do you want, a logic of care asks "what is important to you?" as Mol argues, "the logic of choice tries to separate facts and values while the logic of care attends to them jointly" [16, p. 19]. Mol does not make a normative argument against choice itself. Choice can be empowering, and young people consulted during the evaluation spoke clearly about wanting better information about available services so they could make informed decisions about where to seek care. The problem Mol identifies is more specific: the logic of choice presupposes that care is fixed, knowable in advance, and available to a consumer who arrives with the capacity and information to select between options. Care, in Mol's account, works differently. It is an ongoing process in which facts, values, relationships, constraints, and responses are continually adjusted. Mol's distinction between logics of choice and care proved generative when I encountered repeated difficulty in specifying what a young person would receive when they walked into a hub.

This became concrete to me early in the evaluation work. Youth Access, the national membership organisation for young people's information, advice, counselling, and support services, and the standards body for Early Support Hubs, was a key partner throughout the research. When I asked Youth Access staff and others what would happen to a young person who walked into a hub, the answer I received, repeatedly and from many different people, was some version of: whatever the young person needed. I found this frustrating at the time. It appeared to resist specification in ways that made evaluation difficult. Mol's work reframed what I had been hearing. The resistance was not incidental and it was not evasion. The idea that one could prescribe in advance a singular response to a young person arriving in distress was,

in important ways, contrary to the logic of care that underpinned hubs. As Mol observes, one of the problems with standardised public health approaches is that they treat people "as if one size fits all," while "good care depends on specification"[16, p. 79]. Hubs were designed to be enacted locally, in response to local need, local understandings of what care should mean, and local assessments of what kinds of response were possible. There was no single hub model. There were, however, recognisable logics through which care was assembled and given coherence across sites.

Mol's final contribution to this thesis is methodological: how care within Early Support Hubs can be studied. If logics of care are embedded in practices, habits, buildings, routines, and material arrangements, they are not fully accessible through interviews, surveys, or policy documents alone. They require close empirical attention to cases. As Mol argues, good case studies "inspire theory, shape ideas and shift conceptions. They do not lead to conclusions that are universally valid, but neither do they claim to do so" [16, p. 10]. Instead, she claims, a case study increases our sensitivity. For this thesis, case study research is the method through which implicit logics of care could be rendered visible, compared across sites, and connected to the broader argument about how Early Support Hubs work and what makes them coherent. How the three case studies and the Quality Framework evaluation were designed, conducted, and analysed is the subject of the methods chapter that follows.

These four frameworks constitute a practical ethics of action. Addams establishes the philosophical foundation: knowledge is produced through situated engagement with lived problems, ethics are established through action, and the researcher's presence in the field is a condition of understanding rather than a limitation to be managed. Tronto's ethics of care extends this orientation by providing a structured vocabulary for the moral and relational dimensions of care work, making it possible to analyse attentiveness, responsibility, competence, responsiveness, and participation as ethical and organisational achievements rather than background features of service delivery. Star's frameworks do a different kind of work: boundary object theory accounts for how the category of the Early Support Hub has travelled across service practice, policy, funding, and research while remaining meaningful in each, while her concept of infrastructure provides the conceptual tools to identify

and name the tacit organisational knowledge, routines, and relational conditions that form a core function of hub care but tend to disappear from view when they are providing the functional foundations. Mol's logics of care provides the primary analytic framework for the findings, offering a way of understanding how care is assembled differently across sites without treating variation as inconsistency or failure.

Figure 3.1 below summarises how these four theoretical frameworks informed the thesis. The methods through which these theoretical commitments were translated into research design and analytic practice are the subject of the chapter that follows.

Figure 3.1Table of theoretical frameworks and their applications in this doctoral study

Theory	Author	Brief description	Application in this thesis
Pragmatism and social ethics	Jane Addams[11], [12]	Pragmatism understands knowledge as developed through situated engagement with real-world problems, reflection, action, and consequences. Addams' social ethics extends this orientation by treating ethical understanding as something worked out through participation in social life rather than detached abstraction.	Pragmatism provides the epistemological foundation for the thesis. It underpins the focus on a contemporary policy and practice problem, the use of focused ethnography and comparative case study, and the commitment to producing knowledge that is both analytically robust and useful for services, policy, and future evaluation. It also supports the iterative development of the research question as the field, policy context, and empirical material evolved.
Ethics of care	Joan Tronto[18], [19], with additional influence from Marian Barnes[82]	Ethics of care understands care as relational, practical, political, and morally significant. Tronto identifies phases and ethical qualities of care, including attentiveness, responsibility, competence, responsiveness, and care with. Barnes extends this into questions of trust, listening, and the distinction between systems designed to meet need and the actual practice of care-giving.	Ethics of care shapes how care is understood and evaluated throughout the thesis. It informs the analysis of hub practice, including how staff notice need, hold responsibility, respond to young people, manage boundaries, and enact youth participation. It also informs the analysis of trust as more than interpersonal kindness: trust is treated as an organisational condition that makes disclosure, engagement, return, and effective mental health treatment and support

			possible. The same framework informed the conduct of youth co-design in the Quality Framework evaluation, where participation required attentiveness, safeguarding, fair payment, flexibility, and relational support.
Logics of care	Annemarie Mol[16], [17]	Mol's logic of care examines how care is enacted in practice rather than defined in advance. A logic of care is a situated pattern of coherence embedded in routines, relationships, material arrangements, habits, and practical judgement within health systems. It contrasts with a logic of choice, which assumes that healthcare is comprised of fixed and clearly defined options that can be selected freely by autonomous individuals.	Logics of care provides the main analytic framework for understanding how and why hubs do what they do. It helps explain why hubs resist simple specification as a single model of care. It highlights why responses to young people are often adaptive rather than standardised, and how variation between hubs can reflect locally coherent ways of organising care rather than inconsistency or failure. The concept structures the within-case analysis and the cross-case comparison, showing how shared logics are enacted differently across Dock Hub, Heath Hub, and Shore Hub.
Boundary objects and infrastructure	Susan Leigh Star[13]–[15]	Boundary objects are concepts or artefacts flexible enough to be interpreted differently across social worlds, yet robust enough to coordinate	Boundary object theory helps explain the variable terminology around Early Support Hubs, youth mental health hubs, YIACS, integrated youth services, and Young Futures

	action between them. Star's later work on infrastructure draws attention to the background systems, routines, conventions, and invisible labour that make coordination possible but often disappear from view when they are working well.	Hubs. It supports analysis of how the hub category travelled across practice, policy, funding, research, and advocacy before becoming more specified. It also helps explain the role of the Youth Access Quality Framework as a standardising move: a way of giving clearer structure to a flexible service category without entirely removing local adaptation. Star's concept of infrastructure informs the discussion of trust as organisational infrastructure, sustained through routines, relationships, memory, governance, and continuity.

Chapter 4. Methodology and Methods

Study Aim and Methodological Orientation

This DPhil generates an empirically grounded account of Early Support Hubs in England as models of care underpinned by distinctive logics. It integrates two related but analytically distinct components: comparative case study research across three English hubs, and a national evaluation commissioned to develop the Youth Access Quality Framework. The case studies provide the primary empirical basis for the thesis' account of the enacted model of care. The national evaluation provides a sector-level account of how quality in this emerging model was defined, debated, and translated into a practical framework for services, funders, commissioners, and policymakers.

The aim of the study is explanatory rather than experimental. I sought to establish what model of care is enacted by Early Support Hubs in England, and what logics of care underpin that model. Early Support Hubs are emergent organisational forms that combine counselling, youth work, advice, and system navigation under one roof, yet there is no settled consensus on their single model of care. Rather than evaluating Early Support Hubs as discrete intervention, I examined these hubs as local institutions shaped by relationships, organisational histories, and interactions with wider systems of health, education, and youth support. This required methods capable of observing organisational practice directly within a complex and evolving policy field.

The primary research question guiding the DPhil is: what is the model of care enacted by Early Support Hubs in England, and what logics of care underpin this model? This question begins with the model of care because the thesis seeks to clarify what hubs are, in practice, as a distinct organisational form. It then asks what logics of care underpin that model, on the basis that staffing configurations, the services offered, governance arrangements, and relationships with statutory organisations are shaped by underlying values, histories, and local contexts. Supporting questions explore how hubs conceptualise mental health and distress,

how these logics emerge from local histories and community contexts, how hubs interact with statutory systems, and how they understand and evidence the impact of their work.

I approached the study from a pragmatist orientation. Early Support Hubs were both a subject of scholarly interest and an active policy commitment by the incumbent government in England during the period of this research. This created a dual imperative: to produce analytically robust research while also engaging questions of practical and policy relevance. Addam's pragmatism[11], [12] supported this orientation because she treats knowledge as developing through situated engagement with real and current social problems, particularly through extended relationships with the people experiencing them. In this thesis, inquiry developed through movement between fieldwork, sector engagement, policy change, theory, and analysis.

This pragmatist orientation shaped the relationship between the case study research and the national evaluation. The two components had distinct purposes, datasets, governance arrangements, outputs, and analytic procedures. The case study research examined how care was enacted in everyday practice across three English hubs. The national evaluation examined how quality in the hub model was conceptualised across the wider sector and translated into the Youth Access Quality Framework. The components informed one another across the two and a half years of the DPhil. Emerging case study insights shaped my approach to the Quality Framework, particularly my attention to trusted relationships, open access, youth voice, workforce support, safeguarding, integration, and proportionate evidence and outcomes measurement. In turn, the Quality Framework process sharpened my sensitivity to the features of the case study data that mattered for policy and implementation: how services defined quality, how they described their model, where consensus existed, and where productive disagreement revealed unresolved tensions in the field.

The formal analysis of the two components remained distinct. The case study chapters draw on data generated through the three ethnographic case studies: observation, interviews, fieldnotes, informal conversations, documentary materials, analytic memos, and cross-case comparison. The national evaluation chapter draws

on the Quality Framework dataset: scoping interviews, youth co-design, workshops, public consultation, Steering Group discussion, and iterative framework development. The case studies are analysed in Chapters 5 to 8. The national evaluation is analysed in Chapter 9. Chapter 10 brings the two components into dialogue to examine what they show together about the development of Early Support Hubs as a model of care, and about the policy challenge of defining, evidencing, and strengthening quality in a locally adaptive service form.

This chapter first sets out the methodological orientation underpinning the comparative case study research, and how the research question evolved in response to fieldwork, policy development, and examiner feedback. It then explains my approach to case study design, health systems and focused ethnography, fieldwork design, observation, interviews, and fieldnotes. Then the chapter outlines the design of the national evaluation and development of the Youth Access Quality Framework. It concludes by describing the analytic approach, including coding and cross-case comparison, before addressing ethics, safeguarding, and researcher reflexivity.

Ethical approval for the doctoral case study research was granted by the University of Oxford Central University Research Ethics Committee, CUREC 2, reference R95612/RE001. The national evaluation to develop the Youth Access Quality Framework was conducted under Youth Access governance, with Youth Access holding organisational safeguarding and insurance arrangements for that work. Full details of research ethics, safeguarding, consent, confidentiality, and data handling are provided later in this chapter.

Research question development in a changing policy field

This study was conducted during a period of rapid policy development on Early Support Hubs in England. At the outset, the object of study was not a stable and clearly bounded model of care with settled terminology. The language, policy ownership, and purpose of "hubs" as a broad category evolved across the course of the doctoral study.

As discussed in the Literature Review chapter, at different points the hub model was referred to as youth mental health hubs, Youth Information, Advice and Counselling

Services, one-stop shops, integrated youth support, Early Support Hubs and Young Futures Hubs. For this reason, I treated the changing policy and practice context as an important part of the methodological setting for the study. This section explains how the research question evolved alongside the field it sought to study. It also shows how the final research question emerged from the interaction between scoping of the doctoral study, case study fieldwork, policy change, hub sector advocacy, and academic publication.

Mapping policy development and the DPhil trajectory

The Gantt chart below (Figure 4.1) maps the development of the doctoral project alongside four parallel strands.

The first strand, policy and politics, captures major government and parliamentary developments, including the initial Department of Health and Social Care and Shared Outcomes Fund (SOF) support for early support hubs, the Labour manifesto commitment to Young Futures Hubs, subsequent ministerial statements and the later mental health strategy call for evidence.

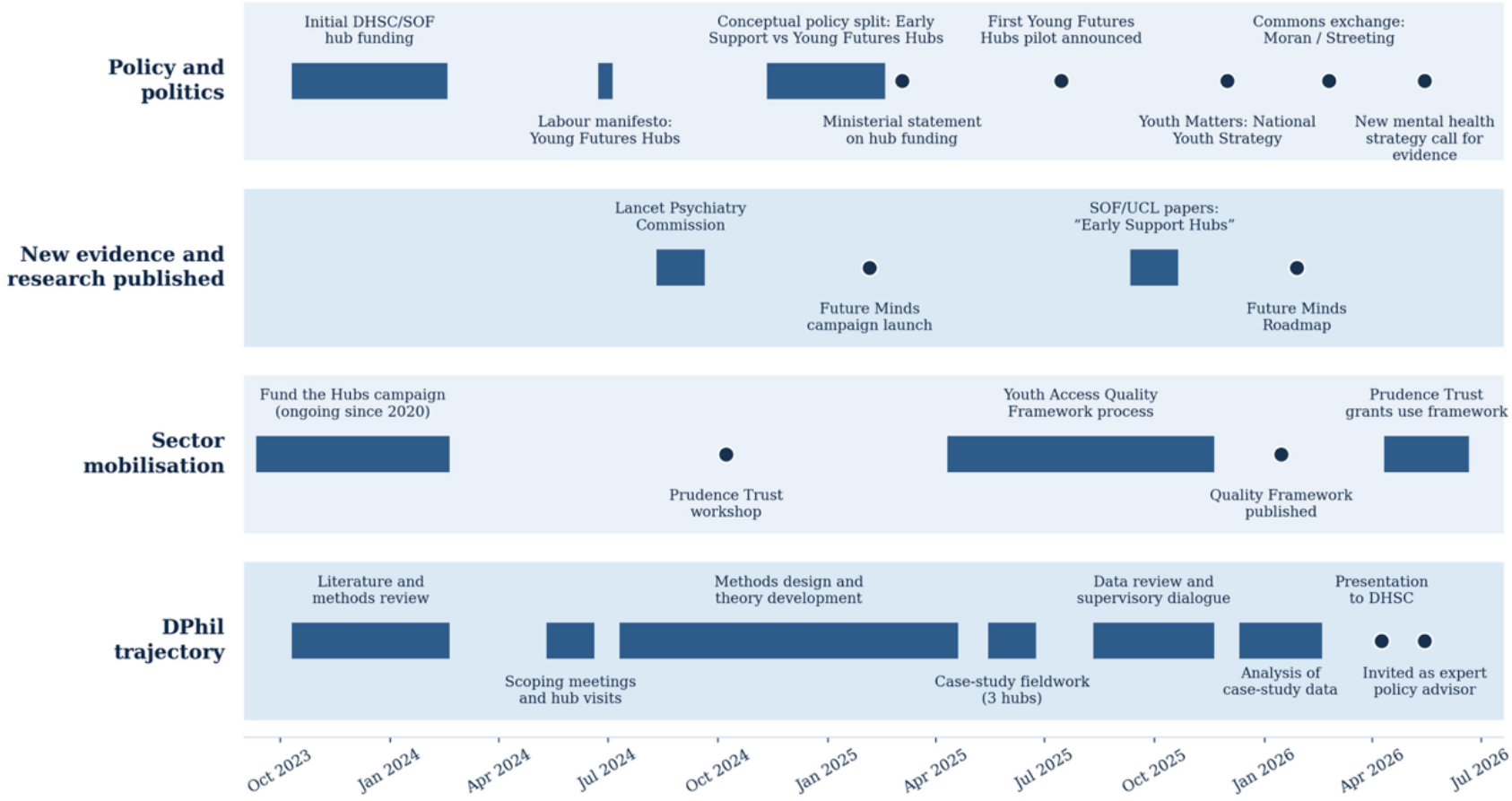
The second strand, new evidence and research published, captures academic and policy-facing publications that shaped the evidence field, including the Lancet Psychiatry Commission on youth mental health, emerging University College London Mental Health Policy Research Unit (UCL) through the Department of Health and Social Care funded Shared Outcomes Fund (SOF) publications, and Centre for Mental Health Future Minds reports.

The third strand, sector mobilisation, captures the role of advocacy, funders and infrastructure-building work, including the Fund the Hubs campaign, the non-profit youth mental health funder The Prudence Trust convening activity, and the Youth Access Quality Framework.

The fourth strand, the DPhil trajectory, captures the development of the doctoral project itself, including scoping, fieldwork, analysis, policy engagement and the evolution of the research question.

There is a further table in figure 4.2 that expands on the details of each of these events and how they impacted the doctoral study.

Figure 4.1 Gantt chart mapping policy development, evidence, sector mobilisation and DPhil trajectory, October 2023–May 2026



This figure does not aim to present a comprehensive policy history. The purpose is to show that the doctoral research question developed in relation to a moving policy and practice field, and how as a researcher I interacted with that process. The hub model was being advocated for, funded, evaluated, renamed and reframed at the same time as the doctoral study was being designed and conducted. This mattered methodologically because the study could not treat a "hub" as a fixed intervention whose model and assumptions were already settled. As my doctoral study evolved, it became clear I needed to focus on providing analysis and clarification on how the model was being enacted in practice, and how different actors understood what hubs were for, to contribute usefully to the academic literature and government policy.

The table in figure 4.2 below provides a more detailed timeline of the events summarised in the Gantt chart of figure 4.1. It includes the date range, event category, event description, source or reference, and analysis of how each event affected the development of the research question and doctoral study. Where events are publicly documented, linked sources are provided. Where events relate to fieldwork, supervision, project correspondence or non-public policy engagement, they are marked as researcher notes.

Figure 4.2: Timeline table of UK Early Support Hubs / Young Futures Hubs / DPhil trajectory, October 2023–July 2026

Date range	Category	Event / Activity	Source / reference	Impact on research question and project
2020-2024	Sector mobilisation	Fund the Hubs campaign	Youth Access: Fund the Hubs campaign timelines[85], [86]	Established hub models of care as a subject of inquiry and framed the original research question around why hubs emerge, succeed or struggle.
Jul 2023	DPhil trajectory	DPhil application question	Researcher notes / DPhil application	The project began as an exploratory success-and-challenge question because hub terminology and policy ownership were still unclear and emerging.
27 Feb 2024	Policy and politics	Initial DHSC / Shared Outcomes Fund hub funding announcement	Extra funding for early support hubs from the Department of Health and Social Care[87]	Further government funding made Early Support Hubs a live policy object and strengthened the rationale for studying English implementation in depth.
May-Jun 2024	DPhil trajectory	Scoping meetings and hub visits for potential case study sites across England.	Researcher notes	Scoping moved the project from abstract comparison to practical questions of site access, model variation and what could be observed ethnographically. Term "youth mental health hub" used to capture all hub models in England and internationally.

Jun-Jul 2024	Policy and politics	Labour manifesto commitment to Young Futures Hubs	Labour Party Manifesto 2024 commitment to Young Futures Hubs[88]	The manifesto made hubs a national political commitment and widened the policy frame beyond clinical mental health towards a tripart aim: mental health, youth unemployment, and reducing anti-social behaviour and knife crime. The term "Young Futures Hubs" emerges in policy for the first time.
Sep-Oct 2024	Evidence and research field	Lancet Psychiatry Commission on youth mental health. Attendance at launch at The British Academy on 7 October 2024 with support from the Prudence Trust	McGorry et al., The Lancet Psychiatry Commission on youth mental health[9]. Researcher notes on attending the launch event	The Commission reinforced international interest in evidence supporting early-access integrated youth mental health models, particularly in headspace Australia, supporting the comparative framing in the question for the Transfer of Status viva.
8 Oct 2024	Sector mobilisation	Prudence Trust workshop on hubs. Leading two workshops on hub literature and outcomes. Coordinated presentation of research	Researcher notes	The workshop connected the DPhil to the emerging evaluation agenda and clarified the importance of outcomes, implementation and evidence standards through discussions with hub staff,

		from Dr Appleton from Shared Outcomes Fund, UCL		academics, and young people with lived experience in attendance.
Jan 2025	DPhil trajectory	Transfer of Status viva: Australia/UK contrasting examples and equity of access for marginalised populations	Researcher notes / Transfer of Status materials	The question narrowed into an international comparative equity study, still drawing on Australia as the mature international reference model. Feedback from discussion led to removal of Australia as a comparator site and increased focus on England and depth of ethnographic methods
5 Feb 2025	Evidence / policy launch	Future Minds campaign and report. Attendance at launch event in UK Parliament, London	Centre for Mental Health launch: Future Minds 2025 report[89]. Researcher notes	The launch linked hubs to national economic and policy priorities, increasing the importance of producing findings useful beyond academic theory.
5 Feb 2025	DPhil / sector mobilisation	Youth Access CEO invitation to apply for lead role on Quality Framework project	Researcher notes	The approach provided an opportunity to create a parallel applied route through which emerging DPhil insights from the data could inform national quality standards and sector development

4 Mar 2025	Policy and politics	Ministerial statement on Early Support Hub funding	Hansard: Early Support Hubs statement from Baroness Merron, The Minister for Patient Safety, Women's Health and Mental Health[90]	The statement confirmed continued Department for Health and Social Care support and evaluation, strengthening 'Early Support Hubs' as a policy and research term
Apr-Nov 2025	Sector / DPhil trajectory	Youth Access Quality Framework development process	Youth Access Quality Framework, Jan 2026 / project document	The quality framework work broadened the project from observation to national co-designed quality definition, while also revealing sector tensions about what counts as a hub and how outcomes are measured
5 May-4 Jul 2025	DPhil trajectory	Case-study fieldwork at three hub sites	Researcher notes / fieldwork records	Fieldwork generated the empirical basis for shifting from international comparison to a deeper account of the enacted English hub model and related logics of care
15 Jul 2025	Policy and politics	First Young Futures Hubs announced	Young Futures Hubs to launch from Prime Minister's Office press release[91]	The announcement broadened hubs into a cross-government model spanning mental health support, mentoring, careers guidance and activity provision
Sep-Oct 2025	Evidence and research field	Shared Outcomes Fund UCL team papers using	Wright et al. & Couchman et al. (analysed in	Academic publication using 'Early Support Hubs' helped stabilise the terminology that

		'Early Support Hubs' terminology	literature review above)[2], [26]	was later adopted in the final thesis question
5 December 2025	Policy and politics	Young Futures Hubs early adopter sites launched	Young Futures Hubs guidance from Department for Culture, Media and Sport on Young Futures Hubs and eight early adopter sites[8]. Researcher notes from discussion with Youth Access and hub sector leadership.	Up until this point, there was discussion about whether Early Support Hubs and Young Futures Hubs might be funded in the same way. This conceptual split on policy showed that 'hub' was becoming a contested policy term, pushing the thesis to ask what model of care was enacted rather than assume one stable model.
10 Dec 2025	Policy and politics	Youth Matters: National Youth Strategy launched	Youth Matters National Youth Strategy from Department for Culture, Media and Sport[92]	The strategy embedded Young Futures Hubs in youth policy rather than only health policy, sharpening the need to distinguish the care model from the policy vehicle
Mid Dec 2025	DPhil / policy engagement	DCMS reaches out for expert advice on workforce, youth participation, and referral systems	Researcher notes / email correspondence.	The request showed direct policy demand for evidence on implementation details, including workforce, referral routes into NHS and CAMHS services, and hub youth voice structures

Dec 2025-Feb 2026	DPhil trajectory	Analysis of hub case-study data	Researcher notes / analysis memos	Analysis moved the project from case description towards a theorised account of the hub model and its underpinning logics of care
Dec 2025 - Jan 2026	Sector / evidence field	Youth Access Quality Framework published	Youth Access Quality Framework launched [93]	The framework consolidated sector language around hubs and quality, supporting the final shift towards Early Support Hubs as the thesis term
28 Jan 2026	Evidence and research field	Future Minds Roadmap launched by The Centre for Mental Health.	Future Minds Roadmap 2026[94]. Researcher notes on expert review and authorship process for evidence and evaluation section.	The Roadmap placed community-based early intervention, Early Support Hubs, and Young Futures Hubs within a wider reform agenda and highlighted the need for proportionate evidence and evaluation
24 Feb 2026	Policy and politics	Commons exchange: Moran MP and Streeting MP on hub funding	Hansard dialogue between Layla Moran MP and Wes Streeting MP, Minister for Health and Social Care[10]	The exchange made visible public ambiguity and funding discordance around Early Support Hubs and Young Futures Hubs, reinforcing the need for conceptual clarity on the models and how they relate at the policy level.

Mar 2026	DPhil trajectory	Confirmation question: enacted model of care and logics of care	Researcher notes / Confirmation of Status report	The confirmation question asked what the English hub model is and re-broadened the project around the core question of model and logics of care.
9 Apr 2026	DPhil / policy engagement	Presentation to the Department of Health and Social Care on doctoral study and Future Minds Roadmap	Researcher notes	The presentation and subsequent discussion confirmed that the doctoral project had become directly relevant to national youth mental health policy and evidence design.
May 2026	DPhil trajectory	Final thesis question adopts 'Early Support Hubs'	Researcher notes / final thesis materials	The final question adopted the now-stabilised term of Early Support Hubs in the case studies, and broader term 'hub' for the quality framework, drawing on Star's boundary objects theory[14], [15]
15 May 2026	Policy / DPhil trajectory	New mental health strategy call for evidence; invitation to provide expert advice	New Mental Health Strategy announced by Department for Healthcare and Social Care with call for evidence[95], [96]. Researcher notes from online meeting and email discussions	The strategy's prevention and community-care framing confirmed the timeliness of the thesis and its relevance to national reform. The outcomes of this doctoral study have been submitted as evidence to inform future UK mental health policy

26 May 2026	DPhil trajectory	Final DPhil viva	Submitted doctoral thesis.	Academic and policy applicability of doctoral study confirmed by viva examiners.

The research question evolved across the project through discussion with my doctoral supervisors in response to the context and events outlined above. There were four main stages: the original DPhil application question, the Transfer of Status question, the Confirmation of Status question and the final thesis question. These questions are summarised in the table below (figure 4.3) with further explanation to follow.

Figure 4.3: Table summary of research question evolution

Date / stage	Research question	Framing	How it responded to circumstances
July 2023 - DPhil application	Where hubs exist and are doing well, what explains their success? Where hubs do not exist or are not doing well, what explains the challenges? What can we learn from these examples?	Exploratory success/challenge framing	Broad initial question to frame doctoral study. Hub terminology was unclear, so the project initially asked what could be learned from visible variation in hub presence and performance.
January 2025 - Transfer of Status	What can we learn from a small sample of contrasting examples from Australia and UK about how youth mental health hubs might best address the needs of specific marginalised populations in their communities?	Comparative international equity framing	The question narrowed around international comparison and marginalised populations, with Australia retained as the mature reference model.

March 2026 - Confirmation of Status	What is the model of care enacted by youth mental health hubs in England, and what logics of care underpin this model?	Enacted model/logics framing	Fieldwork showed that the more important contribution was to explain what hubs are in practice, leading to an England-only ethnographic focus.
May 2026 - Final thesis question	What is the model of care enacted by Early Support Hubs in England, and what logics of care underpin that model?	Final terminology and conceptual framing	The question adopted the stabilised policy and academic language of Early Support Hubs while retaining the broader model-of-care problem.

The original DPhil application, submitted in July 2023, asked: "Where hubs exist and are doing well, what explains their success? Where hubs do not exist or are not doing well, what explains the challenges? What can we learn from these examples?" This was a deliberately broad and open question to begin the doctoral study while the terminology surrounding hubs was unclear and varied across the sector and in the academic literature. "Hubs" referred to a family resemblance of models, including youth mental health hubs, Youth Information, Advice and Counselling Services, one-stop shops, integrated youth services and international models such as headspace in Australia. My initial aim was to ask what could be learned from places where hub-like models appeared to be working, and from places where they were absent or struggling.

By Transfer of Status in January 2024, the question had become more focused but remained broad in scope: "What can we learn from a small sample of contrasting examples from Australia and UK about how youth mental health hubs might best address the needs of specific marginalised populations in their communities?" This formulation reflected the original comparative ambition of the project. In response to the Lancet Commission on youth mental health[9], I included the Australian headspace model as it was the most prominent international example of a national youth mental health hub model, while the UK offered an emerging and more fragmented field of community-based provision. The question also foregrounded equity, which, as I discuss below in the reflexivity section, was an important value motivating the doctoral study.

Following Transfer of Status, examiner feedback and supervisory discussion led to an important revision of scope. The proposed comparison between Australia and the UK was judged to be too large for the doctoral study and insufficiently aligned with the methodological contribution of the project. A meaningful comparison with Australia would have required additional fieldwork, policy analysis and system-level interpretation in a second national context. This would have risked weakening the depth of ethnographic engagement with English hubs, which had become the empirical and analytic centre of the thesis. The decision was therefore made to drop the Australian comparison and focus the study on ethnographic case studies of English hubs. Australia, and particularly headspace, remained relevant as part of the

international background literature, but no longer functioned as a comparator case within the empirical design.

By Confirmation of Status in March 2026, the research question had become: "What is the model of care enacted by youth mental health hubs in England, and what logics of care underpin this model?" This shift reflected insights from fieldwork and ongoing policy development that the most pressing contribution was to describe and theorise what the English hub model actually was in practice. Excluding Australia as a comparator at this stage allowed the study to protect the depth and integrity of the ethnography, and to focus closely on three English case studies during an active period of policy development.

The final question presented in this doctoral study is: "What is the model of care enacted by Early Support Hubs in England, and what logics of care underpin that model?" This wording retained the focus on enacted models and underlying logics of care, while adopting the Early Support Hubs terminology that had become clearer through policy, sector and academic developments. In 2023, the language of "hubs" was broad and ambiguous. By 2025–26, "Early Support Hubs" had become a more specific term used in government funding, sector advocacy and academic evaluation for a range of existing and well-established services, while "Young Futures Hubs" had emerged as a specific and new government policy vehicle with a wider set of objectives. This distinction supported greater precision about the empirical object of the thesis. Robust theoretical grounding and the empirical flexibility of the case study methods described in the next section facilitated this process of question evolution across the doctoral study.

Case Study

Case study is the overarching methodological framework for this thesis. It is well suited to service models that are locally embedded, organisationally complex, and shaped by dynamic policy and funding environments. Cleland et al. define a case study in social science as an:

> in-depth investigation of an organisation, an individual, a context or a phenomenon, single or multiple, set in a real-life context, bound by time and space, which aims to develop a deep comprehension of how the object of the research relates to its context.[97]

Early Support Hubs are non-profit organisations operating within evolving funding structures, changing Local Authority and NHS Integrated Care Board arrangements, and broad understandings of how to best respond to youth mental health need. They are continually shaped by local histories, staffing, community context, and relationships with statutory systems. Case study was therefore an appropriate framework because it allowed me to examine hubs as situated organisational forms rather than as standardised interventions.

This project is best understood as a comparative naturalistic case study[98]. Naturalistic case study seeks to generate deep understanding of particular cases in context, with theory used to support interpretation and analysis rather than to test predetermined hypotheses. In applying this method we ask, 'what is going on here?' and prioritise contextualised explanation over the testing of isolated hypotheses. Naturalistic designs may involve a single case, or multiple in-depth comparative cases, as in this DPhil with three contrasting cases across different geographies in England.

The advantage of comparing three in-depth case studies in this project was that it enabled sustained attention to organisational identity, workforce configuration, safeguarding regimes, service boundaries, and relationships with statutory services. It allowed me to examine how hubs operated in practice, how young people moved through them, and how care was interpreted and coordinated within changing local

systems. This level of contextual depth was essential to the explanatory aims of the thesis.

Debates within case study methodology often centre on differing epistemological orientations, most prominently those associated with Stake[99] and Yin[100], and these contrasting approaches have been widely explored in the methodological literature[101]–[103]. This DPhil adopts a pragmatist and interpretivist lens that aligns more closely with Stake's conception of case study. Stake [99] treats the case as intrinsically valuable and asks, 'what is this a case of?' rather than seeking primarily to test pre-existing theories. Implicit in this question is the need to bound the case carefully, so that the inquiry remains focused on a particular phenomenon in context rather than expanding into an open-ended field. This stance prioritises lived experience, relational processes, and contextual meaning, and supports inductive exploration of how marginalised young people and practitioners enact care in practice. By contrast, Yin's [100] structured, hypothesis-driven designs emphasise replication logic and the generation of generalisable theory. While Yin's approach has value in more tightly bounded interventions, it is less suited to emergent organisational forms and answering the research questions of this DPhil project.

Case study provides a methodological approach to study design, inductive analysis, and reporting[99], [102]. In this thesis, it offered a way to organise fieldwork across multiple sites, to move systematically between within-case and cross-case interpretation, and to present findings with sustained attention to context and complexity. I drew on established reporting principles for case study, context, and complex interventions to structure both this chapter and the later presentation of findings[104]. These principles were helpful because they foreground the non-linear progression of events and actions and their dynamic interaction with evolving contexts, which was central to understanding how hub models of care were enacted in practice.

Case study in this thesis contributes through heuristic generalisation. Its value lies in the depth of understanding it provides and in the way close attention to particular cases can sharpen broader analytical insight. One account compares this to a Cézanne painting of a single tree, where sustained attention to one instance reshapes how we perceive all trees and their representations more generally[105]. Heuristic

generalisation has been described as an opportunity to refine analytical understanding rather than to claim universal applicability[106] with case studies constructed to stimulate insight into wider problems and potential theoretical understandings[107]. Through detailed examination of three hubs, I use case study to clarify relationships between organisational values, governance structures, and enacted models and processes of care in youth mental health that might otherwise remain obscured.

The findings are intended to serve a dual purpose: to address gaps in the literature by clarifying what Early Support Hubs are as services in practice, and to contribute to health policy in England by offering empirically grounded accounts of this emerging model. The richness of qualitative case analysis can deepen understanding of organisational form, relational care, and system positioning beyond the immediate sites examined, especially where the object of study is an emergent service model rather than a standardised intervention. By combining comparative case study with focused ethnography, this thesis identifies institutional linkages, relational processes, and organisational tensions that would be difficult to capture through more standardised designs. Case study therefore provides both the structural foundation and the analytic logic for the thesis, enabling rigorous within-case and cross-case analysis of Early Support Hubs in England.

Ethnography

This section sets out the ethnographic orientation of the case study component of the DPhil. I describe the study broadly as a focused ethnography within a health systems orientation because it applies ethnographic principles to the study of care as it is organised, negotiated, and enacted within complex service systems[108], [109]. This method and orientation is particularly relevant to primary, community, and mental health care, where service models are not reducible to discrete interventions, but are produced through relationships, organisational routines, professional judgement, local histories, governance arrangements, and interactions across statutory and voluntary-sector systems.

Focused ethnography was the specific method used in this study. In this section, I first discuss health systems as the methodological orientation that informed the case

study design, before explaining how focused ethnography was the specific practise applied to this DPhil question, and why it was well suited to a pragmatist, applied, and health-system-oriented study of Early Support Hubs.

Ethnography is concerned with how social life is organised through practice, interaction, and meaning[110]. It seeks to understand what people do, how they interpret what they are doing, and how broader institutional and cultural forces shape those activities. As Van Maanen argues, ethnography involves participating in the daily routines of a setting, developing ongoing relationships with those within it, and observing what is happening over time[111]. Drawing on Hammersley and Atkinson, I approached ethnography as an inductive and reflexive enterprise, oriented towards openness, curiosity, and the possibility of surprise rather than the testing of fixed hypotheses[110]. In this study, that meant remaining attentive to how hubs defined and enacted care in practice, and allowing patterns, tensions, and logics to emerge through engagement with the field rather than imposing a predetermined explanatory structure.

Before commencing this doctoral study, I had undertaken qualitative research using interviews and focus groups, but I was a novice ethnographer. I had, however, long been drawn to ethnographic ways of seeing. As a medical student, I was particularly influenced by Anne Fadiman's *The Spirit Catches You and You Fall Down*[112], an ethnographic account of a Hmong child with epilepsy and the profound cultural, clinical, and institutional misunderstandings that shaped her care in the United States. The book showed with clarity how health care is moral, relational, and cultural as well as a technical practice, and can fail when systems do not recognise how illness and care are understood differently by those involved. That sensibility shaped my interest in ethnography as a method for studying Early Support Hubs.

Health systems ethnography has developed as an interdisciplinary approach that applies ethnographic approaches to the study of healthcare services and system implementation[108], [113]. It is particularly useful where the object of study is not a single intervention but a complex and evolving arrangement of people, practices, technologies, values, and institutional relationships. Cubellis and colleagues have discussed how health systems ethnography can move productively between observing how care is enacted in everyday practice and analysing how those

practices become formalised as recognisable service models[114]. Health systems ethnography can provide insights into problems that are complex, poorly defined, and distributed across multiple systems, because it can illuminate relational processes, organisational dynamics, and local histories that are often flattened in more standardised designs[115]. Black and colleagues also argue that health systems ethnography can contribute to how health systems understand quality and reflect on the implementation of system improvements in practice[109]. For these reasons, health systems ethnography was well suited to answering my research question, since I was seeking to understand not a discrete intervention, but the model of care enacted by Early Support Hubs and the logics that underpin it in practice.

Medical sociologist Catherine Pope's work was particularly important in shaping this methodological approach. In her writing on ethnography in medical settings, Pope shows that health care ethnography is not simply a matter of open-ended immersion, but depends on negotiated access, ongoing consent, careful movement along a continuum between observer and participant roles, and systematic contemporaneous recording of fieldnotes[108]. In her book on Qualitative Research in Healthcare, coedited with Nicholas Mays[116], ethnography is argued to be a valuable method because health services are only partly captured by formal policy, written protocols, or retrospective interview accounts. Much of what shapes care is routine, tacit, contingent, and organisationally embedded. Observational methods are therefore essential where the aim is to understand how care is actually assembled in practice, through handovers, interruptions, waiting, workarounds, documentation, humour, practical reasoning, and the small acts of coordination and repair that make services function day to day[117].

In Early Support Hubs, much of the model of care was visible not only in formal service descriptions, but in reception encounters, safeguarding discussions, triage decisions, shared meals, youth groups, staff debriefs, and the informal ways in which staff distributed and contained risk, responsibility, and relational continuity. For example, Pope's attention to the hidden labour of front-line non-clinical staff in primary care is pertinent here, as her revisiting of classic work on general practice reception shows how enabling access and the ordering of patient demand are organisationally and morally charged activities rather than merely administrative ones[118]. This sharpened my attention to hub reception and access points as

analytically important sites where care was enacted, and where organisational values became visible in daily practice.

Anthropologist David Mosse's work is helpful in showing how ethnography can expand what becomes visible in mental health systems research. He argues that ethnography is an especially valuable method when the aim is to understand how a model of care is translated and enacted in practice rather than simply described in formal or policy terms[113]. In this way, ethnography can make visible the institutional, relational, and moral dimensions of mental health services that are often obscured in more standardised forms of evaluation[119]. Mosse encourages ethnographers working in institutional settings to remain reflexively alert to alliances, dependencies, and power relations, because these shape what becomes visible in fieldwork and what remains obscured[120]. Organisational actors are not neutral informants, and nor is the researcher a neutral observer. Access is mediated, trust is uneven, and what people are willing to say or show depends partly on how they position the researcher and what they think is at stake. Institutions often present themselves through authorised narratives of coherence, competence, and care, while more ambivalent realities may only become visible through longer presence, informal conversation, and attention to contradiction. In this DPhil, these insights shaped my approach to negotiated access, role boundaries, and the use of reflexive journalling and supervision to support analysis. They also made me attentive to the ways my own clinical background, sympathy for hub values, and policy-facing role could influence the field. Mosse's work was helpful for me as a novice ethnographer because it framed reflexivity not as a confessional exercise, but as a methodological necessity in analysing how institutional knowledge is produced, performed, and partially withheld.

Other ethnographic approaches within health research also informed my thinking. Clinical ethnography has drawn attention to cultural meaning, explanatory models, power, and the lived experience of care[121], [122], while collaborative ethnography has emphasised the co-construction of knowledge, relational practice, and the limits of bureaucratic systems in capturing lived experience and hope[123]. Work by Bhui and colleagues shows how ethnographic approaches can deepen understanding of mental health care by attending to cultural meaning, institutional practice, structural inequality, and the lived mechanisms through which systems succeed or fail[124],

[125]. Work by Neil Armstrong similarly highlights how knowledge and care are produced relationally within organisational contexts, and how collaborative ethnography can illuminate new understandings of health systems and their impacts beyond the medical or policy perspective[123], [126]. My study did not adopt either as its primary method, because my focus was not the therapeutic encounter alone nor a fully collaborative ethnographic design across all three sites. However, both informed my attentiveness to differing understandings of distress, power and inequality, relational practice, and the importance of youth voice and participation across the project.

As a novice ethnographer, in addition to engagement with contemporary health systems ethnography, I undertook close reading of foundational ethnographic texts to strengthen my approach to immersion, documentation, analysis, and representation. Fieldnotes were used to gather data, and I relied on Clifford's construction of fieldnotes as acts of inscription, transcription, and description through which lived events are turned into analytic texts that can later be revisited and reinterpreted[127]. Geertz's account of thick description was also important in shaping my understanding that ethnographic writing must move beyond surface description to interpret the layered systems of meaning that make action socially intelligible[128]. These ideas informed how I observed hubs, wrote fieldnotes, and later used short narrative vignettes to represent practice analytically.

In practice, the applied form of ethnography used in this doctoral study was necessarily focused rather than open-ended or long-term. The next section explains focused ethnography in more detail: its theoretical underpinning, why it was appropriate for a time-bounded comparative case study of three hubs, how data were collected and analysed, and what benefits and limitations followed from this methodological choice.

Focused Ethnography

Focused ethnography as a method supported an intensive and time-bounded investigation into how Early Support Hubs enacted care in everyday organisational practice. It was well suited to this DPhil because the study had a defined empirical focus, bounded case sites, an applied health systems orientation, and a concern with

the practices, interactions, meanings, and organisational arrangements through which care was produced.

Knoblauch's foundational account of focused ethnography emphasises short-term field engagement, data intensity, analytic intensity, and the value of background knowledge in studying specialised practices within contemporary social settings[129]. Wall similarly describes focused ethnography as a methodological adaptation that preserves ethnography's concern with culture, meaning, practice, values, knowledge, and power while enabling research in applied and emerging contexts. Trundle and Phillips caution that focused ethnography should not be treated as a rigid methodological category or as an over-simplified departure from conventional ethnography[130]. I use the term 'focused ethnography' in this thesis to describe the practical form of work undertaken: intensive, bounded, reflexive, comparative, theory informed, and oriented towards understanding care in practice.

Focused ethnography is well suited to targeted and well-defined areas of health services research. Bikker et al.'s multi-sited focused ethnography in UK primary care demonstrates how the method can be used as it has been in this doctoral study to examine a specific healthcare phenomenon as it occurs in everyday organisational life, using targeted observation, interviews, fieldnotes, document review, and cross-site comparison[131]. In medical education research, Andreassen et al. similarly argue that focused ethnography is useful to subjects where researchers enter the field with some existing professional familiarity and seek to understand practice in context[132]. This was relevant to my own position as a GP with experience in youth mental health. My clinical background helped me recognise the significance of clinical language, safeguarding concerns, access decisions, risk work, interprofessional tensions, and the everyday negotiation of boundaries and responsibility. As discussed in my reflexivity section, it also required continual reflection and supervisory input into the assumptions I brought to the subject.

Focused ethnography has been shown to be appropriate for studying youth mental health and community services. Kitchen et al.'s focused ethnography of a Child and Adolescent Mental Health Service showed how ethnographic methods can illuminate the organisational pressures, staff turnover, professional cultures, and implementation conditions that shape mental health care in practice[133]. Kelly's

work on focused ethnography in community development non-profit organisations is relevant because Early Support Hubs exist as services within the voluntary and community sector with some NHS commissioning and early intervention healthcare activities[134]. Kelly's account highlights the value of focused ethnography for studying specific practices within non-profit organisations, while making clear the balance between applying prior knowledge and paying careful attention to power, triangulation, and transparency within the fieldwork process.

In this study, focused ethnography enabled close attention to how hub care was enacted through everyday practices. Observation made visible forms of work that were not fully captured in formal service descriptions or interview accounts: how young people were welcomed into drop-in spaces, how staff noticed distress, how waiting was managed, how informal conversations became support, how risk was distributed, how safeguarding concerns were discussed, how youth workers maintained relationships, and how staff moved between warmth, flexibility, boundary-setting, and escalation. It also helped me examine how different elements of the hub model such as youth work, counselling, advice, clinical input, outreach, governance, and partnership working were coordinated in practice.

The method aligned with the pragmatist orientation of the thesis. The study was concerned with how a model of care was enacted in practice, what kinds of knowledge and judgement staff used, and what implications followed for future research, policy, quality, and implementation. Focused ethnography allowed me to study Early Support Hubs as lived organisational systems, not only as policy models or service descriptions within resources, time frame, and scope of a doctoral study. It supported practical and theoretical inquiry at the same time: practical because it examined how hubs organised and delivered care; theoretical because it allowed the analysis to identify the logics, tensions, and relational conditions underpinning the model.

The time-bounded nature of the fieldwork shaped both the strengths and limits of the study. Pink and Morgan argue that short-term ethnography can provide intense routes to knowing when fieldwork is theoretically informed, deliberately focused, and attentive to the detail of everyday practice[135]. The rapid and focused ethnography literature also highlights risks relevant to compressed fieldwork in

healthcare, including dependence on accessible participants, limited capacity to capture change over time, insufficient reflexivity, and weak reporting of data collection and analysis[136]. In this study, these risks were addressed through two intensive fieldwork periods at each site divided by a one-month period, observation across varied hub activities, formal and informal interviews, documentary review, fieldnotes, analytic memos, reflexive journalling, supervisory dialogue, and cross-case comparison. The details of these procedures are set out in the sections that follow.

Focused ethnography provided a coherent methodological approach for this doctoral health systems study. It made visible how Early Support Hubs enacted care, access, trust, safeguarding, and quality in everyday practice. Its value lay in the intensity and specificity of observation across contrasting sites. Its limits lay in the partial, situated, and time-bounded nature of what could be observed and heard. These strengths and limitations will be addressed further in the discussion section.

Study Design

Figure 4.4 Summary of characteristics of Early Support Hub Case Study Sites

Case site	Region and geography	Organisational & spatial form	Core hub provision	Additional services relevant to the case	Rationale for selection
Dock Hub	Northwest England. Urban socio-economically deprived city populations	Large (staff>150+), mature (existed >50 years), multi-site voluntary-sector hub. Three main Dock Hub centres and extended 'hub and spoke' model into schools and GP clinics across Dock City	Open-access drop-in information, advice and guidance counselling youth groups youth voice and participation	Primary care co-location in GP practices for mental health assessment parenting support LGBTQI+ youth groups refugee and asylum-seeker support wellbeing support in high schools counselling in primary schools across the city	Selected as one of the oldest hub models in England, embedded across schools and GP practices, with long-term city-wide commissioning, multi-site provision, and a strong focus on outcomes measurement and data.
Heath Hub	Eastern England.	Mature (existed >30 years) voluntary-sector hub.	Open-access drop-in	Non-medical clinical advice	Selected as a mature hub with a long-term commitment to information,

	Rural and coastal communities Dispersed geography	One main Health Hub drop-in centre with two smaller drop-in centres in Seaside and Arching. Counselling services operate across a wide rural and coastal area.	information, advice and guidance counselling youth groups youth voice and participation	counselling across a wide rural and coastal geographic area therapeutic leadership and supervision young parents / advice work rural and coastal access work	advice and guidance, and to early support hub standards nationally; selected to examine a dispersed hub model serving wide rural and coastal communities.
Shore Hub	Southern England. City-centre service with wider rural counselling catchment	Mature (existed >25 years) voluntary-sector hub combining a central city drop-in site with Shore City outreach and wider counselling provision to rural and island areas	Open-access drop-in information, advice and guidance counselling youth groups youth voice and participation	Practical support including showers, laundry, food and housing support Crisis support Drug and alcohol harm reduction Sexual health nurse collocated clinic Youth worker community outreach	Selected as a hub serving some of Shore City's most vulnerable young people, providing early intervention and crisis support with a strong history of youth work and community outreach.

Case selection followed two defined criteria aligned with the aims of this DPhil. First, sites were required to be recognised within the English hub sector as Early Support Hubs, and to be members of the national advocacy network associated with the Children and Young People's Mental Health Coalition and the #FundtheHubs campaign during 2023 to 2024. These organisations were convened through Youth Access, a national charity and standards body for hub services. Youth Access positions its members as not only mental healthcare providers, but as early intervention services supporting young people with their mental health alongside transitions, crisis, education, employment, benefits, housing, and relational challenges. Their framing is intentionally broader than clinical mental illness, with an emphasis on prevention and holistic youth development.

Although other youth organisations across England also used the language of "hubs", restricting the sampling frame to Youth Access members provided a clearer values base and a more coherent outline of the service model under study. Youth Access member hubs shared a common commitment to counselling, advice and guidance, youth work, and youth voice and participation. Because Youth Access and the Children and Young People's Mental Health Coalition were also the main sector organisations leading policy advocacy and engagement with government during this period, this focus helped me narrow the study to the version of the hub model that was most salient in national policy and implementation debates. This gave me a clearer basis for defining what counted as a hub for the purposes of case selection.

Second, sites were required to be participating in the Department of Health and Social Care Shared Outcomes Fund programme from 2023 to 2025, delivered in partnership with the University College London Mental Health Policy team. This programme provided 12 months of funding to extend service reach in exchange for the provision of demographic and outcomes data across participating sites. Although the Shared Outcomes Fund did not examine models of care in the depth pursued in this DPhil, alignment with it positioned the study to speak to active government interest in hubs as a policy model and enabled comparison with national quantitative reporting in the longer term.

Application of these criteria yielded seven eligible hub sites, all of which I approached to explore participation. Final selection of three hubs was guided by four further considerations. I prioritised organisational maturity and integration, drawing on discussions with Youth Access to identify sites regarded as established examples of hubs that were integrated within their local service context. Practical feasibility was also important, including willingness to participate in the study and capacity to accommodate two weeks of on-site fieldwork. Geographic variation was a third criterion. I sought variation in region, with an explicit commitment to including hubs in both the north and south of England, alongside differences in population density and levels of social deprivation. Finally, where possible, I aimed not to concentrate my case study research in areas most accessible to major universities, particularly London, Oxford, and Cambridge, to broaden geographic representation.

Following case assessment, the three selected sites were:

1. Dock Hub, in Northwest England, a large multi-site urban organisation serving socio-economically deprived city populations.
2. Heath Hub, in Eastern England, operating across rural and coastal communities with dispersed service provision.
3. Shore Hub, in Southern England, a city-centre drop-in service with community youth work outreach and a large rural counselling catchment.

I selected all three hubs to have relatively high levels of organisational maturity to understand what a well-developed hub model looked like in practice. Smaller and emerging hubs were examined through the national evaluation component described later in the chapter.

Case boundaries

In keeping with a case study approach, I bounded each case organisationally, geographically, and temporally. Organisationally, the case was defined by the nonprofit hub service and the services it offered within its local area. All three selected hubs provided open access drop-in provision, information, advice and guidance, counselling, youth groups facilitated by youth workers, and youth voice or advocacy activity. Additional services varied by site and included parenting

support, drug and alcohol services, sexual health support, food bank provision, showers and laundry facilities, school-based wellbeing work, primary care mental health liaison, childhood behaviour programmes, emergency department youth work, and community justice outreach.

Geographically, each case was bounded by the region served by the hub organisation rather than by a single building. This was particularly important because the selected hubs varied in spatial form. Dock Hub operated across several city sites. Heath Hub worked across a dispersed rural and coastal geography. Shore Hub combined a central city drop-in site with outreach and counselling provision across a wider area.

Observation and interviews were conducted between April and October 2025. However, access negotiation and relationship-building began in early 2024, and sense-checking of final data analysis with the three case sites continued into early 2026.

The case included nonprofit hub-led services and hub-system interactions but excluded direct observation of NHS clinical services and private counselling sessions. For example, where hub youth workers were co-located in emergency departments, I engaged staff in informal interviews about these interactions within hub spaces, but did not conduct observation in NHS clinical environments where patients or NHS staff might be observed. Through the invitation of the Dock Hub primary care team, and with permission from a general practice, I observed one afternoon of a hub primary care liaison clinic in a private room where no other patients or NHS staff could be observed. I did not observe one-to-one counselling sessions between accredited counsellors and young people. As a GP familiar with confidential therapeutic spaces, I judged that observation of these encounters was not sufficiently important to my research questions on the broader hub model of care to justify entering them. I therefore chose not to pursue these settings to protect young people's privacy and the integrity of their therapeutic relationships.

Access was initially brokered through introductions from Youth Access and through professional networks, including engagement with charitable organisation YoungMinds UK and attendance at #FundtheHubs advocacy events. In late 2023, I

delivered a seminar on international hub models for The Prudence Trust, including discussion of the Australian headspace model, which facilitated early dialogue with several sites. Across 2024, I conducted preliminary visits, online meetings, and informal discussions to establish feasibility, trust, and clarity of expectations prior to fieldwork commencing in April 2025.

Fieldwork design

Given the doctoral timeframe and the geographic distribution of sites, fieldwork adopted a patchwork focused ethnographic design[137]. Each hub was visited for two intensive one-week blocks, Monday to Friday, each period separated by approximately four weeks or more. This design recognised the practical realities of access and travel while allowing iterative analysis between visits.

Across the three sites, fieldwork spanned approximately six months. Between visits, I reviewed fieldnotes, developed analytic memos, and met with supervisors to reflect on emerging themes and concepts requiring further exploration. The interval between blocks allowed follow-up of organisational developments, clarification of analytic ambiguities, and further attention to evolving practices.

Observation

Observation formed the core method of data generation. Hours varied by site according to service structures and opening times. At Dock Hub and Shore Hub, I typically observed between six and eight hours per day, including evening sessions up to 8pm where relevant. At Heath Hub, where services were more geographically dispersed and more restricted in opening hours, observation usually ranged from four to six hours per day, with additional travel time to rural and coastal sites. Total direct observation across all three sites exceeded 200 hours. This excludes preliminary visits undertaken to build access and trust but includes later online meetings used for sense-checking analysis in early 2026.

Observation usually began with attendance at morning staff briefings. I regularly introduced myself to any staff who had not yet met me and reiterated my role as a researcher. My observations focused primarily on drop-in waiting areas, reception and triage spaces, information and advice desks, mental health wellbeing sessions, youth groups, governance and management meetings, safeguarding discussions, and multidisciplinary meetings involving statutory partners. In hubs offering outreach-based services, I also joined youth workers in community settings.

Posters describing the study, including a photograph of me, were displayed in common areas at each site. These outlined the purpose of the research, what observation involved, and made clear that no personal information would be recorded. Stickers were made available so that young people could discreetly indicate if they preferred not to be included in my observational fieldnotes. In practice, young people often used the posters as a prompt to ask me about the research, and staff referred to them when explaining my presence before facilitating informal conversations.

Across sites, the practical shape of observation varied. At Dock Hub, I rotated across three city sites within one local authority area. At Heath Hub, I was primarily based at a rural town drop-in centre but travelled to two smaller coastal services for a day of observation at each site. At Shore Hub, I spent most of my time at the city-centre drop-in service, accompanied youth workers on community outreach, and observed drug and alcohol provision.

My positioning was primarily observer-as-participant, using Gold's classic formulation of fieldwork roles, in which the researcher's observational role is explicit but participation remains limited and bounded[138] I discussed with staff across all settings that I was present as a researcher and was not licensed to provide clinical care or case input. However, I participated in everyday organisational life in bounded ways, such as helping with practical tasks in communal spaces when staff were overstretched. Sharing meals, informal conversations, and tea breaks facilitated relational access and reduced hierarchical distance. A wholly detached stance would have made trust more difficult and would likely have reduced the quality of observational data.

Documentary analysis formed a small and opportunistic part of fieldwork observation rather than a discrete method in its own right. Gorsky and Mold describe documentary analysis as a qualitative method concerned with reading documents not as repositories of authoritative information but as social products shaped by institutional purposes and contexts[139]. In this study, I reviewed documents such as annual reports, safeguarding protocols, induction materials, and intake forms during observation periods to understand how hubs formally represented their work. I took fieldnotes on these materials in situ but did not retain the documents themselves. Given the limited and supplementary role they played, I treat documentary review as part of fieldwork observation rather than as a standalone analytic method.

Interviews

I conducted interviews to complement observational data and to explore how staff and young people understood care within hubs. In-depth interviews are particularly useful for accessing participants' interpretations of events, practices, and relationships, while also recognising that interviews are shaped by the interaction between researcher and participant rather than functioning as neutral vessels of information[140]. In this study, that point was especially important because most formal interviews took place after periods of observation and informal conversation, meaning that I entered many interviews with prior knowledge of the site, the participants, and the organisational issues they were navigating.

Interviews took two forms. Formal interviews were planned within fieldwork days, usually lasted 60 to 90 minutes, and were conducted in private, quiet spaces within the hubs. These interviews were audio-recorded and transcribed for analysis. Informal interviews occurred more organically in communal staff spaces, at the end of the day, between appointments, or in response to young people approaching me after seeing the study posters. The formal interview structure is described below.

Interviews with staff

I recruited at each hub to conduct a minimum of five staff interviews, which was achieved at all sites, and included a small number of joint interviews with two or three participants. Sampling for staff interviews was purposive. I sought diversity across frontline and leadership roles, in line with qualitative interview guidance that emphasises selecting participants able to illuminate the research question rather than aiming for numerical representativeness[140]. Interviewing continued until key organisational perspectives at each site were represented and no major new issues were emerging that substantially altered the developing analysis. Participants included service leads, counsellors, youth workers, drug and alcohol specialists, therapeutic leads, administrative staff, and operational managers. Most interviews lasted around 60 minutes, with some extending to 90 minutes.

Interview topic guides acted as flexible scaffolds rather than rigid schedules. Questions were refined iteratively across fieldwork in response to observation, informal conversations, and emerging analytic concerns, and were tailored to each staff member's role, expertise, and areas of involvement within the hub. Core areas included young people's needs, meanings of mental health and distress, organisational purpose and identity, ethical and safeguarding dilemmas, workforce sustainability, quality and impact, and relationships with statutory services. All formal interviews were audio-recorded with written consent. Recordings were transcribed using secure two-factor authenticated transcription software, then reviewed and checked manually.

Interviews with young people

At each site, I interviewed two young people, giving a total of six interviews across the three sites. Hub staff purposively identified potential participants who had

previously accessed support and maintained some ongoing involvement with the service, including through peer support or advisory roles. This sample does not claim to represent all service users. Rather, it offered insight into youth voice, meaning-making, and sustained engagement within hubs.

Interviews with young people were guided by flexible topic prompts rather than a fixed schedule. Question topics focused on how they first came to the hub, what made it easier or harder to seek help, their experiences of relationships with staff, what forms of support had or had not been helpful, any perceived gaps or limitations in the service, and what the hub meant within the context of their wider lives. The order, wording, and depth of questions were adapted to each participant, allowing interviews to remain conversational, developmentally appropriate, and responsive to what mattered most to them.

Participants were aged 16 to 25. On the day of interviewing, I discussed the proposed participants with a member of hub staff who knew the young person to ensure they were well, emotionally stable, and considered suitable to take part. As a GP, I also brought clinical experience in assessing capacity and readiness to participate in sensitive conversations. Before recording began, I spoke with each young person about the study, the nature of the interview, confidentiality, and their right not to answer questions or to stop at any time, to confirm that they understood the research and were able to give informed consent. All participants then provided verbal and written consent to participate and to have the interview recorded. After each interview, I had a plan to check-in with hub staff about whether any further support was needed. In practice, all young people were willing and comfortable participants, and no concerns arose. Further detail on consent and safeguarding is provided in the ethics section below.

Interview sample size and information power

I judged the adequacy of the formal interview sample using Malterud, Siersma and Guassora's concept of information power[141]. Information power proposes that the more relevant and in-depth information a sample holds for the study aim, the fewer participants are required. In this study, the interview sample had strong information power for five reasons.

First, the study aim was focused: interviews were not intended to represent all young people or all hub staff in England, but to deepen understanding of how care was enacted within three purposively selected Early Support Hubs. Second, the sample was specific: staff participants were selected because they occupied roles central to the hub model, including drop-in, advice, youth work, counselling, safeguarding, clinical liaison, operations, participation, and specialist support. Young people were selected because they had direct experience of hub support and, in several cases, sustained involvement through youth participation, advisory, peer research, or group roles. Third, the interviews were theoretically informed by the study's prior engagement with ethics of care, logics of care, youth mental health hubs, and health systems and focused ethnography. Fourth, the quality of dialogue was strengthened by the fieldwork design: most interviews occurred after periods of observation and informal conversation, so I entered them with contextual knowledge of the site, the participant's role, and the organisational issues they were navigating. Fifth, interviews were not the sole data source. They were analysed alongside more than 200 hours of observation, fieldnotes, informal conversations, documentary review, analytic memos, and cross-case comparison. For these reasons, the interview sample was sufficient to support the study's interpretive and case-oriented aims, while remaining appropriately bounded and de-identified.

Fieldnotes and documentation

Fieldnotes were recorded in a style consistent with Clifford's account of inscription, transcription, and description[127]. During observations in drop-in spaces, youth groups, meetings, and informal interactions, I recorded brief inscriptions in real time. These were often fragmentary words or short phrases. Their purpose was to act as an aide-memoire, capturing details that might otherwise have been lost and creating a small degree of analytic distance from unfolding events.

Transcription notes were written during observation periods when I had informal conversations with staff or young people in communal spaces, or when I debriefed with staff at the end of a session to clarify what I had observed. These notes aimed to capture the language people used to describe their experiences, motivations, concerns, and interpretations of young people's support needs. Where appropriate, I

checked with participants that my notes reflected the substance of what they intended to convey. All notes were de-identified at the point of writing.

Description was produced primarily at the end of each day of observation. I reviewed inscriptions and transcription notes and expanded them into fuller narrative accounts of interactions, routines, atmosphere, and organisational culture. I wrote with attention to sequence, setting, relational dynamics, and to how staff understood what they were doing and why. These descriptive accounts were later developed into analytic memos, usually every two to three days.

Analytic memos were often dictated initially to allow freer association, then edited into a more structured form and shared with supervisors. Supervision occurred at least monthly, with additional informal contact when salient themes or ethical uncertainties arose. Alongside supervisory discussion, I maintained a reflexive journal at the end of each fieldwork week and after supervision to track how feedback reshaped my interpretations and how my own positioning and values were entering the analytic frame. As Van Maanen suggests, ethnography is shaped not only by what is observed, but also by the narrative and rhetorical conventions through which it is rendered[111]. I therefore often organised each day into short vignettes, aiming to write with care and restraint while remaining attentive to meaning, motivation, pressure, and how care was understood by those involved.

Data analysis

This section explains how I analysed the doctoral case study research. I first describe the analytic process used for the ethnographic case studies, including coding, within-case interpretation, and comparison across cases. I then outline how I approached trustworthiness, sense-checking, limitations, and the use of vignettes in presenting findings. I conclude by clarifying the analytic relationship between the case study research and the national evaluation, since the two strands developed alongside one another in practice while remaining distinct in formal analysis.

Case study analysis and coding process

My analysis of the case study component was iterative, inductive, and interpretive, consistent with the pragmatist and ethnographic orientation of the project.

Following Pope, Ziebland, and Mays, I treated analysis as a process that developed alongside data collection, with early observations and interpretations shaping subsequent interviews, attention in the field, and emerging lines of inquiry[142]. This was particularly important for an ethnographic case study design, where patterns, tensions, and organisational logics became clearer through repeated movement between observation, fieldnotes, interviews, and supervision.

I drew on Braun and Clarke's reflexive thematic analysis, working through familiarisation, coding, exploration of patterns and concepts, and iterative refinement of themes[143]. I did not begin with a fixed coding frame. Instead, I generated codes through close engagement with transcripts, fieldnotes, analytic memos, and reflexive notes, and progressively refined these as patterns became clearer across sites and participant groups. Themes were not treated as discoveries waiting to be extracted from the material, but as interpretive constructions developed through sustained engagement with the data.

I undertook coding manually. Because I conducted all observations and interviews myself, and reviewed, edited, and cleaned all transcripts, familiarisation with the data began during fieldwork and continued throughout the writing process. Further familiarisation involved repeated rereading of transcripts and fieldnotes, with annotations first made in Word documents through highlighting and comments, and later by hand on printed summaries and transcripts with photographs of physical hub spaces (with no staff, young people, or personally identifiable or confidential information represented). I generated initial descriptive and conceptual codes in the margins, highlighting recurring ideas around care practices, workforce relationships, safeguarding thresholds, youth voice, and relationships with statutory services. I then clustered these into provisional thematic groupings and revised them iteratively as comparison progressed.

This manual approach was deliberate. I experimented with NVivo early in the project, but for this dataset I found software-assisted coding more time-consuming and less helpful to the kind of close, case-oriented comparison I needed. Pope, Ziebland, and Mays note that paper systems, matrices, spreadsheets, and manual cut-and-paste approaches, although labour-intensive, can help the researcher develop an intimate knowledge of the data, and that software does not in itself

reduce the interpretive labour of qualitative analysis[142]. That reflected my experience; printing transcripts and summaries, annotating them by hand, drawing connections across pages, and physically arranging documents allowed me to work holistically across interviews, observation days, and sites. For this project, manual analysis supported sustained immersion rather than distance from the material.

Following Stake's account of case study methods, analysis was ongoing throughout fieldwork[99]. Early interviews and observations generated provisional concepts, which I recorded in reflexive journals and analytic notes. This informed subsequent data collection. I adjusted interview questions to explore emerging relationships, tensions, and the meaning participants gave to their work or interactions with hubs. This process is often described as progressive focusing: an iterative narrowing and refining of analytic attention as understanding deepens through engagement with the field[144].

Analysis moved between within-case interpretation and cross-case comparison. I first developed narrative and analytic accounts of each hub as a standalone case, synthesising interviews, observation, documentary review, and fieldnotes. These within-case accounts then formed the basis for systematic comparison across sites. By laying summaries, observation days, and interview excerpts alongside one another, I examined how hubs conceptualised their work with young people, spoke about mental health, organised relational care, navigated informal and often hidden work, and positioned themselves within local systems. Through this process, and through ongoing supervisory dialogue, I developed a set of cross-cutting interpretations about the model of care enacted by Early Support Hubs and the conditions shaping that model in practice.

Theoretical concepts, such as Mol's logics of care[16], were integrated inductively. Early in the analysis, I attended to recurring tensions in how hubs described and enacted care, including tensions between flexibility and standardisation, relational presence and measurable outputs, and youth work ethos and clinical accountability. These empirical patterns resonated with theoretical discussions introduced in earlier chapters. Theory functioned as an analytic resource and foundation for reflection rather than a template for organising data. It helped sharpen attention to patterns that were already becoming visible in the data. Crabtree and Miller describe

qualitative analysis as a form of dynamic craft rather than a mechanical procedure[145], and I approached it in this way, combining repeated close attention to the material with creative and reflexive judgement, in dialogue with supervisors.

I produced a one-page de-identified analytic summary for each interview, and each significant day of fieldwork, and on some occasions for a cluster of closely related observation days within hubs. These summaries distilled key concepts, illustrative quotations, contextual notes, and emerging questions. They functioned as analytic case synopses and as tools for comparison. From these summaries, I developed comparative memos at several levels: across young people's accounts within a site, across staff interviews within a site, and across the three hubs. These memos were discussed in supervision and revised in response to challenge and critique. I found that the most generative comparisons occurred when working with the smallest meaningful analytic unit: a single interview or a cluster of closely related observation days laid out side by side, with quotations and contextual detail still visible.

Supervisory review sessions functioned as more than structured analytic dialogue. They created a space for me to test emerging interpretations, reflect on my own assumptions, and step back from the density of the material to see broader patterns without losing sight of case-specific detail. I brought the physical printed summaries and memos outlined above to meetings and used these to interrogate conceptual boundaries, deviant cases, and the adequacy of emerging interpretations. These discussions often helped me see the wood for the trees, especially when I was very close to a particular case, interview, or cluster of observations. We developed what we informally referred to as a 'long dining table' method: a manual system of laying out interview summaries, fieldnote excerpts, and comparative memos across a large surface in order to examine patterns without collapsing the cases too quickly into abstraction.

To strengthen transparency, I later created an Excel coding matrix retrospectively from my interview data which I discussed with supervisors. This Excel matrix did not contribute to the analysis but provided a simple system for transcribing quotes during the final writing process. I developed it to document the analytic categories,

quote excerpts, and cross-case comparisons more systematically and to provide an audit trail for readers and future researchers which can be provided on request.

Trustworthiness, sense-checking, and limitations

Golden-Biddle and Locke argue that ethnographic texts persuade through authenticity, plausibility, and criticality[146]. These ideas were helpful to this study because they foreground the work of writing and interpretation. Throughout the findings and analytic chapters, I have tried to sustain authenticity through close attention to physical spaces, routine interactions, and local meanings, plausibility by making the analytic argument visible and linking it to wider debates, and criticality by surfacing tensions in care, funding, accountability, and professional identity rather than presenting hubs as either idealised solutions or poorly functioning organisations. This approach relates to trustworthiness in case reports as described by Lincoln and Guba, who in comparison to Golden-Biddle and Locke, highlight the importance of credibility, dependability, confirmability, and transferability[147]. These features were strengthened through prolonged engagement across three sites, persistent observation, triangulation across interviews, observations, informal conversations, and documentary materials, and repeated supervisory dialogue in which interpretations were tested and refined. Supervisory dialogue also functioned as a form of analytic triangulation, with emerging interpretations repeatedly tested, challenged, and refined.

At the conclusion of my analysis, I conducted a sense-checking exercise with each participating case study site[98]. I prepared a non-academic service evaluation report for each hub, synthesising my observations and interpretations, and presented these in online meetings open to all staff. Participants were invited to question, extend, or disagree with the analysis, and to provide written feedback on the document. The purpose of this process was not to achieve complete consensus, but to foster dialogue and ensure that my interpretations were intelligible, contestable, and grounded in the realities of the settings from which they were drawn.

There are limits to the research approach taken. This was a focused ethnography conducted over defined periods within three purposively selected hubs. My presence was intermittent rather than continuous, and I did not follow individual

young people longitudinally. While the cases provide analytically rich accounts that illuminate patterns and tensions within particular contexts, the findings of this ethnographic study are not universally generalisable across England. Their transferability rests with the reader and is supported by thick description, careful boundary-setting, and cross-case comparison.

Narrative formed part of my analytic strategy and reporting structure. For each findings chapter, I begin with a brief vignette of my first day at each hub, drawing on traditions of structured narrative in health services research, and later I include vignettes of poignant encounters across the course of the chapter. Such vignettes, used effectively in health systems ethnography, ground conceptual claims in situated experience[148]. Clinician-author Abraham Verghese has demonstrated the power of narrative vignettes to capture complexity and moral texture in healthcare on the subject of medical error[149]. I use short vignettes to bring analytic themes to life in each results chapter. Vignettes are de-identified and composite where necessary to protect participants, while preserving contextual integrity.

Analytic relationship between the case studies and Quality Framework evaluation

The case study research and the national evaluation were iterative in practice and distinct in formal analysis. Both strands addressed the same evolving academic and policy problems: how to understand, define, and strengthen Early Support Hubs as an emerging model of care. The case studies examined how care was enacted in everyday practice across three English hubs. The national evaluation examined how quality in the hub model was conceptualised across the wider sector and translated into the Youth Access Quality Framework.

The relationship between the strands was shaped by the pragmatist orientation of the DPhil. Knowledge developed through active engagement with a changing field of practice, policy, advocacy, and research. During the period from April to November 2025, emerging case study insights informed how I approached the Quality Framework process. Observation and interviews drew my attention to trusted relationships, open access, youth voice, safeguarding, workforce support, internal coordination, system integration, and the difficulty of evidencing relational

and preventive work. These concerns shaped the questions I asked in scoping interviews, workshops, Steering Group discussions, and public consultation.

The national evaluation informed my developing interpretation of the case studies. Through the Quality Framework process, hub leaders, young people, commissioners, funders, standards bodies, and policy actors repeatedly described what they understood quality, impact, evidence, and model integrity to mean. This sharpened my sensitivity to features of the case study data that were especially important for analysis: how services defined their model, how they balanced flexibility and standardisation, how they understood youth voice, how they evidenced quality, and where consensus and productive disagreement revealed unresolved tensions in the field.

The formal analysis of the two components remained separate. In Chapters 5 to 8, I analyse the data generated through the three ethnographic case studies: observation, interviews, fieldnotes, informal conversations, documentary materials, analytic memos, and cross-case comparison. The national evaluation data are not used as evidence within those case study chapters. The Quality Framework work had its own dataset, governance arrangements, purposes, outputs, and decision-making processes. Its data included scoping interviews, youth co-design, workshops, public consultation, Steering Group discussion, and iterative framework development. These are analysed separately in Chapter 9.

The timing of the analysis also supported this distinction. The Quality Framework project concluded in November 2025. I then used the following three months, from December 2025 to February 2026, to focus intensively on doctoral case study comparison and analytic writing. By this stage, my understanding as a researcher had been shaped by both strands, but the evidential basis for the case study chapters remained the case study material alone.

Chapter 10 brings the two strands into dialogue. The synthesis draws on the case studies to theorise the model of care enacted by Early Support Hubs in England, and on the national evaluation to examine how quality in that model was defined, debated, and made usable for policy and practice. This dialogue supports the thesis' wider argument: Early Support Hubs were moving from a broad and flexible service

category towards a more specified model of care, while retaining local adaptation, relational practice, and youth voice as central features of the model.

National evaluation and Quality Framework development

This section describes a separate but related strand of work that I undertook during the DPhil period: a national evaluation commissioned by Youth Access to develop the Youth Access Quality Framework. This evaluation ran alongside my ethnographic case studies, but it was methodologically and analytically distinct from the doctoral case study research. It arose as an organic consultation opportunity during the DPhil, shaped by the project's policy orientation and by my developing expertise in Early Support Hubs, but it was not part of the original empirical case study design.

Youth Access has given verbal and written permission for the Youth Access Quality Framework to be included and discussed within this doctoral thesis. I am grateful to Youth Access for permitting this. The intellectual property in the framework remains theirs.

Rationale for the National Evaluation Strand

The opportunity for the national evaluation emerged in late 2024, when the Chief Executive of Youth Access approached me about an open tender to develop a national quality framework for hubs in England. Youth Access self-funded the project in the context of growing government interest in hub services expansion through the developing Young Futures Hubs agenda. Although there had been earlier attempts within the sector to describe shared standards, these had not produced a widely accepted framework. Hubs varied in scale, governance, service offer, and organisational history, and there was no agreed account of what "quality" meant within this model.

With my supervisors' support, I applied for the tender and was appointed in April 2025 as Project Lead on a paid consultancy basis, with Youth Access as the client organisation. This opportunity aligned closely with the broader pragmatist orientation of the DPhil. My case study research could generate deep understanding

of care in three local settings, but it could not on its own produce a practical tool that services could use for quality improvement or that commissioners and funders could use to understand the model. I took on the national evaluation to address that gap. It also responded to a policy moment in which there was a risk that hub "quality" would be defined primarily through narrow compliance or performance logics rather than through the relational, developmental, and youth work values that services described as central to their effectiveness.

Insights from my case study fieldwork informed my understanding of the Early Support Hub model and therefore shaped the process of the national evaluation. However, I kept the analysis of the case studies distinct from the evaluation, which had its own governance, users, outputs, and decision-making processes. In the case study findings reported in Chapters 5 to 8, I sought to understand the model of care enacted by Early Support Hubs through detailed analysis of three organisations in practice. In the national evaluation, I sought to understand how quality in that emerging model was conceptualised across the sector and whether it was possible to develop a national voluntary framework that services, commissioners, funders, and policymakers could use. I present the national evaluation findings in Chapter 9 and then combine and analyse the research and evaluation through the discussion in Chapter 10. This structure made the most sense because the two components were methodologically distinct but conceptually related, and their combined analysis allowed me to move from local enactments of care to the national attempt to define, support, and standardise quality within the model.

The Youth Access Quality Framework was launched by Youth Access in December 2025, with further implementation work continuing into 2026.

Evaluation design and methods

I designed the evaluation using three applied methodological orientations: Utilisation-Focused Evaluation, appreciative inquiry, and participatory co-design with young people. This orientation aligned closely with the broader pragmatist stance of the DPhil, because it treated usefulness in practice as a central evaluative principle.

First, Michael Patton's Utilisation-Focused Evaluation begins with a practical question: who will use this, and how?[150], [151]. It provides a structured approach that starts with clarity about the purpose of the evaluation, identifies the primary intended users, and prioritises what matters most to them. It also requires an explicit theory of change, iterative review of emerging data, and active attention to how findings will be interpreted and applied. In this project, utilisation-focused evaluation helped me design the framework as a tool for use in practice rather than as an external audit instrument. It also gave me a disciplined way to keep returning to usefulness as the key judgement criterion when trade-offs arose.

Second, I drew on Cooperrider's appreciative inquiry as a strengths-based approach to organisational learning and change[152]. This mattered in a voluntary sector context where hubs operated under long term and fluctuating resource constraints. Beginning from what hubs were proud of, what they believed enabled good care, and what they wanted to protect was both ethically appropriate and methodologically useful.

Third, I had the opportunity to make youth co-design central to the project. Young people were involved not as consultees at the end of the process, but as active contributors to the design and facilitation of creative workshops, the drafting and line-by-line review of the framework, and its wider communication and advocacy. This participatory approach strengthened the evaluation by improving its relevance, credibility, and legitimacy among young people and hub services for whom youth voice is a central value. I describe this process in more detail in the following subsection.

Youth Access commissioned the project with an explicit theory of change. At the outset, we agreed that a voluntary self-assessment quality framework should support four linked goals:

1. strengthen quality through structured self-reflection and quality improvement within established hubs
2. support emerging services to expand their offer and develop into hub models
3. provide commissioners and funders with a shared benchmark for what good looks like in this model and how to resource it

4. inform national policy discussion by clarifying what hubs offer and what quality within them entails

These aims were agreed at project outset and shaped the design of the evaluation from the beginning.

Conceptual approach to youth co-design

The Quality Framework evaluation incorporated youth co-design as a methodological expression of the ethics of care[153]. The process was designed to ensure that young people with lived experience of hub services had substantive influence over how quality was defined, interpreted, tested, and communicated. This reflected the wider theoretical position of the thesis: that care is enacted through relationships, attentiveness, responsiveness, responsibility, and the practical conditions that allow people to participate safely and meaningfully[18], [19].

Co-design was used to support collective creativity and production across the development of the Quality Framework. In partnership with Youth Access, I drew on Sanders and Stappers' definition of co-design as collective creativity applied across the whole span of a design process[154]. The Youth Engagement Co-designers were positioned as people with experiential knowledge and creative and analytic skills directly relevant to defining quality in services designed for young people. Their role was to help shape the questions asked of young people, the methods used to explore those questions, the interpretation of workshop findings, the language and content of the Quality Framework, and the feedback returned to participants.

Youth voice was treated as a principle of quality and a condition of methodological legitimacy. The Quality Framework aimed to define what good looks like in hub services, and within this sector, the legitimacy of hub services depends partly on the integration of youth voice. Through discussion with hub staff, young people, the Steering Group, and Youth Access, Youth Voice became the first foundational standard of the Quality Framework on which services are assessed and measured[93]. Its placement at the front of the framework was both a methodological commitment in how the framework was developed and a finding from the evaluation process of what quality is in a hub. The co-design process

therefore supported methodological coherence, ethical legitimacy, and sector credibility.

Experiential knowledge was treated as a form of evidence about quality. The youth co-design process focused on what the Youth Engagement Co-designers and the young people we worked with had experienced in hubs, CAMHS, general practice, schools, community services, and other sources of mental health and wellbeing support. Their experiential knowledge helped define what quality meant, where services became difficult to access or trust, and what forms of care were recognised as safe, respectful, and useful. I understood these data through the lens of experience-based design outlined by Bate and Robert[155], where healthcare improvement depends on learning from knowledge generated through direct encounters with a service, including its spaces, relationships, thresholds, routines, exclusions, and moments of help or harm.

Power and influence were considered explicitly before the project began and throughout its development. Youth Access and I discussed where the Youth Engagement Co-designers could hold meaningful influence within the constraints of a commissioned national evaluation. Drawing on experience-based co-design work by Donetto and colleagues[156], I understood co-design as requiring attention to role renegotiation, decision-making, and the distribution of interpretive authority between service users, researchers, staff, and institutions. In this project, power and influence were supported through two main routes. First, the co-designers led the youth consultation process, including workshop design, facilitation, analysis, synthesis, presentation to the Steering Group, and the production of the youth-facing feedback zine. Second, they were involved in the evolving Quality Framework itself through access to draft documents, short briefings at the start of weekly meetings, discussion of emerging concepts, contribution to the literature review, review of consultation findings, and supported line-by-line review of the final framework language. This meant that they had opportunities to question, disagree with, redirect, or refine any element of the Quality Framework as it developed.

The limits of co-design were also shaped by the speed, scale, and governance of the project. Youth Access remained the commissioning organisation and owner of the

Quality Framework. I led the evaluation design, synthesis, and drafting. The Quality Framework was a lengthy and fast-moving document, and it would have been unreasonable to expect the co-designers to review every iteration in full. Instead, the process was adapted so that they could access current drafts if they wished with their time paid, receive clear summaries of changes, discuss key conceptual decisions in weekly meetings, and receive dedicated time and support for reviewing the parts of the framework where their lived, creative, and analytic expertise was most directly relevant. Their strongest areas of influence were youth consultation, accessibility, language, interpretation, tone, and the embedding of youth voice throughout the framework. The practical organisation of this process is described in more detail in the following section.

The co-design process was structured around Youth Access's existing principles for youth-led social action and Lundy's model of participation[157]–[159]. These frameworks emphasise space, voice, audience, and influence as necessary conditions for meaningful participation. Space meant creating regular, accessible, supported opportunities for young people to contribute. Voice meant using creative, flexible, and non-clinical methods that allowed young people to express what quality meant to them. Audience meant ensuring that the co-designers' analysis was presented to the Steering Group, Youth Access, and the wider sector. Influence meant documenting how young people's contributions shaped the Quality Framework and closing the feedback loop through the "You Said, We Did" zine.

The practical standards for youth involvement were checked against Lloyd et al.'s review, titled 'No decision about me, without me', which focuses on youth participation in mental health research[160]. Lloyd and colleagues outline the conditions for meaningful involvement with young people, including careful scene-setting, clarity about roles and decision-making, safeguarding, flexible routes to contribution, fair remuneration, skills development, and feedback about impact. These principles shaped the organisation of the co-design process from recruitment through to final review. They informed the decision to recruit paid co-designers through existing hubs, provide interview questions in advance, agree clear expectations, offer training and development opportunities, allocate work flexibly, and build in multiple routes for raising concerns.

Safeguarding and relational support were central to the ethics of the co-design process. Guo et al.'s guidance on youth participation and mental health safeguarding provided an additional basis for the practical design of the work[161]. Their emphasis on boundaries, access support, wellbeing, emotional safety, and realistic expectations was important because the evaluation involved young people with lived experience discussing mental health services, distress, unmet need, and difficult experiences of care. Safeguarding arrangements, named support people in host hubs, emotional check-ins, debriefs, access adjustments, payment, and flexible work allocation were therefore part of the method itself. These arrangements created the conditions under which young people could contribute without the work becoming extractive or unsafe.

The ethics-of-care orientation was reinforced by Mand et al.'s account of involvement and by Mendes et al.'s work on youth mental health co-production[153], [162]. These accounts emphasise relational responsibility, emotional attentiveness, dialogue, flexibility, and mutual respect. This aligned with what I observed across the co-design process. The co-designers' contributions were strongest when the working structure allowed enough preparation, emotional safety, informality, flexibility, and trust for them to think critically and creatively. In practice, care was expressed through timely communication, predictable weekly online meetings, supported travel, access adjustments, debriefing after emotionally demanding sessions, and willingness to adapt workload when life circumstances changed.

The three Youth Engagement Co-designers were integral to the Quality Framework process. They have given permission for their first names, associated hubs, locations, and photographs to be used in public-facing work. I was fortunate to work with Amy from 42nd Street in Manchester, Kyra-Sky from No5 Young People in Reading, and Charlotte from the Isle of Wight Youth Trust. Each brought a different combination of lived experience, creative practice, policy interest, analysis, facilitation, writing, and advocacy skills. The practicalities of their involvement are described in the following section. It is impossible to clearly delineate their influence and impact retrospectively because they were central to the process and informed the Quality Framework at every stage. Their involvement strengthened the relevance, accessibility, tone, and legitimacy of the Quality Framework, and

provided a practical example of the relational and youth-centred care that the framework itself sought to describe.

How youth co-design was organised in practice

Youth co-design was organised through three paid Youth Engagement Co-designer roles developed with Youth Access. Youth Access circulated an advertisement through member hubs and their youth voice groups. Applicants were asked to describe their interest in youth mental health, their experience of hub services, and the skills they wished to contribute or develop through the project. To take part, each young person needed to be linked with a hub and to have a named support person within that organisation. This requirement provided a safeguarding and wellbeing structure around participation, so that young people had a known local contact outside the national project team if they needed support.

Recruitment was designed to be accessible and transparent. Six applicants were invited to interview with me and the Youth Access policy lead. Interview questions were provided in advance to support access requirements and to reduce unnecessary anxiety. Selection was based on agreed criteria, including interest in youth mental health and service improvement, lived experience of hub services, communication and creative skills, capacity to work collaboratively, availability across the project period, and interest in developing skills in research, facilitation, analysis, presentation, writing, or advocacy. We also considered how the selected co-designers might work together as a small team, including the balance of their strengths, interests, geographic locations, and preferred modes of contribution. Amy, Charlotte, and Kyra were offered roles in our first round, and all accepted.

Onboarding was treated as part of the method because it shaped whether young people could participate safely and confidently. Youth Access supported the co-designers to set up tax and invoicing arrangements, complete contracting requirements, and undertake safeguarding training and DBS processes before commencing the project. Co-designers were paid £25 per hour for their time, and reasonable travel, food, and other expenses were covered in addition. This also included payment for meetings, preparation, workshop facilitation, analysis, review of documents, presentation work, and contribution to communications. Fair

remuneration was important because the project asked young people to contribute skilled labour, lived experience, creative work, and analytic judgement.

The working structure was agreed collaboratively at the start of the project. Because the team was geographically dispersed across Manchester, Reading, the Isle of Wight, and Oxford, we agreed to meet weekly online. My responsibility as project lead was to provide clear communication, predictable meeting structures, written materials in advance, and practical adjustments for access needs. For one co-designer, this included ensuring that documents could be printed and reviewed in hard copy, with funding provided for printing. Written agendas, notes, and draft materials were shared in advance wherever possible, so that participants could prepare in the way that suited them.

Weekly meetings were designed to combine emotional grounding, project coordination, and shared decision-making. At the co-designers' suggestion, each meeting began with a short creative emotional grounding activity (for example, draw what weather or animal you are feeling like today and why?), facilitated in rotation. This helped create a working rhythm that was relational, reflective, and less formal than a conventional project meeting. We then reviewed where the project had reached, what decisions were needed that week, and what tasks needed to be completed. Activities were allocated together, taking account of each co-designer's availability, access needs, interests, skill-development goals, and confidence with different kinds of work. Each agreed task had a named person, timeframe, and follow-up plan.

The main purpose of the weekly working group was to enable the co-designers to lead the youth consultation process and contribute to the evolving Quality Framework. The design, delivery, and analysis of the young people's workshops are described in the following section. Within the working group, the co-designers shaped the purpose of those workshops, decided that creative methods would be more appropriate than conventional focus groups alone, and used their developing analysis of workshop findings to inform the framework. My role was to support facilitation, document decisions, maintain links with Youth Access and the Steering Group, and translate emerging findings into draft framework language.

The co-designers' analysis was connected to decision-making structures throughout the project. They presented their synthesis of youth workshop findings to the Steering Group and described what young people wanted from hubs and mental health services. Their findings emphasised clear communication, respect, recognition of identity and background, understanding of social and economic barriers, shorter waits, accessible explanations of support, and willingness from services to learn. This presentation helped position youth voice as a practical quality requirement within the framework.

The co-designers contributed to the evolving Quality Framework over the course of the evaluation. They were given access to draft documents throughout the project, and weekly meetings included short briefings on how the framework was changing. Because the document was long and revised frequently, they were not expected to read every full draft. Instead, they were supported to engage with the framework in several ways: discussing key concepts as they emerged, reviewing youth-facing sections and language, contributing to interpretation of consultation feedback, testing whether draft wording matched the youth workshop findings, and identifying where language felt inaccessible, bureaucratic, unclear, or insufficiently relational. They also contributed to the literature review and interpretation of youth participation evidence, with the intention that they will be co-authors on future outputs from this strand of work.

Dedicated time was set aside for a final review of the Quality Framework. After the youth workshops had been completed and analysed, the co-designers were supported to review the full framework line by line. This review drew on their lived experience, their experience of facilitating workshops, and their analysis of young people's feedback. They provided verbal and written comments on tone, accessibility, language, omissions, and whether the framework reflected what young people had said. Their feedback informed revisions across Youth Voice, Trusted Relationships, Accessibility and Anti-Oppressive Practice, Safe and Welcoming Spaces, Values and Culture, and the Services areas.

Routes for raising concerns were built into the process. Co-designers could raise issues in the group, individually with me after meetings, with the Youth Access policy lead, or with their named support person at their hub. These multiple routes

were deliberate because young people may not always feel able to raise concerns directly with the person leading or paying them for the work. In practice, the project required ongoing flexibility. One co-designer experienced housing instability and needed adjusted workload expectations, additional check-ins, and practical support coordinated with their hub contact. Another experienced significant anxiety about travel from a rural area and needed detailed planning and support to participate safely. After emotionally demanding sessions, debriefing and follow-up were used to check whether the work remained manageable.

Skill development was treated as part of meaningful participation. At the outset, the co-designers were asked what they wanted to learn or practise through the project. Across the evaluation, they were supported to develop skills in facilitation, qualitative analysis, presentation, written communication, literature review, advocacy, and professional collaboration. The distribution of tasks reflected both project needs and the skills each co-designer wanted to build. This mattered because the project relied on young people's labour and experience, and therefore had a responsibility to offer development, recognition, and practical benefit in return.

The co-design process had limits. The three co-designers could not represent all young people using hubs, and the workshop participants were recruited through existing services, meaning that young people not connected to hubs were less visible in the process. The project was also commissioned, time-limited, and oriented towards producing a practical Quality Framework for Youth Access. These constraints shaped where decision-making could realistically be shared. Within those limits, the co-designers had sustained influence over the questions asked of young people, the methods used to gather youth perspectives, the interpretation of workshop data, the presentation of findings, the accessibility and tone of the framework, and the feedback returned to participants. Their involvement was therefore central to the credibility and usefulness of the Quality Framework.

Evaluation data collection and analysis

I led and conducted the data collection and analysis iteratively, with opportunities across the project for hubs, young people, and system stakeholders to shape the emerging definitions and indicators of quality. This reflected the utilisation-focused

evaluation emphasis on ownership, use, and responsiveness, and helped build collaboration and legitimacy across the sector. A recurring message from hubs was that they did not want a self-assessment framework that felt, in one participant's words, like "Ofsted vibes", referring to school inspection and audit processes with the Office for Standards in Education, Children's Services and Skills. I treated this as important feedback for both design and implementation. If the framework felt like top-down surveillance or unnecessarily cumbersome, it was unlikely to be trusted or used well in practice. Participation, tone, and usability therefore became central concerns throughout the evaluation.

Although I led the overall evaluation design and synthesis, elements of data generation and analysis were shared with Youth Access staff and the Youth Engagement Co-designers. Most notably, the co-designers created and facilitated the young people's workshops and played a central role in analysing the workshop data. Their interpretations informed both the workshop synthesis presented to the Steering Group and the drafting of relevant areas of the Quality Framework. These findings are presented in Chapter 9 National Evaluation: The Youth Access Quality Framework. All evaluation activities for the framework were as summarised in the table below.

Table 4.3 Quality Framework development activities and data sources

Activity	Participants	Dates	Purpose	Output	Analytic contribution
Youth Access commissioning and project set-up	Youth Access Chief Executive and policy team, Isabel Hanson as independent project lead, DPhil supervisors consulted for fit with doctoral work	Late 2024 to April 2025	Establish the scope, governance, purpose and intended users of a national voluntary Quality Framework for youth hub services.	Project brief, agreed theory of change, consultancy appointment, governance arrangements and permission for inclusion in thesis.	Defined the Quality Framework as a separate but related national evaluation strand, analytically distinct from the doctoral case studies but conceptually linked to the thesis question.
Youth Engagement Co-designers	Three paid young co-designers aged 18 to 25 with lived experience of hub services, recruited through Youth Access networks	April to December 2025 (full scope of project and public dissemination)	Embed youth voice throughout the evaluation. Support workshop design, facilitation, analysis, draft review and communication of findings.	Weekly co-design meetings, facilitation training, qualitative analysis training, draft framework feedback and final youth-facing feedback zine.	Shaped the language, priorities, ordering and legitimacy of the Quality Framework. Enacted youth voice as a methodological principle rather than a late-stage consultation exercise.

Scoping interviews with hub leaders	Eight CEOs or senior managers from Youth Access member hubs, purposively selected for variation in size, geography and urban or rural context	April to May 2025	Understand how hub leaders defined quality, what they were proud of, what challenges they faced and how a framework might be used in practice.	Detailed contemporaneous notes from eight semi-structured online interviews.	Informed the first draft quality domains and helped identify what established hubs regarded as core to quality, feasibility and sector legitimacy.
Standards body interviews	Advice Services Alliance UK, British Association for Counselling and Psychotherapy, and National Youth Agency	April to May 2025	Understand existing quality assurance and accreditation approaches across advice, counselling and youth work, and explore possible passporting arrangements.	Structured notes from three standards-body conversations.	Located the Quality Framework within an existing standards ecology and clarified where it should align with, complement or avoid duplicating existing accreditation systems.
Literature and standards review	Academic literature on youth hubs, quality improvement,	April to May 2025	Ground the Quality Framework in relevant evidence on youth hubs, quality	Evidence summaries, draft quality architecture and	Supported the improvement-oriented design of the framework and

	implementation and service standards, existing quality frameworks and accreditation materials		improvement, organisational learning and healthcare quality systems.	early domain descriptors.	informed its emphasis on iterative learning, relational quality, youth voice, workforce development and proportionate evidence.
Steering Group oversight	Five CEOs from established youth hubs, senior experts in youth work and service quality, and Youth Access leadership	April to November 2025 (full scope of project)	Provide formal oversight, external scrutiny, sector challenge and iterative sense-checking throughout development.	Monthly Steering Group meetings, revised drafts, meeting notes and revision log.	Tested the framework against practical implementation conditions, helped calibrate expectations across different hub models and identified risks of unrealistic, inequitable or overly burdensome standards.
National hubs workshop	Hub practitioners and leaders from Youth Access member hubs and services involved in the Shared	June 2025	Test the draft Quality Framework with those working directly in and around hub delivery.	Ninety-minute online workshop, plenary discussion, breakout notes, Mentimeter polling	Generated sector feedback on clarity, relevance, feasibility and usability. Informed revisions to language, duplication, evidence

	Outcomes Fund programme, 38 participants			and researcher fieldnotes.	expectations and applicability across hubs of different size and maturity.
Commissioners and funders workshop	Government commissioners, Integrated Care Board commissioners and non-profit funders invited through Youth Access networks	June 2025	Explore how quality was understood, assessed and evidenced in commissioning and funding decisions.	Online workshop, discussion notes, Mentimeter responses and researcher fieldnotes.	Clarified the framework's external accountability functions and strengthened attention to evidence plurality, including quantitative outcomes, relational impact, local trust and young people's experience.
Young people's creative workshops	Thirty-eight young people recruited through host hubs, workshops facilitated by Youth Engagement Co-designers with support from Isabel	July to September 2025	Explore what young people understood quality to mean in hubs and mental health services, using accessible and creative methods.	Three workshops in Manchester, Croydon and online, annotated drawings, support maps, discussion notes, fieldnotes and workshop synthesis.	Identified young people's priorities around emotional, logistical and physical dimensions of hub quality. Shaped the Youth Voice, Trusted Relationships, Safe and

	Hanson and Youth Access staff				Welcoming Spaces, Accessibility and Anti-Oppressive Practice, and Services areas.
Public consultation	Hub staff, young people, funders, researchers, policy professionals, counselling regulators and other sector stakeholders, 36 organisational and individual responses	July to August 2025	Test the full draft Quality Framework for clarity, completeness, feasibility, usefulness and legitimacy across the wider sector.	Three-week public consultation, structured online responses, consultation log and thematic analysis.	Provided a final sector-wide quality assurance step. Identified areas requiring clearer wording, calibration and stronger treatment of equity, youth voice, workforce support, counselling scope, safeguarding and evidence requirements.
Iterative drafting, revision and sense-checking	Isabel Hanson, Youth Access staff, Youth Engagement Co-designers, Steering Group, hub stakeholders and standards bodies	April to November 2025	Translate evaluation findings into a usable voluntary Quality Framework and implementation approach.	Successive framework drafts, revision log, final Quality Framework, implementation recommendations	Integrated feedback across stakeholder groups and made visible areas of consensus and productive disagreement,

				and digital self-assessment content.	including relational evidence, proportionality, clinical and non-clinical boundaries, and self-assessment credibility.
Final Quality Framework and implementation planning	Youth Access, Isabel Hanson, Youth Engagement Co-designers, Steering Group and implementation partners	November 2025 to 2026	Finalise, launch and support implementation of the Youth Access Quality Framework and associated self-assessment tool.	Published Quality Framework, youth feedback zine, implementation report, digital self-assessment tool and 2026 implementation planning.	Produced the main output of the national evaluation and created the basis for analysing how quality in hub models can be defined, evidenced, supported and potentially misused.

Young people's workshops, July to September 2025 (n=38 participants across 3 workshops).
Three young people's workshops were held between July and September 2025, in Manchester City, Croydon in Southeast London, and online, reaching 38 young people between the ages of 18 and 25 years. Each workshop was designed to be accessible, creative, and safe for young people to speak from their own experience. The Youth Engagement Co-designers Amy, Charlotte, and Kyra-Sky designed and facilitated the workshops, with support from me for the first two workshops and from a Youth Access staff member for the final workshop. Participants were recruited through existing hubs, which shared an invitation with young people using their services through formal and informal youth participation networks. This provided a safeguarding structure in which all attendees were known to a hub, and a hub staff member was available for follow-up after the workshop if distress or safeguarding concerns arose. In practice, no safeguarding concerns were identified at any of the three workshops.

In addition to being paid for their time, young people attending the in-person workshops were provided with lunch, non-alcoholic drinks, tea, and cakes. Music was played as participants arrived, and the co-designers and I welcomed participants before sessions began. These practical details helped to set the tone: this was not a clinical consultation, but a space designed to feel welcoming and youth centred.

Workshop activities included three main activities. First was drawing "the weather in your head", a creative exercise used to build rapport and open emotional vocabulary before discussion. Second, a circle of support mapping activity, in which young people drew and annotated the relationships and resources they drew on for their wellbeing. Finally, with these two activities setting the context, the co-designers facilitated open discussion of what had felt supportive and unsupportive for the workshop participants in their experiences of mental health and wellbeing services. Each workshop closed with a structured debrief, an expression of thanks, and a clear explanation of where participants' data would go and how it would be used.

Workshop data were analysed collaboratively with the Youth Engagement Co-designers using an inductive thematic approach, drawing on their knowledge of the draft Quality Framework, the data, their experiences facilitating the workshops, and

their own lived experience. Following each workshop, fieldnotes, written outputs, annotated drawings, and discussion summaries were reviewed together in weekly project meetings. The co-designers identified recurrent themes across the three workshops, compared how they appeared in different settings, and grouped them into higher-order categories that captured what young people wanted from hubs and what they found difficult or unhelpful in services. My role was to support the analytic process, document decisions, and help translate emergent themes into draft framework language.

In November 2025, the co-designers produced a feedback zine, distributed to all young people who had attended, completing the feedback loop and reflecting the co-designers' commitment to valuing the voices of young people. A zine is a short, accessible, visually designed booklet used to communicate ideas in a creative and reader-friendly way, and it was design to capture what young people experienced in services and what they wanted more of. This can be viewed in Appendix B.

Scoping interviews with hub CEOs, April to May 2025 (n=8).

I conducted eight semi-structured online interviews of up to an hour in length via Microsoft Teams with CEOs or senior managers from Youth Access member hubs. I selected participants purposively in collaboration with Youth Access to reflect variation in size, geography, and urban or rural context, and sent interview questions by email in advance. Interviews explored how quality was defined and evidenced in practice, what hubs were proud of, current challenges, and how a framework might be used. These interviews were not audio-recorded. I took detailed contemporaneous notes and applied thematic analysis to shape the first draft quality domains in combination with the academic literature on hubs outlined in Chapter 2.

The decision not to audio-record these scoping interviews was pragmatic, reflecting the applied and developmental nature of the evaluation and the need to build trust quickly with senior hub leaders at the outset of the project. However, this created limitations. Contemporaneous notes cannot capture the full detail, phrasing, pauses, emphasis, and interactional texture of recorded interviews, and they provide a less complete audit trail for later analysis. They also increase reliance on the researcher's judgement about what was salient at the time. I mitigated this by using a semi-structured topic guide, sending questions in advance, writing detailed notes during

and immediately after each interview, and using the interviews primarily to inform the first draft of the Quality Framework rather than as a stand-alone evidential dataset. Emerging themes from the scoping interviews were then tested and refined through the Steering Group, hub workshops, youth workshops, standards body conversations, public consultation, and iterative drafting.

Standards body interviews, April to May 2025 (n=3).

I held structured conversations with three standards bodies relevant to core hub functions across advice, counselling, and youth work: Advice Services Alliance UK, the British Association for Counselling and Psychotherapy, and the National Youth Agency. My aim was to understand their approaches to quality assurance and to explore potential "passporting" arrangements, whereby existing accreditation or standards processes might count as evidence for relevant sections of the framework. All three organisations agreed in principle that this could be feasible, subject to implementation detail.

The number of standards body conversations was determined purposively rather than by sample size logic. These three organisations were selected because they corresponded to the three main practice and standards domains underpinning the Youth Access hub model: advice, counselling, and youth work. Advice Services Alliance UK was relevant to information, advice, and guidance; the British Association for Counselling and Psychotherapy was relevant to counselling and therapeutic provision; and the National Youth Agency was relevant to youth work, youth participation, and wider youth sector quality. The purpose of these conversations was therefore specific: to understand how the Quality Framework should relate to existing standards systems and where passporting might be possible. Additional interviews were not required because the aim was not to map all possible regulators or professional bodies, but to consult the standards bodies most directly aligned with the core functions of hub services.

Literature Review on Quality Improvement, April to May 2025

In addition to reviewing the academic literature on the hubs, the Quality Framework's improvement orientation drew on health systems literature on quality improvement[163], and on my own experience running a cardiovascular quality improvement project in general practice in Sydney, Australia. Working with PDSA

cycles in that primary care context[164], testing changes in practice on a small scale, studying outcomes, and adapting accordingly, made concrete what the literature argues in the abstract: that improvement involves a continuous process of iteration rather than a single destination. That orientation shaped the Quality Framework from the outset, positioning it as an instrument for ongoing organisational learning rather than a one-off compliance check.

In developing the Quality Framework, I considered existing UK healthcare quality frameworks while deliberately widening the definition of what counted as quality. Approaches such as the Quality and Outcomes Framework, clinical audit, and peer review in primary care have long structured quality monitoring and remain useful for driving measurable improvements[165], [166]. One limitation to this approach can be a tendency to privilege quantifiable outputs over the relational, experiential, and developmental dimensions of care that define hub practice[167]. The Quality Framework built on the rigour of these models while beginning from principles, placing youth voice, trusted relationships, and youth work ethos before governance and service delivery in the quality architecture.

The Health Foundation's reports 'The Habits of an Improver' and 'Quality Improvement Made Simple' reinforced the case that sustained improvement depends on organisational culture and staff capability as much as on targets[168], [169]. These ideas influenced the Workforce Development and Service Learning and Improvement areas of the Quality Framework. The result was a Quality Framework that offered a shared language for improvement across diverse services without imposing a single rigid model, and that treated quality as something services move iteratively towards over time.

Steering Group oversight, April to November 2025.

A monthly Steering Group provided formal oversight, external scrutiny, and iterative sense-checking throughout the development of the Quality Framework. The group met from April to November 2025 and included five CEOs from established youth hubs, two senior experts in youth work and service quality, and members of the Youth Access leadership team. This composition was intended to compare operational, strategic, and sector-level perspectives. Draft materials were circulated in advance of each meeting, usually including revised framework domains,

proposed quality statements, and specific questions for discussion where conceptual or practical tensions remained unresolved. Youth Access chaired while I presented the substantive content of these meetings, set the agenda in collaboration with Youth Access, presented the rationale for draft revisions, and invited challenge on areas of ambiguity, feasibility, or unintended consequences. Detailed notes were taken after each meeting and used as part of an ongoing revision log. This group played an important role in reality-checking the framework against the practical conditions of implementation, ensuring that standards were meaningful across different service contexts and identifying where proposed criteria might be unrealistic, inequitable, or difficult to operationalise.

National hubs workshop, June 2025.

In June 2025, I convened a structured 90-minute online workshop with 38 participants drawn from Youth Access member hubs and from services involved in the government's Shared Outcomes Fund programme. The purpose of the workshop was to test the draft framework with those working directly in and around hub delivery, and to gather feedback on its clarity, relevance, feasibility, and likely value in practice. Participants were sent the draft framework in advance so that the session could focus on substantive critique rather than first impressions alone. The workshop combined plenary discussion, small-group breakout sessions, and real-time polling. Breakout groups were facilitated by the Youth Engagement Co-designers, with Youth Access staff supporting notetaking in each online meeting room. This structure allowed participants to comment on specific domains, proposed standards, and areas of uncertainty. I also kept contemporaneous fieldnotes during the session, focusing on recurring concerns, points of consensus, and differences in perspective between services. Mentimeter polling was used to generate structured feedback on usability, content, and the overall framing of quality. The workshop generated both qualitative and simple descriptive data, which were reviewed after the session and used to revise wording, reduce duplication, and clarify how the framework should work across hubs of different size, maturity, and service mix.

Commissioners and funders workshop, June 2025.

I led a separate online workshop in June 2025 with government commissioners and non-profit funders to explore how quality was currently understood, assessed, and evidenced in commissioning and funding decisions. Participants were invited

through Youth Access networks and included Integrated Care Board commissioners and non-profit funders from across England. This session was designed to complement the provider-facing workshop by examining the framework from the perspective of those responsible for assurance, investment, and accountability.

Participants were asked how they currently judged service quality, what kinds of evidence they found persuasive, and where existing approaches failed to capture the value of early support hubs. The discussion highlighted the continued importance of quantitative information, particularly around access, reach, and outcomes, but also a clear recognition that these measures alone were insufficient. Participants emphasised the need for qualitative evidence capable of demonstrating relational impact, local trust, service accessibility, and the quality of young people's experience. As in the hubs workshop, I recorded detailed fieldnotes and used Mentimeter to capture structured responses. This workshop was important in showing that the framework needed to speak across two audiences at once: services using it for reflection and improvement, and external stakeholders using it for assurance and decision-making. It helped strengthen the framework's attention to evidence plurality by recognising both measurable outcomes and practice-based forms of value.

Public consultation, July 2025.

In July 2025, Youth Access hosted a three-week public consultation on the draft framework. A full draft and an accessible summary version were published alongside an online structured feedback form designed to elicit comments on clarity, content, omissions, feasibility, and overall usefulness. The consultation was circulated through Youth Access networks and invited responses from services, commissioners, funders, government partners, and young people. Thirty-six detailed organisational and individual submissions were received. These varied in length and format, but many included substantial written comments on particular domains, suggested revisions to language, and reflections on implementation challenges. I logged all submissions and undertook a thematic analysis of the feedback in partnership with the Youth Engagement Co-designers. We reviewed areas of repetition, disagreement, and strong endorsement, and grouped comments according to framework sections and cross-cutting themes. Emerging findings were then discussed with the Steering Group to support decisions about final revisions.

The consultation functioned as both a quality assurance step and a final test of sector legitimacy. It helped identify where draft standards required clearer wording, where expectations needed calibration, and where important issues such as equity, youth voice, workforce support, and proportionate evidence requirements needed stronger articulation.

Iterative Development and Sense-Checking

Development proceeded through repeated cycles of drafting, analysis, and sense-checking, with formal consultation points used to test both content and acceptability. After the initial scoping interviews and literature review, I generated an initial set of draft quality domains and descriptors. I then returned these to the Youth Engagement Co-designers and the Steering Group for critique, focusing on clarity, feasibility, and whether the framing aligned with hub values. I used feedback from standards bodies and the national hubs workshop to revise domains, refine language, and adjust expectations for services of different sizes and maturity.

Across the evaluation, I treated sense-checking as a continuous process rather than a final stage. After each major phase of data collection, I synthesised emerging themes and discussed them formally through Steering Group meetings, workshops, and interviews, and informally with stakeholders where relevant, to test whether they reflected lived realities and would be usable in practice. Weekly contact with the Youth Engagement Co-designers supported rapid iteration on accessibility and youth voice, while monthly Steering Group input provided leadership accountability and sector critique. Public consultation functioned as the final large-scale test of content and legitimacy. I analysed all submissions, mapped them to specific sections of the framework, and incorporated agreed revisions through final review with Youth Access, the Youth Engagement Co-designers, and the Steering Group.

Alongside the framework itself, we began developing a digital self-assessment tool and implementation guidance to support uptake. My final report to Youth Access included recommendations on implementation and support. I present the findings of the national evaluation, including the final Youth Access Quality Framework and its content, in Chapter 9.

Research and evaluation ethics

This section integrates the ethical considerations for both the doctoral case study research and the national evaluation. I have presented them in a single section because, although the two strands differed in governance and formal approval arrangements, the ethical issues they raised substantially overlapped, particularly around safeguarding, confidentiality, youth participation, and ongoing judgement in relational fieldwork.

Research ethics in the case study fieldwork

Ethical approval for the doctoral case study research was granted by the University of Oxford Central University Research Ethics Committee, CUREC 2, reference R95612/RE001. Participant information sheets and consent materials stated that the University of Oxford was the data controller for the doctoral research and that the study had received ethical review and approval through the University's processes.

Ethics in this project involved more than formal approval. In keeping with an ethnographic approach, I treated ethics as an ongoing practice of judgement in the field, particularly in relation to observation in shared spaces, informal conversations, confidentiality, safeguarding, and the protection of young people in early intervention youth mental health settings[170].

For the ethnographic component, I negotiated access with each participating service, which permitted my presence in designated public and shared areas of the hubs. In busy waiting areas, where it was not feasible to obtain verbal or written consent from every young person entering and leaving, posters were displayed with my photograph, a plain-language summary of the research, the topics under exploration, and a clear statement that no personal information would be recorded. This reflected the opt-out approach approved for observation in shared service environments. Participant-facing study materials, including posters, information sheets, and interview consent form, are included in Appendix C.

When informal discussions took place in shared spaces during fieldwork, young people were usually introduced to me by a youth worker or staff member, who explained my role as a researcher and the purpose of the study. Participation was

entirely voluntary. Had any young person appeared uncomfortable or raised concerns, I would have offered to leave the space. In practice, this did not occur. These informal conversations were not audio-recorded. Where they were documented in note form, I showed young people my brief notes afterwards, reflected back what I had written, and invited clarification or correction. This supported transparency and helped ensure that any recorded material felt accurate and respectful.

For formal interviews, all participants received written information sheets outlining the purpose of the study, the voluntary nature of participation, confidentiality arrangements, and their right to withdraw. Written informed consent was obtained before audio recording. The consent form stated that participants could withdraw at any time without giving a reason up to the date specified on the consent form. In line with the participant information sheets, any data already collected from participants who withdrew within the approved withdrawal period would be deleted and not used in the study. Although my original ethics approval included provision for go-along interviews with young people, none of the six young people interviewed chose this option in practice. All preferred to be interviewed in private rooms within the hub premises, which was easily accommodated.

Safeguarding and the management of disclosures were considered carefully throughout. In each hub, it was clear which staff members held safeguarding responsibility and were available if concerns arose. Young people who participated in interviews or informal discussions were discussed with staff beforehand and considered well and appropriate to take part. I also assessed willingness and understanding through conversation before proceeding. This was consistent with the ethics application, which specified that interview participants should be stable, willing, and able to provide informed consent, with capacity and appropriateness considered case by case in discussion with staff and through my own assessment before interview. Clear boundaries around confidentiality, including its limits, were explained at the outset of interviews. No disclosures arose that required safeguarding escalation.

I also made deliberate ethical decisions about where not to observe. I did not observe NHS clinical services directly, except for one afternoon of a primary care liaison

clinic in a private room where no other patients or NHS staff could be observed. I also chose not to observe one-to-one counselling sessions between accredited counsellors and young people. As a GP familiar with confidential therapeutic spaces, I judged that such observation was not sufficiently important to my research questions on the broader hub model of care to justify entering them. This decision helped protect young people's privacy and the integrity of the therapeutic relationship.

Ethics and safeguarding in the national evaluation

The national evaluation strand was conducted in collaboration with Youth Access, which held organisational insurance and safeguarding infrastructure for youth participation activities. I was contracted as an independent consultant and covered by my own professional indemnity insurance for this work. As a registered general practitioner working with young people, I also hold advanced safeguarding training and DBS clearance. All three Youth Engagement Co-designers completed DBS checks and safeguarding training appropriate to their facilitation roles.

There were two principal ethical considerations in the evaluation. The first concerned the wellbeing of the three Youth Engagement Co-designers. A clear arrangement was developed between Youth Access and supporting hubs to ensure shared responsibility for support and safeguarding. The work exposed co-designers to accounts of trauma, distress, and barriers to help-seeking, and this required active emotional attunement rather than procedural inclusion alone. On one occasion, following a workshop, a co-designer became visibly distressed. Immediate support was provided through debriefing, help with travel arrangements, and follow-up contact to ensure they returned home safely. Further support was coordinated with Youth Access and the host hub. The episode resolved well, but it reinforced the importance of shared safeguarding pathways and relational care within youth co-design work.

The second consideration concerned the young people attending workshops. These participants were engaged under Youth Access governance, with host hubs holding primary safeguarding responsibility. Written consent was obtained and held by Youth Access for participation and photography where relevant. Participants were

informed that notes and artwork produced in workshops would be synthesised anonymously. Young people were paid for their time and provided with lunch and refreshments. Risk registers and safeguarding assessments were completed for each workshop, and designated safeguarding leads were present throughout in-person and online sessions.

No safeguarding escalations were required during the evaluation process. At one Manchester workshop, a young person remained quiet and declined to introduce themselves. I checked in privately during the break to ensure they were safe and well. They reported no acute concerns, wished to remain present without speaking, and subsequently followed up with the hub safeguarding lead for additional support. No further concerns were reported.

Although the national evaluation was commissioned work conducted under Youth Access governance rather than under the doctoral ethics approval, the ethical issues were substantively similar: emotional exposure, power dynamics, confidentiality, and safeguarding. I therefore applied the same standards of transparency, care, and structured support to the evaluation as to the doctoral research.

Patient and Public Involvement and Engagement in Research and Evaluation

Patient and public involvement and engagement (PPIE) is an important component of health research and evaluation, particularly in mental health research where questions of relevance, acceptability, power, trust and epistemic justice are central[162], [171], [172]. Involving people with lived experience can improve the relevance of research questions, strengthen the quality of data analysis, and bring to light questions and issues that may otherwise remain invisible to researchers[162], [173], [174]. In youth mental health systems research and service design, participation and involvement are especially important because services are intended to be youth-friendly and responsive to young people's needs, priorities and preferences to improve access and engagement. This has led to the development of youth involvement models in both research and service settings, including the NeurOx Young People's Advisory Group model[175], youth participation strategies within Orygen and the participatory ethos of headspace[176], and recent reviews of

how young people are involved as experts by experience in mental health research[160].

PPIE is not a single method, and its inclusion is not an unambiguous marker of ethical quality in research and evaluation. A systematic review of PPIE frameworks in health research identified a theoretically heterogeneous literature, encompassing power-focused, partnership-focused, priority-setting, study-focused and reporting-focused approaches, each with different implications for practice[171]. Lignou, Sheehan, and Singh argue that different rationales sit behind PPI in mental health research, including outcomes-based, rights-based and emancipatory approaches, each carrying different implications for who should be involved, how involvement should be structured, and what ethical responsibilities follow[177].

Ilina Singh, a bioethicist at the University of Oxford whose work focuses on ethics in child and adolescent mental health research, has cautioned against assuming that more PPIE is automatically leads to better research. Singh et al. argue that, in the context of discovery science, concepts such as "lived experience", "voice" and "expertise by experience" require careful theoretical and ethical scrutiny, and that poorly conceptualised PPIE with weak support infrastructure risks tokenism, selective amplification of some voices over others, emotional burden, and the use of young people's accounts to legitimise pre-existing professional or institutional agendas[178], [179]. This doctoral research is social science rather than discovery science, but the caution is applicable: the purposes of PPIE should be conceptually clear, and the process should provide adequate preparation, remuneration, safeguarding and feedback, and not require young people to perform vulnerability, speak on behalf of a wider group, or disclose difficult experiences without support.

PPIE can be understood as an ethical practice requiring attention to power and care dynamics. Mand et al. argue that although PPIE often falls outside formal research ethics review, ethical issues arise because involvement is relational, emotional and embedded within power relations between researchers, the researched, and the institutions they operate within[162]. Drawing on the ethics of care theory foundational to this doctoral study[18], [82], they propose that PPIE should be evaluated not only through procedural principles but through attentiveness, responsibility, competence, responsiveness and solidarity. This framing relates to

both the process of conducting this doctoral work and its empirical findings that relational care, trust, boundaries, safeguarding and organisational conditions are central to how hubs function. This approach aligned with the ethical orientation is required within hubs, and in the research and evaluation processes that have been applied in this doctoral study.

For the case study research component of this thesis, I did not establish a separate PPIE advisory group. This was a deliberate decision, reached through discussion with supervisors, about the limited resource capacity of doctoral research and the ethical responsibilities involved in engaging young people with lived experience of mental health challenges. The primary focus of the case study research was to examine hubs as organisational, relational and ethical models of care: how they are structured, how staff reason and act, how access and relationships are organised, and how governance, safeguarding and quality are negotiated in practice. Young people's perspectives were included as data through interviews and ethnographic observation: two young people were interviewed per hub, alongside five to eight staff interviews, with sustained observation of young people and staff across each site. These data allowed young people's experiences to inform the analysis, but they do not make this a co-produced or youth-led study.

In the first year of the research, I explored the possibility of developing my own PPIE group. I spoke with several young people aged over eighteen whom I met through youth mental health policy, creative arts, and research events in Manchester and London, some of whom expressed interest in contributing to this work. At that stage, the design, case selection and research questions were still evolving. I did not have the funding, administrative infrastructure, project clarity, safeguarding arrangements, or supervisory capacity and experience to support meaningful and safe PPIE with young people over the course of the doctorate. Inviting young people into an under-resourced advisory role would have risked being performative and may have created unclear expectations about decision-making power, time commitment, emotional labour and responsibility for support. For these reasons, I chose not to create a PPIE structure that I could not adequately sustain.

The Youth Access Quality Framework evaluation undertaken in the second year of my doctoral work provided a more appropriate structure for youth co-design.

Unlike the case study research, the evaluation had a defined translational task: to develop a quality framework for hubs for use by services, funders and commissioners. It also had organisational support from Youth Access, a clear project scope, dedicated funding, administrative systems for payment, established safeguarding arrangements, and a team structure through which youth involvement could be supported and acted upon.

Several features made this co-design process more ethically and methodologically sound than would have been possible within the doctoral study. Youth Access provided administrative infrastructure for payment and onboarding. The defined scope allowed role expectations, time commitments and routes to influence to be communicated clearly from the outset. Safeguarding responsibilities were distributed across a team with named contacts in each host hub, rather than held by the doctoral researcher alone. The co-designers received preparation and training, including facilitation support and engagement with qualitative analysis. Their contribution was substantive: they designed and led creative workshops, presented findings, reviewed the draft Quality Framework line by line, and supported dissemination and feedback on the final product. Participants were paid for their time, and food, drinks and wellbeing support were provided at in-person events.

Even with this infrastructure in place, leading the co-design process required a significant investment of my time, attention, and emotional labour. Support had to be adapted in response to individual circumstances of the Youth Engagement Co-designers, including anxiety, travel barriers, and housing instability. These experiences reinforced the argument that meaningful youth involvement requires attentiveness to need, responsibility for the conditions of participation, competence in facilitation and safeguarding, responsiveness to how young people experience the work, and solidarity in ensuring that their contributions genuinely shape the final output[162].

The contrast between these two strands demonstrates how PPIE can be meaningfully applied, and the conditions necessary to make that possible. In the case study work, I included young people as participants and observed their interactions with hubs, without claiming participatory design. In the evaluation, co-design was possible because the project had the scope, funding, staffing, safeguarding infrastructure and

organisational commitment to support it. This distinction reflects the central argument of this thesis: relational work requires infrastructure, and meaningful involvement depends on the conditions that make care, trust, and shared influence possible.

Confidentiality and data handling

Anonymised research data were stored within the Nuffield Department of Primary Care Health Sciences, University of Oxford, on password-protected University systems and MSDIT servers. Printed de-identified materials used during analysis were kept in a securely locked cabinet when not in use. Personal details, including names, consent forms, and contact information, were stored securely and separately from the main research dataset. Participant codes, site pseudonyms, and the linkage file connecting identifiable information to research records were maintained in a separate password-protected digital file that was not directly linked to the study data files. This reflected the approved protocol and participant-facing materials, which stated that identifiable data would be stored securely and separately from non-identifiable research data.

I minimised the processing of personal data throughout the study. Participants were assigned unique identifiers, which were used on transcripts, fieldnotes, and analytic documents wherever possible. Audio recordings were transferred securely, transcribed, checked, and then deleted. Contact details were stored separately from research data and deleted once transcription was complete and no further communication was required. Where transcription support was used, this was undertaken through confidential, GDPR-compliant arrangements.

The linkage file connecting interview participants' names to participant IDs was retained only for the period of active analysis and de-identification review and was then destroyed in accordance with the approved protocol. Consent forms and de-identified transcripts and fieldnotes are to be retained for three years after publication or public release of the research, in line with the approved study materials and University requirements.

Confidentiality required particular care because this was an ethnographic case study conducted in a relatively small field of Early Support Hubs. The risk of identification

arose not only from interview recordings but also from fieldnotes, organisational detail, and distinctive incidents. I therefore avoided recording unnecessary identifying information in fieldnotes and analytic summaries, minimised contextual detail where it was not analytically essential, and used pseudonyms for all hub sites and participants throughout. Hub sites were identified only by pseudonym and broad geographic region rather than by specific town or locality. In writing the thesis, I also used composite vignettes where necessary to preserve organisational and relational texture while reducing the likelihood that individual young people, staff members, or incidents could be recognised. This process of de-identification, amalgamation, and alteration of non-essential details was reviewed and discussed with supervisors as an additional layer of privacy protection. As acknowledged in the ethics application, full de-identification cannot always be guaranteed in context-rich qualitative research, especially in a small service field, but I took all practical steps to reduce recognisability while preserving analytic integrity.

Researcher reflexivity

During the course of this DPhil, I encountered a light-hearted critique that doctors are not well suited to ethnography. Pushkar, a clinician and ethnographer, provides a "comradely critique" of our profession[180], questioning whether clinicians can generate sufficient analytic distance from practices they see as common sense, and whether we can extract ourselves from the normative clinical logics of care. He invites clinician-ethnographers to closely consider how we interrogate what is assumed to be obvious, and for whom we are writing. These questions were central to my reflexive practice.

I entered this research as a general practitioner with a Diploma in Child Health and experience providing mental health counselling through the Royal Australian College of General Practitioners. Clinically, I have worked with young people presenting with depression, anxiety, OCD, emotional-based school avoidance, substance use, family violence, self-harm, and suicidal ideation. Even the way I categorise these clinical presentations reflects my starting orientation that youth mental health extends beyond just diagnosis to encompass school and home environments, family stress, poverty, racism, sleep, exercise, diet, and substance use. This holistic framing shaped my interest in community-based hubs that offer non-

clinical and relational responses with links to clinical care. At the same time, my clinical training provided a prior conceptual map of what counts as 'mental health', which inevitably influenced what I noticed and how I interpreted practice.

In response to discussion of whether doctors can conduct ethnography at transfer of status examination, I paused my clinical practice for nine months during the period of fieldwork. My usual work involves remote Aboriginal and Torres Strait Islander health services in Australia, including child and adolescent health, antenatal care, chronic disease management, and addiction medicine. General practice shapes a particular cognitive posture: rapid diagnostic reasoning, evaluative judgement, and pressure towards resolution. Stepping away from that work helped me sustain a more explicitly observational stance and resist the clinical pull towards problem-solving. The discipline of remaining with what I was seeing, rather than moving too quickly towards interpretation or response, was something I had to practise with intention.

The research process has impacted my clinical work as a general practitioner by sharpening how I understand what I am doing when I interact with patients. I came into this doctoral work with an unconscious hierarchy between two kinds of clinical listening: the structured elicitation of symptoms, illness timeline, and risk factors, and the more open-ended work of attending to what a patient volunteers, how they frame their experience, what they leave out. I had ranked the first as producing medical knowledge and the second as valuable but supplementary. Ethnographic fieldwork unsettled that ranking.

The most tangible effect on my practice has been in my teaching. Returning to clinical work in Aboriginal health in the Top End of Australia, at the time of writing I am supervising a first term GP registrar. Our teaching sessions now explicitly cover three components: clinical content, cultural context, and what I refer to as the craft of general practice. That third category attends to how the dialogue and expressions of the ethics of care are a part of the treatment, and how this requires lifelong development of skill and attention. This draws on Balint's formulation of the doctor as drug[181], the idea that the clinician themselves, not only their technical decisions, is a therapeutic instrument. Ethnographic training, my experiences in this doctoral study, has made me a more deliberate teacher of that dimension of medical practice.

Before moving to England, I worked for over a decade with Aboriginal and Torres Strait Islander children and families, both as a GP and as a long-term volunteer and health officer with an Aboriginal children's breakfast club called Life for Koori Kids. I came to understand mental distress as deeply structured by poverty, racial exclusion, intergenerational trauma, and discrimination. This orientation led me to attend closely to deprivation, housing and food insecurity, and educational exclusion experienced by young people visiting English hubs, and to interpret service models considering structural drivers before clinical categorisation.

I occupied an ambiguous position in the research field as both insider and outsider. I was an insider in some important respects. As a GP with experience in youth mental health care, and with longstanding familiarity with the values and practices of relational, community-based support, I could understand much of the language, moral purpose, and everyday judgement that staff described. This helped me build rapport and trust, particularly with practitioners who recognised that I understood the pressures of care work, safeguarding responsibility, and the limits of formal systems. At the same time, I was also an outsider. I was an Australian clinician-researcher undertaking a DPhil at the University of Oxford, and I was not a practitioner within the NHS or within the local histories of the services I was studying. This outsider position gave me enough distance to notice what was locally taken for granted and to ask questions that insiders might not ask. My positioning shaped both access and interpretation. It made some forms of trust easier, but it also required me to remain alert to the ways institutional prestige, professional identity, and cultural difference could influence what people chose to show me or withhold.

My identity as a GP is also bound up with my own values of care. I value continuity, compassionate listening, emotional containment, and accompaniment over time. These commitments shaped what I instinctively regarded as good practice in hubs and contributed to my engagement with ethics of care and logics of care as analytical lenses. They also pulled me towards qualitative inquiry, as I wanted to explore aspects of care that are often undervalued or obscured within quantitative outcome frameworks. Making these commitments explicit has been part of maintaining analytic transparency.

I have long been interested in the capacity of attention and witnessing as a component of therapeutic care. This comes partly from a personal background of secular meditation in the Vipassana tradition, and partly from an interest in Simone Weil's writing on attention as a disciplined form of receptivity[182]. In fieldwork, this shaped my effort to listen without rushing too quickly to categorisation, solution, or judgement. As a clinician, I am trained to categorise and respond. As an ethnographer, I needed at times to restrain that impulse and remain with uncertainty for longer. Attention, in this sense, became part of my methodological stance.

Attention extends towards others, but it must also turn inwards towards the self. In emotionally demanding work, attention to one's own bodily and affective responses can be protective, helping to identify the risk of overwhelm before compassion becomes empathic distress. For example, in one hub I came to know a young woman with a history of complex trauma and abuse through her daily visits for food, rest, and social connection. During a subsequent supervision session, I found myself breaking down in tears at the sadness of her circumstances and at the apparent futility of the surrounding systems to alter the structural conditions shaping her life. This was a bounded episode of empathic distress rather than a pervasive difficulty, but it reminded me that this kind of research requires containment as well as openness. Anthropologist and Zen Buddhist teacher Joan Halifax's work on compassion and the limits of empathic exposure was also helpful in thinking through and balancing these risks[183].

As a GP with a strong interest in mental health, I have learned from psychologist and social work colleagues that psychological supervision, distinct from ordinary professional supervision, is essential to sustaining emotionally demanding work. I have sought out my own psychological supervision for many years in clinical practice. I have come to think that our capacity to accompany others is shaped, in part, by how far we have been able to attend to our own pain, vulnerability, and uncertainty. This also resonates with the idea of the wounded healer, drawn from the Greek myth of Chiron, whose own incurable wound shaped his capacity to accompany others through suffering[184]. A GP mentor introduced me to this idea in medical school, and it has remained with me as a way of thinking about how personal suffering, when processed and reflected on rather than suppressed, can deepen one's capacity for care. Reflexive journalling and supervisory dialogue

therefore functioned not only as analytic tools, but also as practices that helped me maintain perspective, notice vulnerability, and distinguish empathy from enmeshment.

It is also important to be transparent about the commissioned nature of the national evaluation strand. I was paid by Youth Access as a consultant to lead the development of the Quality Framework – a relatively modest stream of funding which helpfully supplemented my doctoral stipend. The contractual outputs were defined by Youth Access and aligned with their organisational objectives. My consultancy contract concluded in November 2025. While I maintain professional relationships with individuals working at Youth Access and in the Department of Health and Social Care, I derive no ongoing professional or financial benefit from publishing this doctoral research or details of the national evaluation.

Ongoing professional relationships inevitably shape interpretation and therefore warrant scrutiny and reflection. Over the course of this doctoral research, I developed professional rapport and respect for many of the front-line hub staff, and I continue to contribute to broader policy discussions on youth mental health. Such proximity and shared commitments incline me towards sympathetic interpretation. My supervisors paid close attention to this risk in the early stages of fieldwork and challenged me when my fieldnotes or comments tipped too far towards admiration rather than analysis. This helped me remain attentive to the difference between recognising good practice and writing in a way that became celebratory. To counterbalance this further, I conducted the final analytic phase over a three-month period without visiting hubs or undertaking paid or voluntary work with participating organisations. This deliberate temporal and relational pause created space for greater critical distance and supported a more independent re-engagement with the data.

I recognise my own personal alignment with values of social justice and youth advocacy frequently articulated within hubs. Many staff described their work in moral and relational terms that resonated with my own political commitments. This alignment facilitated trust and depth of access, but it also shaped what I foregrounded. Throughout the thesis, I have attempted to hold this tension openly. The interpretations presented here are not neutral. They are shaped by my clinical

training, political commitments, and moral sensibilities. Making those influences visible is part of ensuring analytic integrity rather than pretending to detachment.

My route into academic research has been indirect. Before medicine, I worked in the Strategy Unit of the Australian Department of the Prime Minister and Cabinet in the early 2010s, when enthusiasm for evidence-based policy and behavioural economics was at its height. That early exposure gave me a lasting interest in what evidence can and cannot do inside institutions, and experience that research findings rarely travel directly from publication to practice. The distance is crossed through translation, sustained engagement, and ethical judgement as much as through methodological rigour. Nearly a decade later, after a pivot to medicine, the General Practice Academic Registrar programme sharpened this further. Research and teaching, combined with clinical practice, made plain that good inquiry must remain answerable to the complexity of clinical uncertainty, institutional constraint, and the lived experience of patients. Under the mentorship of Professor Trish Greenhalgh, I have come to understand my vocation as combining general practice, academic research, and policy translation. This trajectory makes retrospective sense to me in a way it did not while I was living it. My commitment, in this thesis and in the work that follows, is to use rigorous and ethically grounded research to make the realities of care visible to institutions, so that services can better respond to the needs of young people.

Chapter 5. Findings: Dock Hub

Introduction to Results Chapters

In the following three chapters, I present each Early Support Hub as a bounded case study, examining how care is organised, enacted and sustained within distinct local systems.

The findings are organised to move from the tangible and observable foundations of each service, through relational practice and system positioning, to an analysis of the logics of care that shape the model. I have structured the chapters in this way to show how history, context, and everyday organisational arrangements and interactions give rise to particular forms of care. This progression allows the reader to see how values are translated into day-to-day work, how formal structures and informal practices interact, and how particular configurations of care emerge from their organisational and institutional conditions.

As outlined in the Methods chapter, these findings draw on ethnographic observation and in-depth interviews conducted across three youth mental health hub sites. All names, sites, and identifying details have been changed. The vignettes are drawn from observed events but are fictionalised accounts derived from recurring patterns in the data. I use them deliberately to set the scene and bring to life the tone, context, people and interactions that shape each hub, making visible the relational dynamics and recurring concepts that emerge across cases rather than recounting any single identifiable event.

Each findings chapter follows the same six-part structure:

1. **Setting and History**
   Each hub is situated within its local context, origin story and institutional development. Attention is given to the problems the service sought to address and the historical, political and commissioning conditions that shaped its formation. This establishes the hub as a bounded system in time and place.
2. **Organising Care**
   Care is described in terms of its structures and practices, including staffing

models, service configuration, triage processes, safeguarding and escalation pathways, physical environment and internal coordination. This section examines how organisational design enables, structures and constrains forms of care delivery.

3. **Ethics of Care and Youth Participation:**
   The ethical dimensions of care are examined as enacted through continuity, trusted adult relationships, emotional labour and informal work in young people's lives. Youth participation is analysed in terms of co-production and shared responsibility, exploring how trust, belonging and voice shape how care is experienced and sustained within the hub model.
4. **Professional Cultures**
   The identities, values and status hierarchies shaping practice are explored, including distinctions between youth work, counselling and clinical roles. Dress, language, accreditation, NHS alignment and internal tensions are examined to show how professional projects influence which forms of care are legitimised and prioritised.
5. **System Integration**
   The hub's relationship to the wider health and social care system is examined, including referral pathways, commissioning arrangements, boundary work with statutory services, safeguarding thresholds and risk negotiation. This situates the service within broader institutional ecologies and considers how it negotiates legitimacy and influence.
6. **Logics of Care**
   The preceding analysis is synthesised to identify the dominant and competing logics of care operating within each site. Tensions between logics and working practices are analysed to develop a conceptual account of the youth mental health hub as a distinct model of care.

Dock Hub is presented first, as it represents the most embedded and system-integrated of the three sites, with significant scale, longevity and formal alignment with statutory services. Presenting this case first establishes a reference point against which the subsequent cases can be understood.

Chapter 6 presents Heath Hub and Chapter 7 presents Shore Hub, which are smaller in scale and differ in geography, organisational history and system positioning.

Presenting these after Dock Hub allows contrasts to emerge, particularly in relation to organisational maturity, degrees of integration and the configuration of care logics.

Chapter 8 combines all three hubs into a case comparison synthesis. Chapter 9 presents findings from the Youth Access Quality Framework project, a complementary but discrete national evaluation process. Chapter 10 offers further analysis by relating the case studies and evaluation components.

Across these results chapters, I aim to offer a detailed account of Early Support Hubs as situated systems of care and lay the groundwork for conceptual and policy analysis in the discussion chapters that follow. The remaining sections in this chapter relate to Dock Hub.

Setting and History

Dock Hub is a charitable mental health and wellbeing service for children and young people aged 5 to 25. It was founded in 1966 by a youth worker and counsellor in response to unmet mental health need among young people in Dock City. This origin story, a practitioner-initiated response to visible, unaddressed need, remains significant because it shaped the organisational identity that persists today: a service that positions itself as relational, community-facing and prepared to hold need that some statutory systems may not reach.

Over six decades, Dock Hub evolved from a small voluntary service into a substantial organisation employing approximately 150 paid staff across counselling, wellbeing, youth work, administrative and leadership roles. Its most recent impact report records more than 10,000 children, young people and parents supported annually, with over 15,000 therapeutic appointments and 21,500 wellbeing contacts delivered in a single year, including more than 1,500 open-access drop-in attendances. Wellbeing clinics are embedded across 95 primary schools and 35 secondary schools across the city.

The organisation is explicitly positioned across Child and Adolescent Mental Health Service (CAMHS) tiers 1 to 3, covering universal, early-intervention and mild-to-

moderate support, with capacity to engage some specialist-adjacent presentations. Staff consistently framed their work as sitting below statutory thresholds while maintaining close collaborative relationships with CAMHS, general practice and hospital services. This positioning is strategic and developed through sustained commissioner engagement over many years.

Dock Hub's services are organised into three broad strands: therapeutic provision, wellbeing provision and parenting support. Each strand contains multiple programmes with distinctive, accessible names widely recognised by staff and young people. For example, Buddings delivers talking and creative therapies within primary schools for children aged 5 to 11, Rainbow Room provides LGBTQ+ youth group provision for young people aged 11 to 25 across two age cohorts, and Bridgepoint embeds mental health practitioners within GP practices to offer brief interventions, advice and early assessment. These examples illustrate the range of settings in which Dock Hub operates: schools, community-based youth spaces and primary care. They reflect an organisation designed to meet young people where they already are, rather than requiring them to present through a single access point.

Dock City has a population of approximately half a million people, with a relatively young demographic profile. Senior staff described it as a city with a strong northern identity, a culture of directness and community loyalty, and experience of socio-economic deprivation. Adverse childhood experiences, poverty and family instability are understood as the predisposing conditions under which distress emerges, rather than as background factors separate from it. This framing shaped how the service conceptualised appropriate responses: support oriented to young people's social and material circumstances as well as clinical or diagnostic needs, delivered within a single service structure capable of addressing them concurrently rather than directing young people across fragmented systems.

Funding diversification has been central to the service's longevity. Income now spans NHS and local authority commissions, Department of Health and Social Care funding streams, and charitable contributions. This portfolio model has enabled resilience against any single contract loss, contrasting with services dependent on short-term or single-stream funding. A long-standing senior staff member captured this durability directly:

> "We've been around for a long time because people have funded us... we haven't dropped off the edge of the Earth." (S1-ST-003)

For voluntary sector organisations delivering mental health support to young people, organisational survival is not guaranteed. Sustained funding requires credibility, commissioner confidence, and the continuous demonstration of value. That Dock Hub has maintained funding across six decades reflects an organisation that has consistently been seen as worth the investment.

Longevity is also linked to leadership continuity. During my fieldwork, the Chief Executive, whom I will call Amanda, was regularly referenced by staff at all levels as setting the tone of the organisation. Amanda presents as confident, outspoken and warm. She has a strong identity tied to Dock City and speaks with visible pride about the organisation's history and civic role. What became clear across meetings and interviews was that this was not casual interpersonal enthusiasm but carefully developed professional advocacy. Dock Hub is skilled at narrating itself: its history, and its place within the local mental health system. Amanda's repeated formulations about the organisation's origins, values and commissioner relationships were consistent and polished in a way that registered as strategic and genuine. Commissioner relationships were described as built over years of sustained engagement, requiring patience and credibility rather than transactional contract management. The organisation's identity is itself a resource, actively maintained and deployed.

Dock Hub's three main sites function as organisational anchors, while staff are embedded across schools and GP practices throughout the city. In practice, I observed a model that combined centralised governance and leadership oversight with dispersed delivery across education and primary care settings, requiring a conscious and adaptive balance between central control and local autonomy.

The first, Dock Hub South is functional and the most formal of the three sites. The physical entry at the front door is controlled, and the internal layout prioritises calm, predictability and privacy. Children's artwork and bright colours soften the space, but the emphasis is on safety and organisation. The second, Dock Hub North, is

more open and informal set beside an area of natural grassland and walking paths in a low brick building with a large outdoor play area. Inside, the space is arranged for younger children and group activity, with an open-plan kitchen at the centre and low chairs and art materials marking the rhythm of the day. The environment is deliberately domestic and community oriented.

The final and largest site, Dock Hub Central, occupies an ageing multi-storey brick building in the city centre. Entry through the main door is controlled, requiring a buzzer and sign-in with reception staff behind glass. Staff explained this as a safeguarding response to previous incidents involving intoxicated adults entering and disrupting services. Within the building, spaces diverge. Upstairs are counselling rooms and managerial offices. Below, a separate ground-floor entrance opens directly into a community space with smaller counselling rooms used for drop-in services during the day and youth groups in the evening. Colourful collages line the windows, a small kitchenette supports shared meals, and the atmosphere is less formal. A street-level rear entrance is managed relationally by youth workers for group attendees rather than requiring sign-in through the main security infrastructure.

Across all sites, physical space is actively used as part of care delivery. Safety, containment and welcome are balanced differently depending on the population served, but spatial design consistently reflects the organisation's dual commitments to protection and relational engagement.

Table 5.1 below summarises the fieldwork dates, observation settings, interview sample and broad participant roles (without compromising participant anonymity and privacy) informing this case study chapter.

Figure 5.1 Dock Hub case summary

Feature	Summary
Case site	Dock Hub
Fieldwork dates and structure	Two intensive one-week fieldwork blocks: • 12-16 May 2025 • 16-20 June 2025

	Observation followed a structured programme across different hub services and internal staff settings between 9.30am and 8pm, Monday to Friday.
Direct observation hours	77 hours
Main observation settings	Urban hub provision across three sites with different programmes. Observation included drop-in, reception and triage spaces, information, advice and guidance, youth groups, a primary care liaison clinic, staff briefings, governance and management meetings, safeguarding discussions and multidisciplinary discussions where permitted.
Formal staff interviews	8 formal staff interviews, representing 12 individual staff participants
Types of staff and roles interviewed	Primary care mental health liaison practitioner, school-facing safeguarding practitioner, parenting programmes lead, youth participation and peer research lead, senior drop-in worker, clinical administration and referral/triage staff, LGBTQ+ youth group leaders, and therapeutic counsellors and arts-based practitioners working with refugee and asylum-seeking young people.
Young person interviews	2 young person interviews
Broad young person involvement represented	Counselling, LGBTQ+ youth groups, peer research, youth participation, programme design, youth leadership and neurodiversity-related support.

Vignette: Arriving at Dock Hub

I arrive at Dock Hub South on a cold, wet northern morning to begin my fieldwork. The site sits on a wide stretch of uneven grass, flanked by a large, single-storey brick community building with white-framed windows and an electric blue double door. The structure is functional and clearly marked. Dock Hub's branding is prominent on the exterior, signalling presence and legitimacy in the neighbourhood.

Inside, a receptionist sits behind a glass screen. She looks up and smiles warmly. The waiting area contains two rows of brown plastic chairs, with children's artwork pinned across the windows. Despite the artwork, the initial atmosphere feels formal. Entry is controlled by a security door, and the central space is calm, quiet and orderly. A one-and-a-half-metre papier-mâché giraffe stands in one corner of the main entry hall, softening the clinical feel.

I am taken through to the internal office space and offered tea. This becomes a recurring feature of my time at Dock Hub. Tea or coffee is offered at the start of meetings, between sessions, and often again as new staff enter the room and spot me as an outsider. It functions as a small but consistent gesture of welcome, and over time comes to signal the northern English culture of hospitality.

Conversations with senior leaders are warm and professionally confident. They speak with a relaxed ease about the week ahead, about local culture and shared interests. They describe Dock City as culturally distinct, marked by a strong northern identity expressed through humour, pride and directness. They refer repeatedly to the matriarchal structure of many local families, where mothers and grandmothers hold households and neighbourhood networks together. These accounts situate the hub not simply as a service but as part of a wider civic and relational fabric.

I am given a printed schedule for my week-long visit. It is colour-coded and tightly structured, covering full days of observation that stretch from early morning GP clinics through to evening parenting groups. The schedule has been prepared weeks in advance. These meetings have been arranged without my input. Staff across the organisation appear to know who I am and why I am there. Later, I learn that an all-

staff internal email has circulated with my photograph and a description of my research.

This first day sets the tone for the case study. Dock Hub presents as organised, welcoming and assured. At the same time, it is clear that access, trust and deeper understanding will need to be earned over time.

Organising Care

Dock Hub organises care through multiple service threads delivered across three hub sites and a wide range of community settings. Young people enter through different points, often beginning with brief contact through open-access drop-in or information, advice and guidance, and then returning as needs shift. Movement through the service is rarely linear. A young person might use the drop-in during a difficult period, receive one-to-one advice while waiting for therapy, join a youth group for connection and stability, and then enter counselling months later. Waiting times for therapeutic input vary by need and capacity and, during my fieldwork, staff commonly described waits of three to six months for some routes into therapy. Young people may have more than one episode of counselling across adolescence, and some later become involved in youth participation roles. The organising challenge for Dock Hub is less about delivering a single programme well and more about coordinating multiple forms of care so that young people can move between them without losing continuity.

Safeguarding and clinical governance are treated as core responsibilities across all roles at Dock Hub. Lines of responsibility are explicit. Frontline staff escalate concerns to managers, who escalate further to senior leads when required. Senior staff are reliably available, including by phone when not physically on site. This is particularly important for teams working across dispersed settings such as schools and GP practices, where a practitioner may (for example) be alone when a complex disclosure occurs and need immediate advice. A supervising manager in Bridgepoint described the operating principle directly:

> "I don't like the word hierarchy, but that's how it works." (S1-ST-001)

In an organisation that emphasises relational and community-facing values, the language of hierarchy sits uneasily. But the comment also acknowledges that clear lines of authority serve a practical function in safeguarding: they enable rapid access to senior judgement, provide containment for less experienced staff encountering complex presentations, and ensure that no practitioner carries risk alone. During my fieldwork, staff described being able to escalate questions by phone at any point in the working day, with a named senior person always available to advise and share accountability for next steps.

Although Dock Hub positions itself within early-intervention and mild-to-moderate need, staff routinely encounter higher-risk presentations in primary care and drop-in work, including disclosures relating to exploitation, violence, suicidality and self-harm. These were not treated as exceptional events. Clear escalation protocols were in place, and the structure had been developed with such encounters in mind. Relational continuity was understood as the mechanism through which risk often becomes visible: young people who had declined formal intervention sometimes disclosed to a worker they had come to trust over time. The escalation structure enables practitioners to hold risk as something monitored and revisited, while having immediate access to senior guidance when a disclosure requires urgent response.

Administrative staff are also incorporated into the safeguarding support structure. Following difficult contacts, a brief debrief practice known internally as a "huddle" is used to process the interaction and ensure staff welfare:

> "If someone has a difficult checking call, we do a 'huddle'." (S1-ST-022)

This practice extends the safeguarding infrastructure beyond clinical roles. Administrative staff who conduct routine checking calls with young people on waiting lists sometimes encounter disclosures or deterioration. The huddle acknowledges that the emotional labour of managing risk is not confined to qualified practitioners, and that administrative staff sustaining care require their own support structures.

Dock Hub's model depends on a mixed professional workforce. At the frontline level, three broad groups are visible. Counsellors typically hold professional accreditation, most often with the British Association for Counselling and Psychotherapy (BACP) or comparable bodies, and deliver one-to-one and specialist therapeutic work. Wellbeing practitioners are commonly trained through Children and Young People's Wellbeing Practitioner or related Health Education England accredited pathways, drawing on CBT-informed and brief intervention approaches. Youth workers include those with formal youth work qualifications and those trained through experience and supervised practice within the organisation.

This mix enables Dock Hub to operate across schools, primary care and community settings, while offering both structured therapeutic interventions and relational, identity-based youth work. Dock Hub also functions as a training organisation. During my observations, trainees and early-career staff were present on placements within groups and clinics, and staff described completing formal qualifications while employed. Regular supervision, reflective practice and access to senior advice were described as central to maintaining safety across this blended model.

Leaders described turnover as a reality in a system where staff could move into statutory services and the NHS for higher pay. Amanda framed this partly as a form of system shaping, arguing that when staff left, they carried Dock Hub's relational and flexible ways of working into NHS organisations. Professionalisation generated its own tensions, however. Many staff entered Dock Hub with youth work or related practice experience and developed confidence in the high-pressure environment of drop-in work, where they were required to manage triage, uncertainty, fluctuating risk, and a wide spectrum of need. Yet once enrolled in Children and Young People's Wellbeing Practitioner training, their permitted caseload narrowed considerably. Because Health Education England set limits on the levels of risk and complexity trainees were allowed to work with, they were no longer able to see many of the young people who characterised open-access drop-in provision, including those with active self-harm, suicidal thoughts, complex safeguarding concerns, or overlapping social and clinical needs. Leaders described having to recruit an additional staff member specifically to identify low-acuity cases suitable for trainee caseloads. In this respect, professionalisation operated as both asset and constraint: it strengthened legitimacy and clinical credibility but could also narrow

what staff were permitted to do in the very parts of the service that required the greatest flexibility, judgement, and tolerance of uncertainty.

Each setting shapes both the form and limits of the care provided. In GP-embedded services, Bridgepoint wellbeing workers emphasised time and building trust in the assessment process. Appointments were up to an hour, considerably longer than those typically available in general practice. Staff described this as enabling careful triage and appropriate onward referral:

> "We are privileged to be able to have the full hour with a young person... to assess and triage to the correct support." (S1-ST-001)

That staff describe extended appointment time as a privilege rather than a standard reflects the conditions of the system they work within. In a GP context structured around ten-minute appointments, an hour with a young person is not the norm; it creates space for contextual understanding rather than symptomatic triage. The service had also adapted its model to individual practices, with the head of Bridgepoint noting:

> "We have been able to offer what we're calling a bespoke hub model to each [primary care] network in the region." (S1-ST-001)

Flexibility here is understood as an essential feature of the service. Adapting to the structure and culture of each service component has driven expansion and signals the organisation's capacity to negotiate institutional fit without compromising its own model.

In schools, wellbeing clinics blend CBT-informed techniques with close attention to classroom life and the conditions of learning. Staff described presentations labelled as behavioural or emotional as frequently sitting within overlapping contexts of neurodiversity, special educational needs, peer dynamics, sensory overload and academic pressure. The work is interpretive and contextual rather than symptom-focused, and staff described a recurring mismatch between the complexity of young people's overlapping needs and the capacity of statutory services to respond flexibly

to them. The following vignette shows how setting constrains depth, how practitioners deliberately modulate what is discussed, and how continuity allows brief work to remain meaningful.

Vignette: Secondary school wellbeing clinic

I observed a school wellbeing clinic held in a small wood-panelled room off a classroom corridor. Posters had been taped to the windows to create privacy. Two teacher chairs faced each other. A small table held laminated worksheets and a card-based game, next to an outdated desktop monitor and an assortment of stationery holders. The space felt improvised but functional.

The wellbeing practitioner, Samantha, spoke with me briefly before the session. She had worked with Beth before. Beth was over sixteen and had agreed in advance that I could sit in. I introduced myself and explained that I was there to learn about Dock Hub, and that she could ask me to leave at any time. She seemed untroubled and did not look at me again until the end of her session.

Beth attended because she was struggling to concentrate with stress in the lead-up to exams. The session focused on coping strategies. Samantha introduced breathing techniques, emotional check-ins, and gentle cognitive reframing, with brief psychoeducation on worry. A simple game was used to make part of the interaction feel lighter and less formal. The tone was calm and contained. After the session ended, Beth returned to class.

Afterwards, Samantha explained that Beth was not seeking deeper therapeutic work at this stage. She had previously had trauma-informed counselling with Dock Hub for instability at home, and right now wanted practical strategies for her worry that could fit safely within the school day. In this setting, care was deliberately bounded. It prioritised skills, containment, and immediate functioning, with careful avoidance of opening material that could not be held in a brief session.

The vignette shows care organised around what a young person can use at a given moment. CBT-informed techniques are applied but structured within the limit time and scope of school contact. Trauma is acknowledged without unnecessary or harmful excavation. The work is calibrated to the school environment and to Beth's immediate capacity, shaped by prior knowledge that the relationship and the organisation remain available. This is not the application of protocol, but practical judgement informed by continuity.

Youth groups were described by young people and staff as complementary to counselling rather than secondary to it. Identity-based groups for LGBTQ+ young people were framed as protective spaces where distress reduced through connection and belonging. The trans youth group lead described the relationship between identity safety and clinical outcomes:

> "I see the self-harm instances and the suicidal ideation drop massively when they start engaging with their community." (S1-ST-003)

This positions identity-based group belonging as a mechanism of care in its own right, capable of producing clinical change through social rather than therapeutic means. The implications for how Dock Hub staff understand the impact of these groups is developed further in the Ethics of Care section.

The drop-in service illustrates how organisational design responds to acuity under strain. The service was originally commissioned as a community-based alternative to accident and emergency attendance for young people in acute mental health distress. Open-access provision of this kind requires minimum staffing levels, clear triage processes and robust safety structures: without them, young people cannot receive timely, appropriate and safe support. When referrals escalated rapidly, that infrastructure was not yet in place. As one staff member recalled:

> "Initially... it meant that it was two of us fighting a tidal wave of everything." (S1-ST-006)

The gap between resource and demand had direct consequences for how roles were defined and maintained. Boundaries between wellbeing workers and counsellors

became blurred. Counsellors were asked to manage unscheduled crises between therapeutic sessions. The distinction between planned, time-limited therapy and open-access crisis support became less clear, and friction emerged around what constituted appropriate professional responsibility. Staff described a period in which the service was under significant pressure, with high demand, role blurring, and limited containment structures. Some staff left during this period.

The account of this earlier period of strain did not emerge immediately in fieldwork. During my first week at Dock Hub, staff had organised an extensive and carefully curated introduction to the service, and I was struck by how much effort had gone into showing me its range and strengths. At the end of that week, I explained to several service leads that while I was grateful for their efforts and could already see the value of the service, I was also interested in how the organisation had arrived at its current form, including the tensions, difficulties, and adaptations through which it had improved. One of the leads visibly shifted in posture and tone, with something like relief, and began to speak more openly about the earlier difficulties in the drop-in. When I returned a month later, this initial conversation had opened the way for a more candid set of discussions with the leader for the wellbeing team, the new lead for the drop-in, and frontline staff who had worked through both iterations of the model. Their willingness to describe what had not worked, and what they had done in response, was generous and revealed something more general about how access and trust operated at this site: before I could understand the service's internal tensions in depth, I first had to demonstrate that I had recognised its achievements and was not approaching the field simply as an evaluator of performance.

In response to these concerns, the service was intentionally restructured. Provision was centralised to one main hub site. An experienced drop-in lead was appointed, with a background in social work and in supporting young people with histories of exploitation and justice system involvement. An appointment system was introduced to manage staffing levels and workflow while retaining capacity for unplanned drop-ins, with formalised limits on daily caseloads. As one drop-in staff member explained they each now have:

> "Five appointments a day... gives us time for the admin." (S1-ST-006)

Capping appointment numbers created time for documentation, debriefing and collegial consultation, the administrative and relational infrastructure through which risk is shared rather than carried individually. The physical space was also adapted. Teams of five to six staff worked in shared proximity between appointments, enabling constant communication and rapid informal debriefing. This co-location distributed risk across the team rather than concentrating it on individual practitioners. At the time of my fieldwork observations, the service presented as well-functioning and collaborative. Staff noted that other days could involve safeguarding concerns related to suicidality or exploitation, with sessions extending for several hours and ambulances occasionally called. These were not treated as crises in the organisational sense. Clear protocols were in place, and the structure had been designed to support them.

Across interviews, the phrase "the right support" recurred as a shared reference point among staff, commonly invoked but rarely explicitly defined. When I asked staff what they meant by it, the answer was consistently contextual rather than programmatic: tailoring support to the young person's needs while acknowledging their broader circumstances.

No staff member described a particular therapeutic approach or evidence-based intervention as the "right support" in isolation. Overtime I understood “the right support” to mean recognising the interaction between mental distress and context, including poverty and adverse childhood experiences, and shaping care for the young person accordingly across time.

This orientation extended beyond the individual young person to the family system. The lead staff member for parents' programmes described parenting support in terms of parental agency:

> "Parents get that light bulb moment... they're the ones that see their [child's] changes." (S1-ST-005)

Supporting a parent’s understanding, capacity, and wellbeing was understood here as an intervention in the conditions shaping a young person’s distress, rather than as a secondary adjunct to treatment. Staff described a now-ended pilot programme for

young people involved in the criminal justice system that extended this logic at a higher level of complexity, combining intensive therapeutic support for the young person with group family therapy and wider case management for the family. They spoke of the programme with pride and of its ending with frustration, describing it as a strong fit with Dock Hub's wider philosophy and approach. They also noted with disappointment that, despite a positive evaluation, the programme was discontinued once pilot funding ended, reflecting the instability of short-term funding cycles and the difficulty of sustaining valued work beyond the life of a pilot.

Routine outcome monitoring sits at the centre of Dock Hub's accountability culture. The organisation holds recognition within the Child Outcomes Research Consortium (CORC) for good practice in outcome monitoring, and leadership frames outcome data as evidence of effectiveness, value and impact. Measures are deployed differently across service strands, reflecting the different forms of work and the populations they serve.

In counselling, paired before-and-after measures track change across an episode of care. These include the Revised Children's Anxiety and Depression Scale (RCADS), which covers anxiety and depressive symptoms across diagnostic categories in children and young people; YP-CORE (Young Person's Clinical Outcomes in Routine Evaluation) and CORE-10, both of which assess general psychological distress and functional wellbeing. Contextual measures include narrative feedback from young people and Adverse Childhood Experiences (ACE) scores, which situate the clinical picture within the young person's broader social history. Across all encounters, feedback surveys are collected via QR code using the Experience of Service Questionnaire (ESQ), providing session-level data on experience of care. Goal Based Outcomes (GBOs), which track progress towards goals identified collaboratively with the young person, are used across services and prioritised as paired measures, administered at both the start and end of an intervention. In youth work and identity-based groups, the Strengths and Difficulties Questionnaire (SDQ) has been the primary measure, with the Patient Health Questionnaire-9 (PHQ-9), a standardised depression symptom severity tool, being introduced progressively over time.

Staff accounts of outcome measures varied by setting and population. A wellbeing worker based in a secondary school described the SDQ in practical terms:

> "Outcome measures are really helpful for you, and they really help you to think about where students are at." (S1-ST-002)

In this account, the measure functions as a clinical orientation tool, helping practitioners structure their thinking about a young person's presentation rather than only generating data for external reporting. This is a different claim from arguing that scores capture the full range of change the service produces, and staff were alert to that distinction.

Tensions around outcome monitoring were most clearly articulated within identity-based youth groups. The trans youth group lead described the challenge of introducing clinical measures into a space deliberately constructed as non-clinical:

> "So I've always tried to kind of distance myself from those things, but also seeing the value of them in terms of, that's how [Dock Hub] works, and have been successful, and it's why modelling works and it helps bring things together a little bit, I think, in terms of the element in the whole organisation.
>
> So, first year, first time, we're piloting using these ROMs [routine outcomes measures] alongside our goal-based measurements." (S1-ST-004)

The ambivalence here reflects the position of experienced staff working in non-clinical spaces within a clinically structured organisation. Outcome measures offer organisational coherence and external legitimacy: a shared evidence frame across diverse forms of work that makes the impact of non-clinical group provision visible in a language commissioners and statutory partners recognise. At the same time, they risk reshaping the meaning of group work, privileging forms of change that are scoreable over those that are relational, developmental or foster identity and belonging. The group lead's discomfort reflects not resistance to accountability but a recognition that the instruments and the work are not perfectly aligned.

Other staff were explicit about what standardised measures failed to capture. Therapeutic staff working with younger children described the limits of self-report tools for children who communicate distress through play, behaviour and relational cues. In these settings, parent and teacher measures were treated as more meaningful than child-completed questionnaires.

The relational quality of outcome measure administration also varied by context. In most encounters I observed during fieldwork, measures were typically introduced with explanation and attentiveness. Under time pressure, particularly in high-volume administrative checking calls, the process could become brisk and procedural. This matters because asking a young person to rate their mood or suicidality is itself a clinical and a relational act, and the quality of that interaction varies considerably depending on time, relationship and setting. The same tool can generate different experiences, and different data, depending on how it is enacted.

Ethics of Care and Youth Participation

At Dock Hub, care ethics were enacted through organisational structures, administrative systems, group practices and youth participation processes, not only through individual therapeutic encounters. This section traces how attentiveness, responsibility, competence and responsiveness were distributed across the organisation. Young people described engagement with Dock Hub as reliable, flexible, and long term. They moved in and out of services in response to school pressures, developmental transitions and life events. Continuity, in this context, was not defined as uninterrupted contact but as the possibility of return. One young person, who I will call Sarah, described returning repeatedly across adolescence:

> "I first came here when I was 12... I came back every year for help, because it was a nine-week offer for counselling... I was struggling with the short-term nature of it." (S1-YP-002)

Her engagement with school followed the same pattern:

> "I kept going back [to school]... I'd be okay for two or three months, then completely drop off again." (S1-YP-002)

Sarah's account shows a young person whose life was characterised by repeated rupture and return. What Dock Hub provided was not resolution of that pattern but a stable point within it: an organisation that remained available each time she came back. Over time, Dock Hub functioned as an organisational anchor. Specific programmes ended, but Sarah's relationship with the organisation persisted. She described the role medication played in making therapeutic work possible:

> "When I did get put on antidepressants, it gave me a flat ground to work from... I could start doing the stuff counsellors were telling me to do." (S1-YP-002)

The phrase "flat ground" describes a state of sufficient calm and self-regulation to engage with psychological strategies that had previously felt out of reach. For Sarah, the hub's contribution was not to replace medical treatment but to create the conditions under which therapeutic and relational work could take hold. Care adapted to her current capacity rather than insisting on a single modality.

Another young person, whom I will call Samuel, contrasted Dock Hub's offer with statutory services. CAMHS, in his account, reflected a feature of some statutory provision: despite evidence informed treatments being available, services can in some instances have less flexibility to adapt to the individual circumstances of the young person in front of them. Samuel, as a neurodiverse and LGBTQ+ young person, found that the standard offer did not fit:

> "By the 3rd time I pretty much made it clear that... this [CBT] does not work for me. But it seems to be like that is the only thing that's offered [by CAMHS]." (S1-YP-001)

At Dock Hub, the range of available forms of support meant that when one modality did not work, others were available. For Samuel, Rainbow Room was more impactful than individual therapy:

> "The groups for me were probably more helpful than the therapy... actually having those spaces where I could just kind of have fun, and have something

> to look forward to, that made the biggest impact on my mental health." (S1-YP-001)

> "Meeting other LGBT young people... helped me be accepting of myself... Even just being around people... saying their pronouns... I never felt like I could really be myself [before]." (S1-YP-001)

These accounts point to recovery that is not reducible to symptom reduction. Belonging, identity safety and structured participation enabled developmental progression over time. Samuel also described the limits of therapy when foundational daily functioning had not yet been established:

> "There's only so much therapy can be helpful. If I didn't know how to look after myself day to day... then it wouldn't have been useful." (S1-YP-001)

> "Actually doing activities... going out on trips and stuff... that was what really helped me to increase my own confidence." (S1-YP-001)

For Samuel, confidence and daily functioning came first, through group activity and structured participation; therapeutic work became meaningful afterwards.

Continuity at Dock Hub is institutional rather than purely interpersonal. The organisation provides a stable site through which young people can move across developmental stages. Samuel described the absence of comparable provision elsewhere:

> "There wasn't any, ever anything like Dock Hub [in the NHS]. I was kind of like from children to adult, and there was never really any transition." (S1-YP-001)

For Samuel, Dock Hub filled the gap that statutory services left at the transition to adulthood. Over time, this support enabled him to enter employment:

> "I really didn't ever think I could hold a job down... but with support, I actually was able to." (S1-YP-001)

The stability and flexibility of Dock Hub's support helped Samuel to maintain and build his capacity for employment. Sarah described a different form of continuity and employment support: progression within the organisation itself.

> "I've grown a lot in the 10 years I've been here, obviously, going from a service user to a volunteer to actually a paid employee." (S1-YP-002)

Both trajectories illustrate what longitudinal and flexible support can produce that time-limited clinical intervention is not designed to provide: the gradual accumulation of confidence and long-term improvements in social function.

This continuity is also actively maintained through administrative structures. Clinical administration teams manage waiting lists, conduct routine check-ins and administer outcome monitoring:

> "With therapy waitlists... we contact every 10 weeks, do checking calls, ROMs [routine outcome measures]." (S1-ST-023)

These calls are brief and standardised with a structured set of questions, use of an outcomes measure, and a list of signposting referrals for while young people were waiting. They cannot substitute for therapeutic contact, but they sustain organisational memory and prevent young people from disengaging or being lost during long waits. Continuity is here a responsibility made visible through systems that support attentiveness over time.

Through an ethics of care framework, trust develops when attentiveness, competence and responsiveness are demonstrated consistently. At Dock Hub, building trust was understood as a precondition for care rather than a product of it, particularly for young people hesitant to engage with any professional service.

Staff described a local culture in Dock City characterised by a "no grass" ethic, where speaking to any kind of professional, even within a voluntary sector organisation, could be perceived as a betrayal of one's community. In this context, attending a first appointment carries its own social risk:

> "Sometimes breaking down their barriers is just getting them to the first appointment." (S1-ST-001)

This framing located trust before intervention, reducing perceived risks before engagement can occur. Staff described relationships that were built gradually, with pace and depth adjusted to what a young person could tolerate. Care unfolded over repeated contact rather than within a single bounded episode.

Several staff spoke about growing up in the same local areas as the young people they supported, or about shared experience of deprivation and low-income backgrounds. These were not presented as therapeutic credentials but framed their capacity to relate to young people visiting Dock Hub, shaping how staff communicated and how they interpreted behaviour:

> "I'm from a low-income background... I just make sure I'm not using any jargon." (S1-ST-001)

Shared socioeconomic experience informed language choice and tone, enabling communication that was accessible and contextually attuned. Staff described being mindful not to assume resources or supports that might not exist in a young person's life. Staff at Dock Hub did not generally frame their capacity to relate in terms of their own lived experience of mental health difficulties or neurodiversity. They emphasised situational understanding: their own familiarity with poverty, early caring responsibilities, deprivation and the material constraints of local life. This orientation, which will be contrasted with other hubs in later chapters, located distress primarily in external circumstances rather than internal deficit. Diagnoses and neurodiversity were acknowledged but not treated as the defining explanatory frame.

Young people experienced this orientation as respectful rather than dismissive. Samuel described the effect of receiving a diagnosis:

> "Now that I've got my diagnosis, I can be more empathetic towards myself." (S1-YP-001)

Diagnosis gave Samuel a framework for self-understanding that supported rather than constrained how he engaged with care. For both Samuel and Sarah, medical care from statutory services had played an important role in their recovery: diagnosis for Samuel and medication support for Sarah. Dock Hub had been a valued and complementary part of recovery, providing relational, community-based and group support alongside what statutory services had offered.

Youth participation at Dock Hub extends beyond consultation to include governance involvement, recruitment participation, programme design and peer research capacity for other organisations in Dock City. This reflects what Tronto describes as "caring with": shared responsibility within institutional structures rather than care only being directed one way from practitioner to recipient[19].

Sarah describes participation as a foundational principle governing how the service is constituted:

> "Young people should always be included at every point in a service... we should have a say in who's working there." (S1-YP-002)

Sarah's comment reflects that youth participation at Dock Hub shapes who is appointed to work with young people, and therefore what the service becomes. Young people also shape and deliver programmes for others. Sarah described designing and facilitating elements of an online group:

> "I designed the online group... six rolling sessions... teaching about ACEs, toxic stress, affirmations, trusted adults, and self-care." (S1-YP-002)

Participation here includes authorship and delivery. The content of the group, and the expertise embedded in it, came from a former service user. Pamela, the youth worker who leads the youth participation group, frames this as a deliberate redistribution of organisational authority:

> "We don't do things to them. We do things with them." (S1-ST-007)

The distinction between doing things to and doing things with young people marks a difference in how authority is understood within the organisation. Care is not solely something practitioners provide; it is something the organisation and young people develop together. With youth worker Pamela's support , the youth participation group contributes to internal programme design, recruitment processes and governance discussions. External to Dock Hub, they engage in advocacy campaigns including Fund the Hubs and work with the Children and Young People's Mental Health Coalition. They have provided consultation to a local children's hospital establishing a vaping clinic and are in discussion about contributing peer research to a project on young people's recreational use of ketamine in Dock City. These are substantive contributions to policy and service development beyond Dock Hub.

Participation also generates its own ethical tensions. Sarah described a project where funding ended before a promised feedback loop to young participants could be completed:

> "The project ended... we tried to carry it on... it feels like what we did was a bit of a waste..." (S1-YP-002)

Sarah's frustration reflects the accountability she had assumed through the group: she had taken responsibility for other young people's participation to have a meaningful outcome, and the structural failure of the funding cycle meant she could not meet that responsibility. This reflects some of the challenges between the valuing co-production and the realities of funding cycles and programme drift.

The group itself provided continuity that youth participation projects alone could not. Sarah described Pamela's way of supporting the group:

> "She treats everyone in the room like we are special... she talks to you like she's your friend, like she's an auntie." (S1-YP-002)

> "The beauty of the group is there's no pressure... you can come back after two years, and it's still the same." (S1-YP-002)

The first quote describes Pamela's attentiveness and responsiveness as a quality of presence which makes the group function. The second describes the group's temporal structure: its stability across interruption. Youth participation at Dock Hub positions young people as partners within the service, navigating the tensions between co-production and the limits of institutional power, and enacting what Tronto describes as democratic care: shared responsibility that acknowledges rather than dissolves the asymmetries within it[19].

Professional Cultures

Dock Hub presents as a highly professionalised organisation. Smart business casual dress among frontline staff, clearly delineated role descriptions and formal reporting lines signal institutional maturity and credibility to commissioners, statutory partners and the young people who use the service. Across observations and interviews, frontline staff expressed pride in their professional competence and positioned Dock Hub as a complementary and integrated component of the local mental health system. A frontline member of the Bridgepoint primary care team described working in a general practice environment:

> "It makes you realise, wow, I am a competent professional in the mental health sphere!" (S1-ST-001)

The enthusiasm in this comment is revealing the value of professional recognition in a clinical space. For voluntary sector workers operating within an NHS physical space, this kind of respect and recognition is not guaranteed. It requires demonstration of overlapping capacities: using clinical language, completing accredited training, managing risk within defined frameworks, and holding one's own within statutory forums. The exclamation reflects the distance between a self-image as a community or youth worker and the experience of being recognised as a clinical professional within a GP practice. Professional identity at Dock Hub is reinforced through accredited training pathways, routine outcome measures, clinical language and the capacity to operate confidently within statutory environments, while retaining an ethos grounded in relationships and local community ties. Professionalism here is presented not as detached from the ethics of care but as the structure that enables ethical attentiveness to be sustained at scale.

The following vignette illustrates how this professional identity is enacted at the frontline, and how wellbeing practitioners negotiate the symbolic authority of NHS medical space.

Vignette: Observing a Bridgepoint primary care clinic

I observe a primary care clinic held within a GP surgery in the north of Dock City. The brick exterior is worn and functional. Wooden panelling lines the corridors. The ceilings are low, with scuffed linoleum floors.

Three young people are booked into the afternoon clinic. The first session takes place before I arrive. Lucy explains that the morning has been disrupted by time, resourcing and technology. She arrives early to set up, but no clinic room is available due to a scheduling error. In the scramble, she begins a full assessment with a sixteen-year-old young woman, only discovering at the end that the same assessment had already been completed at Dock Hub Central a few months earlier. The young person does not realise the GP clinic and Dock Hub are the same organisation. Lucy sighs in kindly frustration. I recognise the familiar inefficiencies of fragmented systems from my own work as a locum GP in rural Australia.

Lucy has come from a background in statutory social work. She is warm and skilled, and cautious with me at first. Over the course of the afternoon, it becomes clear that this caution is less about personal reserve than about the vulnerability of being observed by a GP researcher while working alone in a clinical environment that carries strong symbolic authority.

The second appointment I observe involves an eight-year-old boy and his mother. Before we enter the room, reception staff ask both mother and child whether they are comfortable with me observing. Lucy repeats this explanation in the room, clarifying my role as a researcher and assuring them that no identifying information will be recorded. Both agree. Throughout the session, the mother makes intermittent warm eye contact with me as she tells her and her son's story.

The boy and his Mum each take turns in providing answers to Lucy's questions. They describe outbursts of anger, at times hitting his head with his hands in frustration, and low self-esteem, particularly relating to his weight. He speaks with a gentle hesitancy about his distress. He calms himself by riding his bike or drawing. His friends, a few years younger, knock on his door each afternoon

asking if he can come out to ride bicycles together. The warmth between mother and son sits alongside the description of his distress. Lucy listens carefully, then completes a Strengths and Difficulties Questionnaire (SDQ) as part of the routine outcome measures. She discusses options for counselling and explains the likely waiting time. They elect to go onto the waitlist. Lucy also signposts them to resources and practical strategies that might support him in the interim.

The third young person does not attend. This is his second missed appointment. His family has requested remote appointments due to agoraphobia, but no remote or digital option exists for the clinic. After this missed appointment, he will be removed from the waiting list.

The clinic reveals the friction of co-location without full integration. Lucy enters similar information into multiple digital systems. A referral cannot be sent the same day due to IT constraints. Young people can move between Dock Hub and GP-based services without understanding that they are part of the same organisation.

Despite these frustrations, which I witness across the afternoon, Lucy speaks with pride about working within a GP practice. Being present in this NHS space matters. It signals professional belonging and recognition of the contribution and clinical skills of Dock Hub staff, even at the wellbeing worker level. At the same time, the clinic shows how challenging co-location can be in practice, particularly for staff navigating incomplete integration, technological barriers and differing systems across GP practices in Dock City.

Lucy's experience makes visible that co-location within a GP practice is not the same as integration. However, the symbolic weight of working in NHS clinical space matters to staff independently of whether the operational conditions fully support it. The duplicate assessment, the IT barriers, the missed appointment that produces automatic removal from the waiting list: these are the daily textures of incomplete integration. They also show that Dock Hub's flexibility did not fully translate into the co-located setting. In this case, the service was unable to coordinate the kind of responsive remote or digital follow-up that might have sustained contact with a

young person who did not attend in person. Lucy's pride persists alongside these constraints. This is not naivety; it reflects a practitioner who understands that professional credibility within statutory environments is built through presence, and that presence requires tolerating and finding work arounds for imperfect conditions.

The Dock Hub workforce is predominantly early career. Many staff begin in youth work, social care or community-facing roles and are supported into formal qualifications over time, including Children and Young People's Wellbeing Practitioner training. The CEO Amanda framed these training pathways as a way of developing local talent and extending Dock Hub's values into the wider system. Professionalisation is understood as both individual and collective: staff acquire accredited competencies while remaining embedded within the organisation's care ethos.

Movement between Dock Hub and NHS roles is discussed with ambivalence. Some staff leave after qualification, drawn by higher pay, employment security and formal recognition within statutory services. Amanda described this as a challenge but also framed this positively an opportunity to embed "Dock Hub ways of working" into NHS organisations. Some other staff move in the opposite direction, citing bureaucratic pressures, throughput targets and relational constraints within statutory environments. As one staff member reflects:

> "I just know from my experience of working in a statutory service, that you know, the grass isn't always greener for the sake of an extra 1000 or 2000 pounds [a year]?" (S1-ST-001)

This comment captures the tension between financial incentive and professional meaning. Dock Hub is positioned both as a pathway into the statutory workforce and as an alternative workplace for experienced practitioners seeking more sustained relational engagement. Within the local professional ecosystem, it occupies an intermediary space: accredited and system-facing yet retaining forms of practice that staff perceive as more humane and flexible than those available elsewhere.

The tension between clinical and non-clinical professional identities runs through Dock Hub's workforce. The drop-in service, whose operational restructuring is

described in Section 2, illustrates how this plays out under pressure. When demand exceeded capacity, the professional boundary between counsellors and wellbeing workers became contested. Counsellors were asked to hold crisis presentations that lay outside planned, time-limited therapeutic work. The question of what constituted appropriate professional responsibility was not abstract; it shaped daily decisions about which young people could be seen, by whom, and under what conditions. At the time of my fieldwork, the drop-in service presented as well-functioning and cooperative. Therapeutic and wellbeing strands operated in mutual accommodation. The clinical and non-clinical boundary did not disappear, but it was managed through organisational adjustment rather than left as a source of ongoing friction. Professional legitimacy and open-access ethos were recalibrated as complementary rather than opposed. This boundary will be examined further across the comparative case analysis in Chapter 8, where the tension between clinical authority and youth-work-oriented provision is considered across all three hubs.

System Integration

Dock Hub operates within the youth mental health system for Dock City through two primary connection points: the Single Point of Access referral pathway and the weekly multi-disciplinary team meeting. These interfaces reveal how Dock Hub manages flow, negotiates responsibility, and sustains influence across institutional boundaries.

Young people enter Dock Hub through multiple routes, but the primary referral pathway operates through the Single Point of Access (SPA), a digital platform shared with CAMHS. As one clinical administration staff member explained:

> "The main way we receive referrals is the online digital platform shared between us and [Dock City] CAMHS." (S1-ST-022)

Although Dock Hub received referrals through multiple routes, only one of these was controlled by CAMHS. Referrals could come through the shared Single Point of Access, but also directly via phone calls from parents, carers, and young people, through drop-in, from schools and medical professionals, and by email or letter. The bottleneck sat within the Single Point of Access route, where CAMHS retained

control over triage and onward referral decisions. This meant that Dock Hub was not fully in control of demand flowing through one of its main referral streams, even though other routes provided some autonomy and reduced complete dependence on CAMHS routing decisions.

Once referrals arrive, a large and active clinical administration team manages entry. During observation, this comprised two senior leads and approximately six staff working continuously across phone and digital systems. Their work extends well beyond allocation. Staff interpret eligibility, navigate thresholds, offer signposting, and actively manage waiting lists to avoid young people being repeatedly redirected between services. Triage operates within a level-of-need framework aligned to NHS structures:

> "We triage based on level of need... levels 2 to 3. If it's level 4, that's CAMHS." (S1-ST-023)

This quote describes a triage threshold function, but the clinical administration team's practice extends beyond applying it. Where referrals fall outside eligibility, the response is not automatic refusal:

> "If a referral isn't suitable for us, we don't just say no... We'll signpost... call if needed and help them resubmit [their referral]." (S1-ST-024)

This posture, absorbing uncertainty at the threshold rather than deflecting it, is a defining characteristic of the service model. It reduces the risk of young people falling between services during the highly vulnerable period of waiting for support, and it represents a form of systemic care work that is rarely visible in formal service descriptions.

Demand volatility remains outside Dock Hub's control. When CAMHS releases referral batches, the organisation absorbs sudden surges:

> "Sometimes we get a massive influx of 50 to 60 referrals in one day." (S1-ST-024)

Staff described efforts to smooth upstream coordination, but referral flow remained uneven and largely beyond Dock Hub's influence. The clinical administration team functions as the organisational buffer between this external volatility and the young people waiting for support, sustaining continuity of contact during waits through the structured checking call system described in Section 3.

The second major point of convergence with statutory services is the weekly multi-disciplinary team meeting (MDT). These meetings brought together professionals from CAMHS, social care, hospital services, adult mental health and general practice. Young people and their families were not present. Discussions moved rapidly, focused on clinical details and the coordination of complex cases across systems. Three features of these meetings stood out from my observations.

The first feature was that Dock Hub staff made deliberate use of professional language and titles to establish parity within NHS settings. Internal roles were translated into dual titles such as Senior Clinical Lead or Senior Clinician. For example, one staff member's internal title was Therapeutic Operations Manager, but in NHS-facing meetings their onscreen title appeared as Senior Clinical Lead to match statutory language and expectations. These titles were layered onto existing organisational roles and displayed on NHS-facing systems and online meeting logins. They were not used internally. Their purpose was pragmatic: to make Dock Hub roles legible within statutory hierarchies, enabling staff to participate as credible decision-makers rather than peripheral voluntary sector contributors. This use of language marked an important site of boundary work between voluntary sector and statutory authority, to which I return in the cross-case comparison.

The second feature was that MDTs functioned as a relational workaround to fragmented data infrastructures. With consent, attendees searched their respective systems in real time, sharing safeguarding concerns, medical histories, and prior involvement across organisations. Rather than relying on joined datasets, the meeting assembled a shared picture of a young person's situation through conversation. This reduced the risk that critical information remained siloed within any single agency, while also making visible the system's dependence on human coordination to compensate for structural fragmentation.

The third feature was the particular and bounded contribution of the GP within the MDT. The GP's role was delineated mainly around clarifying the boundary between physical and mental health presentations, advising on whether symptoms warranted medical investigation, and suggesting appropriate tests, such as thyroid function or iron studies, for referral to the young person's own GP. In one case, for example, a young person presenting with anxiety was advised to try Rescue Remedy, a suggestion that sat uneasily alongside this otherwise biomedical gatekeeping role, given its weak evidential basis. There was limited commentary on broader psychosocial formulation, longitudinal uncertainty, or the contextual factors shaping presentation. This suggested a more constrained use of GP expertise than general practice, at its best, can offer, including the integration of physical and mental health, the exclusion of important physiological conditions alongside contextual understanding, and the capacity to hold uncertainty over time. Biomedical authority within the MDT was therefore narrow rather than fully generalist, and its limits were as analytically revealing as its contribution.

Staff described MDTs as generally professional and cooperative, though sometimes tense. Tensions arose when responsibility for complex cases was contested, particularly where needs crossed diagnostic and service boundaries. The MDT did not resolve these structural mismatches. What it offered instead was a space where ambiguity could be spoken, responsibility negotiated, and partial forms of expertise held alongside one another. MDTs functioned less as sites of definitive decision-making and more as arenas for developing a working knowledge of complex cases and managing uncertainty within a fragmented system.

Integration varies considerably across the settings in which Dock Hub operates. In primary care clinics, staff are physically co-located within GP practices but operate largely in parallel, with limited shared systems or daily interaction with GPs. As the Bridgepoint vignette in Section 4 shows, this co-location produces professional recognition without structural connection. Duplicate assessments, separate digital systems and differing appointment formats are the practical consequences.

In schools, integration is more relationally embedded. Regular contact with teachers, pastoral teams and Special Educational Needs Coordinators creates ongoing working relationships that enable earlier identification of need and more

contextually informed referral. This relational integration is less visible as a formal system feature, but more practically effective in producing shared understanding of individual young people across settings.

Place-based commissioning boundaries remain a persistent structural constraint. Eligibility thresholds determined by address or school catchment create abrupt discontinuities at the edges of Dock City, even where need is demonstrable. Staff described young people on one side of a particular street being able to access Dock Hub services while those immediately opposite could not. These boundaries shape who can be held long term and where responsibility must be transferred, generating frontline ethical tensions that no amount of organisational skill can resolve.

Dock Hub's system position appears to be embedded but uneven across some contexts. Integration is usually strongest at the point of entry, where the clinical administration team actively holds young people within the system, and within interagency forums where responsibility is negotiated in real time. Elsewhere, co-location sometimes seems to substitute for deeper structural connection within primary care practices. Through referral navigation and MDT participation, Dock Hub absorbs complexity and redistributes risk across institutional boundaries, while remaining constrained by demand volatility, commissioning rules and the place-based inequity those rules produce.

Logics of Care

My field work suggests that Dock Hub operates through multiple overlapping logics. Clinical orientations prioritise accredited interventions, professional scope and risk thresholds. Participatory logics emphasise shared power and youth involvement in governance and design. Administrative logics are visible in referral triage, routine outcome measures, eligibility criteria and reporting requirements. Alongside these sits a care-ethical logic that shapes how work is enacted in practice, and through which the competing demands of the other logics are interpreted and balanced.

The theoretical frame of a "logic of care" is drawn from Mol, as discussed in Chapter 3, where a logic is a patterned way of organising action[16]. In contrast to a logic of

choice, which assumes stable problems and autonomous decision-making, a logic of care understands needs as evolving, relational and situated. Care is enacted through ongoing adjustment, practical judgement and responsiveness to changing circumstances. It unfolds over time rather than resolving through a single decision or intervention. Across Dock Hub, the orientation towards ethics of care structured how everyday work was understood and enacted. Clinical, participatory and bureaucratic demands were present, but care ethics shaped how these were interpreted and weighted in practice.

In staff accounts and observations, care unfolded over time rather than as a discrete intervention. Engagement with young people had to be built, lost, repaired and sustained. Practitioners spoke about working with what was possible in a young person's life at a given moment rather than pursuing a fixed endpoint. Practice was iterative rather than linear. Decisions were revised in response to unfolding circumstances rather than implemented as fixed plans. Interventions were calibrated to setting, developmental stage and what a young person could currently tolerate.

Dock Hub's logic of care also shaped how mental distress itself was understood. Distress was rarely described as a biological phenomenon detached from context. Diagnoses were acknowledged, but staff accounts consistently located difficulty in young people's social worlds. Poverty, family instability, adverse childhood experiences, school pressure, exploitation and fragmented services were treated as ordinary conditions within which distress emerged. This aligns with Mol's argument in her book 'The Body Multiple' that conditions are not singular objects waiting to be identified, but are enacted differently across settings and practices[17]. At Dock Hub, mental distress did not appear as a stable entity moving intact from referral to intervention. In schools, it took the form of anxiety, sensory overwhelm or non-attendance. In drop-in services, it appeared as crisis or risk. In youth groups, it appeared as isolation or identity vulnerability. In administrative systems, it appeared as scores, thresholds and waiting lists. Each enactment demanded a different care response.

Understanding distress as circumstantial had practical consequences. Care was organised around supporting young people to function within difficult environments rather than targeting symptom reduction alone. This included

advocacy with schools, navigation across fragmented services, parenting support and attention to daily functioning. It also included creating spaces where young people could remain present without being required to perform readiness for change. This framing explains Dock Hub's sustained investment in group-based provision and participation. Group work was treated as an element of care in its own right. Young people described belonging as protective and identity safety as stabilising. For some, supported peer activity generated momentum where individual therapy had stalled.

Dock Hub's enactment of the ethics of care created the conditions for trust to build over time. Young people described returning across years and moving between programmes as circumstances changed. Support was experienced less as a sequence of discrete interventions and more as an ongoing relationship with an organisation that remained available, even when specific interventions ended. As Mol argues, care is not a one-off response to a stable problem[16]. At Dock Hub, counselling offers were often time-limited, but access to other forms of care provided by the organisation was not. Even when interventions ended, relationships frequently persisted through other forms of contact.

Care was also collective. Responsibility was distributed across teams, groups, administrative routines and leadership structures. The redesign of the drop-in service makes this visible: co-location, shared workspace and rapid debriefing created collective capacity to hold complexity. Risk was no longer carried by isolated workers. Decisions circulated through the team. This reflects Mol's insistence that care is infrastructural as well as interpersonal. At Dock Hub, longitudinal care was built into organisational form rather than dependent on individual disposition.

Dock Hub’s logic of care was enacted within statutory systems rather than in opposition to them. Legitimacy and credibility are established through safeguarding structures, outcome measures, supervision, and reporting requirements as integral to holding responsibility and sharing risk. Leaders’ strategic use of NHS-recognisable titles in MDT spaces enabled participation as equals in statutory forums. These features helped the organisation claim authority to hold complexity, negotiate with statutory partners, and sustain care at scale. Qualifications,

registration, escalation pathways, and shared accountability formed part of the infrastructure through which that claim was made.

Outcome measurement fulfilled a similar function. Standardised measures were embedded across services and CORC recognition was valued. Staff described measures as clinically useful and often relationally introduced, while also being clear about what they failed to capture, particularly relational and developmental change. Outcome scores provided visibility and credibility within statutory forums, while narrative accounts and youth participation carried other forms of meaning within the organisation. The process of integrating these was ongoing and imperfect. The broader significance of professional legitimacy, outcome measurement, and their relationship to statutory recognition is examined comparatively in Chapter 8.

Dock Hub is organised around a dominant logic of care that is longitudinal, adaptive and grounded in care ethics. Care unfolds over time, is held collectively across teams and systems, and is revised in response to changing circumstances. For young people, support is experienced less as a sequence of discrete interventions and more as an ongoing relationship with an organisation that remains available.

This ethics of care orientation that builds trust is sustained through professionalism, governance and audit. Safeguarding structures, outcome measures, supervision and statutory alignment form part of the infrastructure that enables care to be delivered at scale, held safely and recognised as legitimate within broader health and schooling systems. Community identity, participation and relational continuity give that infrastructure meaning in young people's lives.

Dock Hub demonstrates that their logic of care extends beyond staff culture and is built into routines, roles, escalation pathways and spaces, and capable of coexisting with accountability without being reduced to it. The case shows that ethical attentiveness at scale requires organisational form, not only individual commitment.

Summary

Dock Hub is an Early Support Hub that is highly organised, professionally mature, and deeply embedded within its local system. Its distinctive strength lies in

combining relational, long-term and adaptive care with formal governance, outcome monitoring, and strong statutory alignment. Across the chapter, I have shown that the ways Dock Hub's enacts its ethics of care are not simply matters of staff goodwill, but are built into organisational routines, spaces, escalation structures, and pathways between services. This enables the service to hold complexity at scale while remaining responsive to young people's changing circumstances over time. At the same time, the case highlights tensions that run through the hub model more broadly, especially between relational flexibility and professional regulation, between belonging and measurement, and between open access aspirations and the structural limits of funding, commissioning and system thresholds.

In the next chapter, I turn to Heath Hub. Dock Hub offers a picture of the hub model in its most established and system-integrated form, and Heath Hub provides a contrasting case: smaller in its scale of services, but spread across a much larger rural geography, differently positioned within its local context, and less formalised in its relationship to statutory systems. Examining Heath Hub next allows further analysis of which features of hub care align across settings, and which depend on particular organisational histories, resources, and local system arrangements.

Chapter 6. Findings: Heath hub

Setting and History

Heath Hub is a voluntary sector advice and counselling organisation for young people aged eleven to twenty-five in Eastern England. It was founded in 1992 by members of a large local church alongside others in the community, as an independent, non-religious organisation to serve young people facing practical need. Initial funding came from an independent charitable trust, originally established to support the education of children from poor families in Heath City. Early activities focused on information, advice and guidance for young people facing practical challenges: housing insecurity, education difficulties, financial hardship and family instability. Over time, Heath Hub expanded into a large regional provider while retaining its founding emphasis on accessible, practical and relational support.

Heath Hub now operates across a large eastern region covering approximately 3,500 square miles of rural, coastal and agricultural land. Serving young people aged eleven to twenty-five across this geographic catchment creates distinct logistical challenges. Public transport is unreliable and infrequent, and for many young people the journey to a Heath Hub site involves long bus journeys with connections that do not always run on time. One young person described being regularly reprimanded at school for lateness caused by delayed buses:

> "My old high school used to give 30-minute detention for people who were just trying to get in." (S2-YP-002)

Transport is a structural barrier that shapes who can physically attend. Heath Hub is primarily an in-person service; at the time of fieldwork, there were no major digital or remote service offerings. The combination of a dispersed population, unreliable transport, and predominantly in-person delivery, affects some young people's ability to access care.

Heath Hub delivers services across three primary physical sites. The central hub is located in Heath City, where the main drop-in advice service, administrative base and central coordination are based. A second site operates in Seaside, a deprived

coastal town approximately one hour east of Heath City. A third site is located in Arching, a historic port town approximately ninety minutes northwest, characterised by distinctive gothic architecture. The three locations form a geographically distributed model: a central urban base combined with satellite sites serving geographically distant communities. In addition to these physical hubs, Heath Hub delivers counselling and therapeutic services across a wider network of schools, community centres and community-based settings, reflecting the organisation's need to adapt to a dispersed rural population with limited transport infrastructure.

According to Heath Hub's most recent impact report, they worked directly with over 5,000 young people during the annual reporting period. The advice service supported almost 2,000 young people, delivering nearly 9,000 advice sessions. The therapeutic support team provided counselling to almost 2,000 young people, delivering approximately 11,000 sessions. Over 95 per cent of young people completing feedback surveys who attended Heath Hub reported feeling listened to and treated well by staff.

The organisation operates a two-strand advice model within its drop-in services. Generalist advisers address practical matters: housing, benefits, employment, education and social welfare. Mental health advisers offer structured fifty-minute sessions delivered by trained advisers, including youth workers, peer workers and non-clinical mental health specialists. This model positions mental health support within a broader ecosystem of practical assistance rather than treating it as a separate clinical pathway.

Alongside advice and counselling, Heath Hub runs a range of youth groups and programmes. These include the Horizons programme for young people at risk of entering care or disengaging from education; youth participation groups in Heath City and Arching, enabling young people to contribute to organisational governance and service design; peer and community groups led by advisers; and specialist support groups under the counselling service for gender-diverse young people. The hub also maintains a regularly stocked food bank, reflecting the level of material deprivation experienced by many of the young people who attend.

Staff described a marked shift in the profile of young people attending the service in recent years. High levels of mental health difficulty and neurodivergence were noted across youth groups and counselling provision. The advice service had also seen a significant increase in asylum-seeking and refugee young people, particularly linked to temporary accommodation in Heath City hotels used to house asylum seekers. The service's founding model of practical advice-led support has proven well-suited to this population, whose needs span welfare, housing and mental health in ways that resist easy separation. This is examined further in the System Positioning section.

Heath Hub began as an entirely charitable initiative, funded through its founding trust. It has since developed a mixed funding model combining the original endowed charity, NHS Integrated Care Board commissioning for therapeutic services, local authority funding for advice provision, and national charitable grants and lottery funding. As with Dock Hub, this diversity is a source of resilience and of ongoing accountability complexity, as each funding stream carries distinct reporting obligations and expectations about what the service should be offering in terms of care.

I have paraphrased the organisation's vision as one in which young people should experience themselves as valued and have the support and information they need to navigate the transition to adulthood. Its mission centres on providing quality information, advice, counselling, and support for the holistic development of young people under twenty-five. These statements frame the organisation's purpose in terms of value, belonging, and developmental transition rather than symptom reduction or clinical treatment. They are consistent with the organisation's trajectory: a service that began in response to practical need and grew into a large regional provider while retaining the relational and developmental character of its origins. Heath Hub's pathway into the youth mental health landscape is therefore distinct from that of more clinically oriented hubs.

Table 6.1 summarises the fieldwork dates, observation settings, interview sample and broad participant roles (without compromising participant anonymity and privacy) informing this case study chapter.

Figure 6.1 Heath Hub case summary

Feature	Summary
Case site	Heath Hub
Fieldwork dates and structure	Two intensive one-week fieldwork blocks: • 5-9 May 2025 • 23-27 June 2025 Semi-structured observation took place primarily in three drop-in centres across a wide rural area between opening hours of 1pm and 5pm, with additional after-hours observation of social youth work and youth voice groups between 5pm and 7pm.
Direct observation hours	58 hours
Main observation settings	Heath City drop-in centre, full-day observation at one coastal drop-in during week 1, full-day observation at a second site drop-in during week 2, counselling team away day, after-hours youth group, drop-in, advice and mental health support spaces, staff briefings and team discussions where permitted.
Formal staff interviews	5 formal staff interviews, representing 5 individual staff participants
Types of staff and roles interviewed	Counsellor, drop-in centre manager, senior advisor and duty senior, non-clinical mental health advisor, and therapeutic lead with responsibility for therapeutic leadership, supervision and clinical governance.
Young person interviews	2 young person interviews
Broad young person involvement represented	Counselling, drop-in, youth advisory board, identity-related support, cultural safety, trans/gender-questioning support group, creative activity and social participation.

Vignette: Arriving at Heath Hub

On my first afternoon at Heath Hub's drop-in, I stood outside and watched young people begin to gather in the car park about twenty minutes before opening. The entrance faced the back door of a shopping centre. Young people lingered near the front in what at first looked like an unstructured cluster: a mix of ages, genders, and racial backgrounds, some alone, some talking quietly with one another, some hanging back. Yet when the door opened promptly at 2 p.m., the group quickly resolved into a line in the exact order in which people had arrived, a small display of the superior English capacity for queueing.

The duty senior stood at the door and invited people in one at a time, creating a small pocket of privacy at the threshold. Each young person was asked, in a few words, why they were there that day. On this basis, an initial triage was made. Those whose needs did not appear acutely urgent were given a letter card, while those considered to need immediate attention, for example because they were at risk of homelessness the next day or had some other urgent concern, were handed a green card that moved them to the front of the queue. Staff explained that they had deliberately moved away from numbers in an effort not to rank young people too overtly, while still maintaining a workable order of priority.

Inside, the main space was bright and carefully arranged. There was a food bank, colourful art on the walls, open tables with snacks placed in the middle, a small kitchenette with tea-making facilities, and games and art supplies in the corner. A few steps led up to a mezzanine level overlooking the room. The space felt warm and youth-oriented, but not casual in the sense of unstructured. A receptionist sat at the front desk and every young person had to check in. Their presence in the building was noted and entered into the system. If they were new to Heath Hub, the initial registration process began with a form and a further check-in by a worker. Across the afternoon, some young people arrived for advice or triage, while others came in simply to gather, have a cup of tea, sit at the tables, or use the art supplies. Even these young people were required to check in, so staff retained a clear awareness of who was in the space. This was not a youth club in the loose

sense. It was an open access environment, but one bounded by surveillance, safeguarding, and controlled entry. At a later date, the CEO told me that the space had been very intentionally designed to feel both welcoming and safe. The desks and chairs, for example, were deliberately heavy so that they could not easily be thrown, a lesson learned from an earlier iteration of the hub.

The youth-only character of the space was actively maintained. At one point, a parent accompanying a school-aged young person was told politely that adults could not remain in the waiting area, which was reserved for young people aged 11 to 26. Staff suggested that they might go for a walk and be called when the appointment was available, which they chose to do. The boundary was clear. The waiting area belonged to young people. I did not sit in that space myself, but remained on the mezzanine with staff, from where I could observe the flow of the afternoon and meet the young people who elected to speak with me about their experiences.

Young people described Heath Hub as a non-judgemental space where people were easily relatable. One person who had attended for the first time said she had had a really positive experience and told me that when you come in, "you might feel mad, but by the end you feel really understood". Others spoke about staff being approachable, practical, and easy to talk to. They noticed the small choices on offer, the mugs, the snacks, the art materials, and the ease of being welcomed in without excessive formality. Yet the afternoon also made visible the limits of that welcome. Some young people arrived after 3 o'clock and were not able to be seen. Others were judged not urgent enough for immediate support and had to wait or return. The service offered warmth, responsiveness, and dignity, but under clear conditions of constraint.

The vignette illustrates two things that shaped my understanding of Heath Hub throughout the fieldwork period. The drop-in is open and welcoming, but it is not uncontained. The triage at the door, the card system, the registration requirement, and the cut-off time, are mechanisms through which an open-access service remains manageable. The design of the space itself, down to the weight of the furniture,

reflects an organisation that has learned to hold complexity without being overwhelmed by it.

Organising Care

Heath Hub organises care across three overlapping service strands: drop-in information, advice and guidance; mental health advice; and counselling. These sit alongside a range of youth work and group activities that are not supplementary to the service but integral to how it operates. The strands are institutionally distinct but practically interwoven, and some young people move through more than one of them over time.

The drop-in advice service operates under a formal Information, Advice and Guidance framework, with accreditation through a national advice standards body and registration with a financial advice regulator for debt and financial guidance. The Duty Senior for drop-in, a managerial role for an experienced adviser, monitors flow and safety across the session and sees young people if capacity allows. Generalist advice sessions run for up to an hour, with advisers typically offering three sessions between 2 and 5 p.m. in an afternoon. Sessions are delivered in semi-private booths behind a shared work surface that staff describe with affectionate informality as the flight deck.

Some elements of these consultations reminded me of my GP practice: the open-ended invitation to name a presenting concern, the collaborative ordering of priorities when multiple issues were present, the mapping of related concerns across different domains, and the closing plan with agreed next steps and referral where needed. Common presenting issues include housing instability, homelessness, employment, benefits and financial advice, education rights, and access to legal support. One adviser described the flexibility and impact of this work:

> "People will come to us homeless… they just think, well, I have no other options… We can look at hostels, short-term placements, private rental options… you can often see this kind of relief of like, wow, I just thought I was going to be homeless." (S2-ST-014)

The staff member's perception of relief in the young person expressed in this quote demonstrates the value of the service in addressing a problem that felt intractable into one with visible next steps, offered within a relationship that is warm and practical rather than clinical or procedural.

Alongside generalist advice, the hub provides fifty-minute mental health advice sessions delivered by trained advisers. These sessions are framed as non-clinical support rather than therapy or diagnosis. The focus is on listening, clarifying concerns, identifying patterns in a young person's experiences, suggesting coping strategies, and signposting to further services. One mental health adviser articulated the approach:

> "Anxiety… you have to separate the problem and the reaction to the problem. Anxiety and the problem are two different things… once you manage anxiety the rest can become clearer." (S2-ST-013)

Senior staff at the drop-in told me that the separation of generalist advice and mental health advice had been a deliberate organisational decision. Young people frequently presented with both practical and emotional needs and attempting to address them concurrently in a single session had proved difficult. As I observed on several occasions, some young people had two separate appointments back-to-back, one generalist and one mental health. This brought structure to each session and assisted with the containment of both time and emotional material, allowing each strand to do its work without either displacing the other.

The boundaries of mental health advice work are less formally specified than those of the generalist advice service, relying more heavily on adviser judgement and experience. This is examined further in the Professional Cultures section.

A distinct youth mental health worker team sits within the therapeutic service. The Therapeutic Lead, who I will call Maya, oversees this team alongside the counselling workforce. Around nine full-time equivalent staff make up this strand, drawn from a range of backgrounds including psychology graduates, mental health nurses and teachers. As with Dock Hub, many of these staff are early career. The role has undergone significant change in recent years. It originated in school-based delivery:

structured group work delivered in five weekly sessions designed to support young people to develop and maintain good mental health. Following a commissioner directive to stop this school-based delivery, linked to the establishment of Mental Health Support Teams in Schools across the region, the role was repurposed into one-to-one delivery of CBT-informed advice, psychoeducation and practical mental health support, now including the Better Sleep Programme. The offer is focused on young people aged fourteen to twenty-five, the same age range as the counselling service. Youth mental health workers use the same rooms and hub spaces as counsellors and operate flexibly across the service.

Maya the Therapeutic Lead described the growth of this team as driven in part by young people's own preferences. For some young people, one-to-one CBT-informed support felt more accessible than counselling: a practical orientation to specific concerns rather than the more exploratory relational work that counselling involves.

I was interested in how this role sat alongside the mental health adviser role without yet being formally integrated with it. Both involve non-clinical practical mental health support delivered outside standard counselling. They have developed separately within the organisation, serving overlapping functions through different routes and with different professional reference points. The boundaries between the roles, in terms of scope, skills and accreditation, are not clearly delineated. Maya is currently reviewing supervision arrangements across the service to assess whether current structures are fit for purpose as the role grows. At present, mental health advisers receive bi-monthly one-to-one supervision, with the intervening month given to group supervision, rather than the monthly individual supervision provided to counsellors. The question of how to professionally train, supervise and support this workforce as it develops is live within Heath Hub and across the hub sector more broadly.

Counselling is delivered through a regionally distributed therapeutic service operating across hubs, schools and community settings. Most counselling is delivered in blocks of twelve to fifteen sessions, with flexibility depending on need. The counselling workforce is trained primarily in humanistic modalities: person-centred, integrative and Gestalt approaches. This orientation emphasises relational engagement, emotional exploration and supporting young people's autonomy.

Waiting times for counselling at the time of fieldwork were approximately six months. Young people could access advice sessions and attend youth groups in the interim, and the drop-in remained available for immediate concerns throughout.

The therapeutic service is funded through long term contracts with the NHS Integrated Care Board. A Current View Tool exercise conducted several years before my fieldwork concluded that Heath Hub sees young people of equivalent severity and complexity to those seen by NHS CAMHS colleagues. The CEO also reported that Heath Hub's data quality on volumes and paired outcome measures was at or above local NHS trust standards at the time of fieldwork. I return to the significance of both claims in the Logics of Care section.

The physical layout of the main centre supports and reflects these organisational distinctions. Generalist advice happens at the flight deck, open and social. Mental health advice sessions take place through a single door at the back of the main space. Counselling rooms are further removed, offering greater privacy and containment. The spatial arrangement is layered: from the open and social, through the semi-private, to the confidential. Young people move through these layers as their needs deepen, and the architecture supports that progression without enforcing it.

Two main strands of youth work operate alongside advice and counselling. The first runs through the advice team and includes peer and social groups. Heath Social is a structured group primarily attended by neurodivergent young people. Activities are planned collaboratively, with young people voting on sessions in advance. During a quiz night I observed, youth workers periodically reminded participants about communication, kindness and respectful interaction, modelling healthy social engagement within the group rather than simply facilitating its content. The second strand involves youth voice and advocacy, funded through local council partnerships, with youth advisory councils in Heath City and Arching enabling young people to contribute to service design and local authority decision-making. My data suggest that these are not consultation exercises bolted onto the margins of the service. They are embedded participation mechanisms, examined in depth in the Ethics of Care section.

A Dungeons and Dragons (a collaborative storytelling game) group also operates from the main centre, facilitated by a mental health adviser with experience of the game as a medium for identity exploration and social connection:

> "The game itself means young people don't have to come to the group and tell someone who they are… they create a character and form connections." (S2-ST-013)

The fictional frame of the game provides protective distance while enabling connection and self-exploration. For young people who may not yet have the language or safety to be direct about who they are, this is an access point that a clinical or even explicitly social format cannot replicate. Be You, a monthly support group for trans and gender-questioning young people, operates alongside these other groups and is described further in the Ethics of Care section.

Young people's accounts of the service captured both what it offers and the limits of what it can guarantee. One young person described the drop-in as fluid and responsive:

> "Drop-in… you say, is anyone free to talk right now? Normally they'll either get you someone at that point, or arrange a phone call later that day" (S2-YP-002).

The same young person had found both counselling and the Be You group for trans and gender-questioning young people helpful and supportive. Of counselling, she said:

> "I used counselling twice… 12 sessions each time… very useful, though the gaps were a bit of a struggle." (S2-YP-002).

A second young person offered a more mixed account. Her own experience of counselling had been freeing, and her involvement in the youth participation group to be transformative. But she shared the experience of a close friend who had tried to access drop-in support during a period of acute distress and been repeatedly turned away:

> “Their experience wasn’t the best. They went there multiple times just to be told, ‘We’re too busy, you need to come back another day.’ Every other day they tried, and like, they couldn’t get any support whatsoever. This was during a time of high distress for them. They weren’t able to get help anywhere else either, because they were met with the same response: ‘You need to wait.’” (S2-YP-001).

The service is experienced as accessible by some young people and as repeatedly closed by others, often depending on the timing and persistence of their attempts. The ethos of open access does not resolve the structural problem of finite capacity.

Safeguarding and risk management at Heath Hub operate through a model of collective responsibility and relational judgement. There are formal escalation structures, including pre-session briefings, escalation to senior advisers, and fortnightly team reviews of complex cases and safeguarding plans. But the first line of risk awareness is affective and interpersonal. At each handover meeting, including meetings I observed, before the drop-in opens the Duty Senior asks a question to all front-line staff: "Does anyone have any gut feelings?" Staff had found that intuitive concerns about particular young people often preceded formal risk disclosures. Giving those concerns a sanctioned space in the pre-brief had proved useful. A Mental Health Advisor described a case where a young person had been misleading about their past criminal activity in a risk assessment for them to use the hub’s common spaces; staff had mentioned gut feelings about them days before. The formalisation of intuition acted as a pragmatic complement to safeguarding procedures.

Heath Hub has no access to statutory records. Young people can attend without disclosing prior involvement with social care, mental health services or criminal justice. The Duty Senior described the uncertainty this creates:

> "You never know what you’re going to get when you open the door." (S2-ST-014)

The service cannot eliminate the risks that follow from this. What it has developed is a culture of collective observation, explicit communication and shared responsibility: risk held by the team, not carried by individuals. Within the counselling service, Maya was direct about the priority structure:

> "Nothing is more important than me talking to you about a young person… I would walk out of a commissioning meeting if someone called me and said 'I'm worried about this young person.'" (S2-ST-012)

This communicates to all staff that the organisational culture will support them in prioritising safety over performance or funding compliance. Maya also grounded the team's approach to risk in a developmental framework:

> "We grounded ourselves in the positives of risk in adolescence… if you're constantly protected, that's actually one of the most risky things." (S2-ST-012)

Responsiveness to young people's safety is situated here within an understanding of what adolescence requires: the presence of reliable adults who can accompany young people through difficulty, not the elimination of it. Maya was equally clear about the proper form of professional responsibility:

> "I am not responsible... none of the team are responsible for any child. I'm responsible to providing the service correctly, which includes safeguarding, but I'm not responsible. They're not my children." (S2-ST-012)

The distinction between being responsible for and responsible to a young person is not a diminishment of care. It is a clarification of its proper professional form. Workers who assume parental responsibility risk both their own wellbeing and the young person's developmental interests. The articulation of this boundary at the level of senior leadership shapes the culture in which all staff practise.

Routine outcome monitoring at Heath Hub operates across service strands with different tools and different degrees of tension. In counselling and youth mental health work, paired measures are used at the beginning, middle and end of an intervention. These include YP-CORE (Young Person's Clinical Outcomes in Routine

Evaluation) and CORE-10, both assessing general psychological distress and wellbeing, and Goal Based Outcomes (GBOs), tracking progress toward collaboratively identified goals. Heath Hub reports these measures to regional NHS teams in the same format as NHS Trust colleagues, coded and submitted as mental health treatment data.

Staff described outcome measures as useful when they supported reflective conversations with young people, and burdensome when they did not. One counsellor captured the dual character of measurement:

> "When a young person can see we started at two and now we're at nine, that can be really impactful." (S2-ST-011)

The same counsellor was clear about what quantification cannot reach:

> "The fact that they come into a session every week... we always see that as enormous... but you can't put a number on that." (S2-ST-011)

The first quote describes outcome measurement as a tool for young people's own understanding of their progress. The second names the limit of that tool honestly: sustained engagement itself carries therapeutic meaning that scores cannot capture.

Practical accessibility of the outcome measures, particularly for young people with limited education or accessibility needs, was a further concern:

> "Young people don't know what the words mean... the data would be skewed if we just left them to it." (S2-ST-011)

This points to an implementation issue with collecting outcomes data. Outcome measures gather different data depending on how carefully they are introduced and explained. Scores generated without adequate staff support may systematically misrepresent a young person's experience. The quality of administration for validated outcomes measures is inseparable from the quality of data produced.

The data requirements introduced through the Shared Outcomes Fund presented distinct challenges. Participation in the grant programme required young people to complete multiple and often overlapping outcome measures focusing on symptom severity. Heath Hub staff reported that young people found this confusing and fatiguing in ways that differed meaningfully from their usual outcome monitoring. In one session, a counsellor had only reached question three before the young person became distressed and the process had to be abandoned. Most young people subsequently declined to participate in the research component, reporting it felt like an additional and unnecessary burden. That the most engaged young person in the service, a youth participation group member, still found the experience cumbersome is itself telling. External research data requirements carry their own logic, oriented towards standardised comparability for funders, commissioners, and policy audiences and, where academic researchers are involved, towards publication and career progression that may conflict with the needs of the therapeutic relationship. When these logics are imported into an active counselling session, it can disrupt the very conditions that make the work possible.

Ethics of Care and Youth Participation

Ethics of care at Heath Hub are enacted through relational continuity, attentiveness to the whole person, and a sustained commitment to young people's active participation in the service. Drawing on Tronto's framework[18], I examine how attentiveness, responsibility, competence, and responsiveness are distributed across the organisation; and how youth participation is understood as a central feature of the service and its ethical integrity.

Continuity at Heath Hub is not primarily the continuity of a named therapeutic relationship but something more diffuse and organisationally embedded: the experience of being known across time, across different staff and across the different strands of a complex service. Young people who attend the drop-in regularly are greeted by name. Staff who encounter the same person in a youth group, an advice session and a corridor conversation accumulate a layered understanding that no single episode could produce. This is sustained attentiveness: care that persists beyond the formal appointment and remains alert to need even when no session is scheduled.

The infrastructure for this continuity takes a particular form. A centralised record system holds each encounter alongside any safeguarding concerns. Alongside it runs a culture of shared awareness, daily handovers and informal communication across teams. Continuity is held collectively rather than assigned to a single keyworker. Both the advice and counselling teams are explicit that the therapeutic relationship is professional rather than personal. In the drop-in, mental health advisers may rotate or formally hand over to a colleague after several sessions, reinforcing that the young person's relationship is with Heath Hub as an institution rather than with any individual practitioner. This is not indifference to relational continuity. It is a deliberate safeguard against a form of dependency that would, if unchecked, become unsustainable for both parties.

This longitudinal awareness accumulates in ways that are difficult to capture formally. One adviser described the experience of reviewing a young person's progress across months:

> "If we look at where you [referring to a young person] were a year ago and look at where you are now... sometimes you forget how new that is for so many people." (S2-ST-013)

The observation captures something about the pace at which change happens in young people's lives, and how easily that change is taken for granted by those witnessing it. The first young person I interviewed had used Heath Hub across several years, including two courses of counselling. What she valued was not the continuity of any single relationship but the constancy of the organisation itself: a place that was reliably there, with familiar values and an ethos she recognised each time she returned. She described counselling as a liberating process:

> "It's very good to have someone to talk to as a whole... it was so freeing." (S2-YP-001)

Heath Hub regularly receives feedback from young people about the kindness they experienced at the service. Maya reflected on what that tells the organisation:

> "That tells me kindness is not found everywhere, because you don't remark on things that are ubiquitous." (S2-ST-012)

This shows that for many young people who arrive at Heath Hub, being given attention, time, and being listened are not the norm. The following vignette, drawn from observations at the Seaside satellite site, shows what that attentiveness looks like in practice in a smaller hub where the team is fewer in number, the young people are known over long periods of time, and the distance from other supports and opportunities is limited by geography.

Vignette: Ryan visits Seaside Drop-In

Seaside is a town marked by visible deprivation and social decline. Once a port town, and later a place shaped by tourism, it now bears the marks of England's changing economic geography. The previous industries of shipping, fishing, or tourism no longer offer major job opportunities for young people. One advisor told me that a significant part of her role is encouraging young people to build the confidence to get the train to Heath City and look for work there instead.

The main strip is loud but hollow: faded neon signage, garish carnival rides, and the sweet chemical smell of takeaways stretching almost the length of the seafront. Behind the seaside veneer of holiday playfulness lies a more unsettled atmosphere. The Heath Hub satellite office sits on a quiet residential street within this setting: four small rooms, a modest sign on the door, and a team of advisors who know many of the young people who come through by name.

I will call him Ryan. He is a tall young man in his early twenties, dressed in a plain tracksuit, softly spoken, and sparing in his eye contact. During his visit, he spoke to me briefly and smiled warmly as he described the hub as "pure magic". His adviser, who had known him for many years, explained my role as a researcher and confirmed that he understood and was happy to speak with me about his experiences. He first contacted Seaside Hub when was 18, after a parent suddenly died and left him in financial debt that he had been unaware of previously. In the aftermath, he was left trying to manage grief and a new adult life with little support and only a partial understanding of the financial arrangements surrounding him.

Today Ryan had to the hub seeking support for a banking scam. Someone had contacted him by phone, claimed to represent a debt recovery company, and extracted several hundred pounds from his personal account. Ryan had told no one initially. He felt ashamed. But he knew the advisor Gerry at Seaside Hub well and came in for help. The advisor, a former secondary school English teacher, accompanied him in person to the bank that day to report the fraud, contest the transaction, and help Ryan begin putting safeguards in place on his account.

Ryan's relationship with the Seaside hub has been intermittent but enduring. At some points he attends once a week. Then staff may not see him again for many months. When he does return, he accesses debt advice, food vouchers, and the informal social support of a place where staff know his name, ask after him, and notice when something is not quite right. Staff describe him with warmth and without condescension. They are also candid about the nature of his needs: they say he will most likely continue to require some degree of support for most of his life, as his vulnerability to exploitation, financial and social, is unlikely to disappear entirely. The task is not to eliminate that vulnerability, but to help contain it and interact safely in a world that is not always kind or fair.

Responsiveness at Heath Hub is shaped by a clear organisational understanding of the limits of each service strand. The service is not attempting to provide unbounded open access care; it is attempting to provide the right kind of care, calibrated to what each area can competently offer within their limited resources, while remaining alert to the moment when a young person's needs exceed that capacity.

The mental health adviser's account of managing difficult disclosures captures this well. When a young person talks about issue that require therapeutic processing rather than advice and signposting, the task is not to pursue it but to acknowledge it and contain it appropriately:

> "You can't interrupt someone at that point… you can say, thank you for telling me that, but I'm going to close that, not because it doesn't matter, but because it matters so much and you need the space where that can be done appropriately." (S2-ST-013)

This is responsiveness in the form of emotional containment: knowing what not to open, and how to acknowledge the presence of psychological pain without delving into it. It requires knowledge of one's own scope, knowledge of the young person, understanding of other available services, and attention to verbal and non-verbal signs of escalating distress.

The same adviser was equally direct about the risk of getting care wrong in the opposite direction:

> "It's possible to care too much, because you can't hold on to the boundaries. You shouldn't be giving three-hour sessions... you have to model something healthy." (S2-ST-013)

Professional boundaries can themselves be therapeutic for young people who may have never come across them. A worker who is endlessly available and never limits the session communicates something about what care looks like that may ultimately harm the young person it is intended to support. Heath Hub's approach positions sustainable professional limits as a form of attentiveness.

The management of dependency reflects the same logic. An adviser described an explicit concern that drop-in attendance could become a substitute for broader social connection:

> "It's important you don't just become dependent on us, because we [individual staff members] won't always be here." (S2-ST-013)

The organisation must hold two things simultaneously: reliable availability, and a commitment in supporting young people's independence. That tension cannot be resolved by policy. It is navigated through relational judgement, case by case, with supervision and collective reflection providing the holding environment for that navigation.

Youth participation at Heath Hub is embedded in the organisation's identity, structured into its governance, and understood by staff as both an ethical commitment and a practical feature of how the service works. Young people contribute to service development, lead advocacy campaigns, participate in civic decision-making, and support one another through peer group structures. This reflects what Tronto describes as caring with: care understood as shared responsibility within a democratic institution rather than as provision directed from practitioner to recipient[19].

The youth advisory councils are the most formalised expression of this. In Heath City, the council meets regularly to advise on service development and engage in

mental health advocacy. In Arching, council membership connects young people to local authority decision-making, giving their voices reach beyond the organisation itself. A mental health awareness event was being planned during my fieldwork, alongside earlier work on inclusive access to play for disabled young people and anti-bullying conferences. These meetings were social as well as being a way of young people being supported by youth workers to exercise collective agency in public life.

The first young person I interviewed had been part of the youth advisory council for three to four years as a school aged young person. Participation had not simply given her influence over Heath Hub services and local campaigns; it had influenced how she saw herself:

> "I found a sense of community here. I love my work here, and I like that I'm actually making a difference…It's made me so much more social... I was very reserved and introverted, and I feel a lot more outgoing now." (S2-YP-001)

This quote describes belonging and purpose, and developmental growth. Young people at Heath Hub are not only cared for within the service's programmes. They are supported to become people who care for others, for communities, and for causes that extend beyond themselves.

A second young person described her engagement with the council in more modest but equally revealing terms:

> "I like it because it helps me socialise more, helps me meet new people... it helps me learn what's going on around me and how I can help." (S2-YP-002)

Youth participation at Heath Hub is simultaneously social, therapeutic and empowering: it builds connection and confidence, offers structure and purpose, and gives young people a direct role in shaping the services and communities they are part of.

Maya articulated her view of organisation's civic orientation:

> "We live in a society where UK's children are some of the unhappiest in the world. If you empower and strengthen someone, they can make their way through lots of different systems." (S2-ST-012)

Youth participation is understood here a core feature of Heath Hub and as a form of political commitment. Youth participation at Heath Hub enacts what Tronto describes as democratic care: shared responsibility that acknowledges asymmetries and supports individual empowerment[19].

Professional Cultures

Heath Hub's professional culture is warm and informal. The staff moving through the drop-in on a busy afternoon are colourfully dressed, each with their own personal expression: printed shirts, knitwear, visible tattoos, brilliant hair colours. The absence of a dress code is part of how the service communicates its welcoming and inclusive identity to the young people it works with.

The team at Heath Hub come from a wide range of backgrounds. I encountered former NHS medical doctors, retired senior teachers, social workers, qualified youth workers, gender studies graduates and lifelong counsellors with voluntary sector backgrounds. Ages ranged from early twenties to late fifties. The team drew its identity from that heterogeneity rather than from any single professional tradition. Staff who had previously worked in statutory settings described them with soft amusement and realism rather than bitterness, bringing with them a preference for relational over procedural practice grounded in direct experience of what statutory systems could and could not offer.

The CEO's background in working with marginalised young adults in drug and alcohol services shaped the organisation's founding culture: a commitment to working with people whom other services found difficult, and an organisational refusal to treat complexity as grounds for exclusion. Maya brought a distinct set of values to the counselling service: racial equity and inclusion, and a strong commitment to the sustainable practice of the counselling workforce.

One mental health adviser, who I will call Anna, had trained as a doctor and spent five years in the NHS before moving into the voluntary sector. She described her role at Heath Hub as doing work a GP might recognise, including advocacy, care coordination and navigating fragmented systems, but with more time and flexibility. She was not practising as a doctor in this context, but she noted that her clinical background allowed her to identify early features of psychosis and respond to medical incidents in the drop-in (with referral to GPs and paramedics when necessary) that staff without that training would have found harder to hold.

Recruitment at Heath Hub is strongly values-led. When discussing how the Heath Hub workforce was developed, Maya's stated directly that skills can be taught but values cannot. The organisation looks for people with relevant experience in mental health or community work and a qualification at an appropriate level, but the governing criterion is whether a candidate shares the organisation's commitments. This approach has produced a workforce with considerable diversity of background and a coherent organisational culture. The following vignette shows the counselling team's shared professional culture from the inside, and how they carry risk and difficulty collectively.

Vignette: Away Day for Counselling team

At Heath Hub's Therapeutic Services Away Day, I began to see more clearly the mutually supportive structure of the counselling team and the values that held it together. Early in the day, staff spoke about the importance of supporting one another, managing risk collectively, and not abandoning young people when they disengaged or became difficult to reach: "don't dump them". The day's theme was difference and commonality. Staff were invited to reflect on their own protected characteristics, on what set them apart, and on what connected them beyond formal categories of identity or vulnerability. The exercise was thoughtful and, at times, challenging. It highlighted how easily both staff and young people can come to be understood through fixed labels, rather than through the more complex relational realities of therapeutic work.

Part way through the day, at the suggestion of the therapeutic lead, the team turned the table on me, conducted an informal interview lead by the Therapeutic Lead, and began asking questions about my own background and interest in their work. This was thoughtful and helpful, shifting the dynamic so that I too was being examined rather than simply observing, and over time it helped build trust with the counselling staff.

Later, in an enthusiastic discussion about counselling with an experienced practitioner over tea, she suggested Isabel Menzies Lyth's 1960 paper on social systems as a defence against anxiety, showing a thoughtful engagement with Heath Hub organisational structure and the problem of how to balance bureaucracy with the flexibility that counselling requires. The challenges of safeguarding and holding risk in the counselling profession remained close to the surface, however, and responsibility could weigh heavily. Over lunch, one counsellor became tearful while recalling a recent occasion when they felt they had not held risk well. The others responded quietly, and with acknowledgement and care.

The vignette shows a team that shares a common ethic, marked by mutual support and a commitment not to abandon young people when risk or disengagement made the work harder. The tearful moment over lunch is as revealing as the structured exercises: it shows that the weight of responsibility is collectively felt, and that the team provides the holding environment within which that weight can be named and shared. The Menzies Lyth paper, offered casually between sessions over tea, reflects a workforce that thinks seriously about its own organisational conditions, not only about the young people it serves.

Many staff carry their own experience of mental health challenges, and several spoke with me about how this shapes how they engage with and support young people. Lived experience operates implicitly in how people practise rather than as a formal feature of the service model. Heath Hub does not actively recruit on the basis of lived experience, and I did not observe it mobilised explicitly in interactions with young people. What animates the workforce is values alignment and relational disposition. Lived experience may inform how some staff practise, but it does not define who is hired or why.

A Duty Senior for the drop-in described the team's capacity to support one another as a practical feature of sustainability:

> "I think everyone feels confident to say, this is feeling like a lot for me... people will just take bits off each other. I don't feel like I take things home... because I know I'm not going to be all on my own with it." (S2-ST-014)

The capacity to name when the work is too much, and to trust that colleagues will absorb the excess without judgement, is something I observed operating in practice at Heath Hub rather than merely aspirational. It was part of what Maya meant when she spoke of staff practice as something requiring active maintenance and collaboration.

One adviser in the drop-in offered a more ambivalent account. The same features of the culture that made Heath Hub sustainable also created operational tensions. Some staff required more flexibility around working hours and unplanned leave, for their health and wellbeing. Over the course of weeks and months, this created workload

imbalances that fell unevenly across the team. The adviser described this with care and without resentment but named it as a tension requiring ongoing management.

The staff team was described as stable at the time of fieldwork: no advisers in the drop-in had left in over three years. This stability is important for the relational model the service depends upon. Young people return to the drop-in because similar staff are there when they return. The institutional memory that holds a young person across multiple presentations and multiple years is only possible if the people who hold that memory stay.

On a busy afternoon, the drop-in at Heath Hub is remarkably coherent given its pace. Advisers move between booths, check in with the Duty Senior, exchange brief updates at the shared desk. The service is operating under considerable demand, but the atmosphere is warm and collegial.

Coordination happens through two overlapping channels. In-person conversation during the session is constant and informal: a quick word at the desk between appointments, a gesture across the room, a moment at the kitchenette that doubles as a clinical handover. Alongside this, a shared digital channel on Teams carries updates across the day, including between the three sites. The Drop-In Manager described the drop-in as having a clear collective purpose: a space for young people to arrive without appointments and access support from a team of advisers, with that team holding the day jointly rather than each practitioner holding their own caseload in isolation.

A Duty Senior described the pace and unpredictability of this work with the confidence of someone who has metabolised it:

> "We're never sure until we open up the door... we have a lot of processes in place in order to manage demand on the day. On a very busy day, the duty senior will be working to resolve capacity issues but also to lower expectations. We can't over-promise anything, but instead we try to ensure nobody goes away empty-handed." (S2-ST-014)

The phrase "nobody goes away empty-handed" recurred across staff accounts and contexts. Even when capacity is insufficient to provide a full appointment, something is offered: a welcome, a next step, a returned phone call. Care begins before the formal session and persists when the session is unavailable.

Social justice at Heath Hub is an explicitly named organisational value, invoked without self-consciousness in interviews and observations, and understood by staff as an organising principle for how they interpret young people's difficulties and how they act in response. Staff frequently described their work in terms that extended beyond service delivery into a broader analysis of structural inequality and the conditions that bring young people to the service. One mental health adviser's critique of what he described as a Victorian model of education, preparing young people for a working world that no longer exists, was the foundation of how he understood distress and what help could mean. Young people's difficulties were read as evidence of structural failure before they were read as individual symptoms

Heath Hub operates in a commissioning and funding environment that speaks the language of outcomes, throughput and evidence-based intervention. The organisation must translate its relational, justice-oriented practice into those terms well enough to secure the contracts that sustain it, without losing what makes the practice distinctive in the translation. This requires a form of institutional bilingualism: speaking funders' language externally while maintaining its own internally. Maya's account suggests this is understood as a permanent condition of the work rather than a problem to be resolved.

System Integration

Heath Hub occupies a distinctive position within the local youth mental health landscape. It is formally embedded in local referral pathways through a shared digital triage platform and weekly multi-disciplinary meetings with statutory services, and its counselling provision is funded in part through NHS Integrated Care Board commissioning. At the same time, it operates without the joint governance structures, shared data systems or operational protocols that characterise more deeply integrated providers. Understanding this position requires attention to

both what connects Heath Hub to the statutory system and what created separation from it.

Entry into Heath Hub does not require formal referral. Young people can self-refer, walk in, or be signposted by schools, health visitors, GPs or other voluntary organisations. Referrals reach the service through three broadly equal streams, each accounting for around a third of incoming young people. The first is the drop-in itself: self-referral and informal signposting through community and professional networks. The second is the regional Single Point of Access (SPA) system for the region, a digital triage platform that is controlled and managed by CAMHS, with a dedicated administrative service manager based in Heath Hub who coordinates the connection between Heath Hub and the wider referral system. The third stream is weekly multi-disciplinary team meetings with local statutory services including CAMHS and Adult Mental Health Services.

The weekly interagency and multi-disciplinary team meetings (MDT) bring together Heath Hub and statutory services to discuss complex cases and determine appropriate pathways. Referrals can move in either direction: from Heath Hub into statutory services when needs exceed voluntary sector capacity, and from statutory services into Heath Hub when young people require a less clinical or more accessible form of support. The meetings create a shared space for thinking through complexity across service boundaries.

A secondary multi-agency meeting operates for the most complex cases, where it is unclear which service can most appropriately provide support for a young person. Coordinated by a local charity rather than any single statutory provider, this forum can connect young people to a wider range of provision including social care, specialist services and private therapeutic offers such as equine therapy. It is particularly significant for young people whose needs do not sit neatly within standard thresholds: those with functional neurological disorder, or those experiencing layered abuse, neglect or instability who are not yet ready for formal therapy but still require coordinated care and some form of containment.

Heath Hub's integration through MDTs and the SPA does not always translate into a shared understanding of what the service can provide. The organisation was well

regarded within the local system, but that regard was not always matched by accurate knowledge of its scope. The Duty Senior described the weight of expectation that arrived with some referrals:

> "Health visitors, health professionals are able to say, oh, [Heath Hub] are great... sometimes it's just, 'go to [Heath Hub], they'll solve the problem.'" (S2-ST-014)

Young people arrive having been told the service will resolve difficulties that require housing support, statutory mental health intervention or social care involvement. Managing those expectations without closing the door is a daily feature of the drop-in:

> "We get young people saying, 'you're going to get me a house'... that can be problematic because we're having to rejig expectations." (S2-ST-014)

A counsellor articulated a similar ambiguity of the organisation's position within the wider system:

> "We are a charity that the NHS refer to... we're sort of out here on our own... there's a reliance on us, but we're not acknowledged as healthcare. It feels as though we're doing such important work, but it doesn't fit the medical model." (S2-ST-011)

The hub is relied upon but not formally recognised as healthcare: this captures the challenge for voluntary sector organisations performing functions the statutory system depends upon while declining to integrate with them. The lack of recognition is not only a matter of professional status. It shapes funding stability, clinical authority, information access and the terms on which Heath Hub can advocate for the young people it serves.

Alongside these formal interfaces, senior staff cultivate working relationships with individuals within statutory organisations whose values appear broadly aligned with their own. Maya described seeking out the police officer working on domestic violence, the social worker specialising in marginalised young people, the council

officer with a rights-based approach to housing, and building sustained dialogue through those points of contact. The aim is to connect the dots on individual young people informally, through trusted personal contacts rather than referral letters routed through administrative systems designed for different purposes.

A counsellor described equivalent work at the level of individual schools: challenging a school's refusal to use a young gender diverse person's chosen name, and reframing gender recognition as a mental health need to bring it within a framework the school might accept. This required knowledge of how the institution thought and a trusted contact within it. It required relationship and an understanding of school protocols.

The Duty Senior described the proactivity this model demanded in serving asylum seekers in a changing policy environment:

> "Proactivity... identifying emerging themes before they become a big thing. When the government changed refugee housing rules... people had four weeks to find their own housing... we had to very quickly understand rights and options." (S2-ST-014)

Voluntary sector organisations like Heath Hub play a recognised and valued role within local mental health systems but are sometimes expected to perform functions that require statutory resources, clinical authority or information access they do not hold. Heath Hub operates from a different organisational ethos, with different access arrangements, different risk thresholds and different accountability frameworks from its statutory counterparts. Full incorporation into NHS governance would likely require conformity with precisely those structures that constrain the relational flexibility, practical breadth and values-led discretion that makes the model work. The current position, collaborative without being absorbed, is the condition under which Heath Hub's distinctive approach remains possible. The tension it generates, between the expectations statutory referrers bring and the services Heath Hub can provide, is a feature of that position rather than a failure of integration.

Understanding Heath Hub’s system positioning requires an understanding of the local crisis and mental health support systems young people had experienced before

arriving. One young person I interviewed chose to talk about Heath Hub through contrast with other services. In doing so, she clarified what Heath Hub represented to her as different.

She described her presentation to A&E following a suicide attempt as traumatic and distressing and reported that she received no CAMHS follow-up afterwards despite the seriousness of the episode. I cannot conclude from the data what level of care was offered in that crisis encounter, or how it was managed clinically, but this account does show that, in her own understanding, engaging with crisis services had felt frightening rather than containing, and that the absence of later follow-up compounded this sense of being unsupported. In her narrative, Heath Hub then came to occupy a different place: not as a crisis service, but as a more relational and accessible form of support after those earlier experiences. She described her interactions with school as similarly unsupportive:

> "School was a horrible place. I was bullied a lot, especially in regards to my race and identity… The support they have is horrible… I felt like I wasn't able to talk about anything. They went back to my mother and told her things, and then my mum and I would get into more arguments. This cycle continued for months." (S2-ST-001)

This account presents school-based support as non-confidential and entangled with adult authority in ways that intensified rather than relieved distress. It illustrates one of the difficulties of safeguarding and confidentiality with adolescents, particularly where relationships with parents or caregivers are already strained. It also helps explain why an independent hub, positioned outside school and family structures, could be experienced as offering something importantly different.

I also often heard Heath Hub staff critique external services and policies as unsatisfactory and shaped by wider political and organisational logics that were not supportive to young people. Maya, the Therapeutic Lead, expressed this attitude in relation to welfare-check systems used by overstretched services:

> "The youth team… classify cases red or amber and call the young person once a month to see if they're alive. I've not yet met a young person who found

> those calls helpful. It's either nothing or harmful… the harm would be, I'm waiting for something, but these people don't seem to care about me." (S2-ST-012)

From Maya's perspective, the problem was not simply the phone call itself, but the thinness of the relationship it represented. A monthly welfare call might provide a minimal form of oversight, but it did not necessarily communicate care, continuity, or meaningful recognition. Her critique was not only of individual practice, but of a wider service logic in which surveillance and risk management had come to substitute for relational support. Heath Hub's alternative was not just greater warmth. It enacted a different logic of care, one in which support depended on relational presence rather than periodic monitoring.

The breadth of need arriving through Heath Hub's doors is not easily captured by clinical categories. A significant and growing proportion of the service's general advice work involves asylum-seeking and refugee young people, a demographic whose needs span welfare entitlements, housing rights, educational access and mental health support in ways that resist clean separation. Heath City has several hotels being used as temporary accommodation for asylum seekers, housing significant numbers of young people who then present at the drop-in for a range of overlapping needs. The service's founding identity as a practical advice organisation makes it well placed to respond. Staff can navigate housing rights, benefits systems and educational entitlements alongside mental health support within a single relationship, without the referral fragmentation that statutory services produce.

Housing instability appeared repeatedly across fieldwork as a health issue as much as an administrative one. Young people living in temporary accommodation, facing eviction, or navigating the asylum system presented with mental health difficulties inseparable from their material circumstances. The service's capacity to accompany young people through bureaucratic processes, attending council offices, challenging decisions, translating rights into practical action, was not a supplement to therapeutic work. For many young people, it was the condition under which any therapeutic work became possible.

Maya offered her image of how to describe Heath Hub's position in the local landscape:

> "I've described it sometimes... we're an island of sanctuary, partly related to the ocean of need. If we go too far out into the ocean of need, we would just all drown. Let's just make the island as good as it can be." (S2-ST-012)

The island metaphor captures the service's self-understanding: a bounded space of care within a much larger field of unmet need. It is not a claim to comprehensiveness. It is a claim to quality within acknowledged limits. The organisation cannot reach everyone. What it can do is ensure that those who reach it encounter something real.

This framing positions Heath Hub alongside statutory systems as a complementary resource. In another register, it positions the service against them: as an advocate for young people navigating structures that are often indifferent or actively harmful. The organisation's social justice orientation shapes how staff interpret young people's difficulties and how they act on their behalf.

Logics of Care

My starting point for understanding Heath Hub's logic of care is its mission statement. As noted above, this has three components: that all young people will know what it is to be valued, will have the support and information they need, and will make a successful transition to adulthood. The first of these, being valued, is especially important. At Heath Hub, being valued means having one's worth recognised and being seen as a person who matters; this establishes a whole-person orientation that runs through the service.

The remaining two components of the mission statement extend this orientation. Practical support, advice and information are understood as core to what young people need to flourish. And the framing of a successful transition to adulthood situates the organisation's purpose within the wider challenges of adolescence: identity, belonging, independence and the practical work of establishing a life. These are the central concerns around which Heath Hub is organised.

This logic is reflected in Heath Hub's therapeutic culture. Person-centred, integrative and Gestalt approaches are the dominant modalities. The emphasis lies less in technique than in empathy, non-judgement, authenticity and helping young people find their own way forward. Counsellors are trained, accredited and supervised within a clinical governance framework. This therapeutic orientation also shapes the wider organisational culture: staff presentation, language and manner reflect a consistent alignment with young people's own ways of being.

The tension around routine outcome measures demonstrates how care logic and accountability logic pull at one another within Heath Hub. Counselling services used standardised measures required through commissioning arrangements, but staff expressed consistent uncertainty about whether these tools captured the kind of change they saw in practice. Several spoke instead about the value of young people's own accounts of feeling heard, understood, or more stable.

One staff member who had previously worked in NHS talking therapies described this pressure directly. They recounted how the expectation of improved paired outcome scores had subtly shaped the way data were gathered. They were clear that records were not being falsified. Rather, when administering outcome questionnaires with young people, they could find themselves encouraging more positive interpretations of ambiguous responses. The measure had become a target, and the target had begun to shape practice. Within a hub context, the risk is that services are pulled towards score production rather than the relational, developmental, and preventive work that makes those scores meaningful in the first place.

This concern was intensified by the kinds of support Heath Hub staff saw as central to their work. Engagement, stabilisation, belonging, system navigation, trust-building, and return after absence were all treated as meaningful forms of progress, but they were difficult to capture through standardised symptom measures. Support that is hardest to measure receives less evaluative attention and, consequently, can become harder to fund. In this sense, the evaluative hierarchy risks reinforcing a hierarchy of legitimacy, in which measurable therapeutic change is easier to recognise than the relational and practical work that makes change possible.

This tension extends to the organisation's commissioning position. Heath Hub's funding spans NHS ICB contributions, local authority grants, charitable and lottery funding, and the original endowed trust. Each stream carries its own accountability requirements and implicit definitions of what the service should be doing. Accountability frameworks tend to operate through a logic of choice: selecting interventions, measuring outcomes, demonstrating cost-effectiveness. Heath Hub's practice is iterative, relational and contextual, and its effects accumulate over time through trust, continuity and the slow development of young people's capacity to function and connect. Translating that into the language commissioners recognise, without losing what makes the practice distinctive in the translation, is a permanent feature of how the organisation positions itself:

> "We're always doing a dance between accommodating to the world as it is and remaining true to the values... and we have to translate what we do into language that unlocks resource." (S2-ST-012)

That capacity for institutional bilingualism, speaking the language of outcomes externally while holding a different language internally, is an organisational competence developed over decades. It is the condition under which Heath Hub's way of working remains possible.

Heath Hub demonstrates that a logic of care can be organised around the recognition of young people's worth. The service begins with that premise and extends through practical support, humanistic therapeutic culture, developmental understanding of adolescence and structural advocacy. Its care ethic is visible in how the organisation understands young people, what help it chooses to provide, and the terms on which it accounts for its work to a wider system. That this approach produces outcomes comparable to statutory provision shows that relational values and clinical effectiveness are compatible rather than competing priorities.

Summary

Heath Hub shows a model of hub care shaped by relational flexibility, practical support, and a social justice ethos. Across the chapter, I have shown that its care is

organised around the recognition of young people's inherent value and developmental trajectories, and then extended through advice, counselling, youth work, and advocacy that address emotional, social and material difficulties together rather than in isolation. Continuity is held institutionally rather than through one key relationship, and responsibility is distributed across teams, handovers, supervision, and shared organisational culture. This produces a model of care that is bounded and developmentally attuned. At the same time, the case highlights important tensions: between open access and finite capacity, between relational work and commissioner requirements for measurable outcomes, and between the organisation's growing role in the local system and its physical and valued-led separation from the data access and resources of statutory services.

In the next chapter, I report on the case study findings of Shore Hub. If Heath Hub foregrounds an advice-led, relational and regionally dispersed model, Shore Hub provides a further contrast: a hub operating closer to providing crisis support, with stronger connections to urgent care pathways, youth work outreach, and more direct contact with young people on the edges of statutory and public systems. Examining Shore Hub extends the comparative analysis by showing how hub care is enacted when need is more complex, system pressures are more acute, and the boundary between early support and crisis response becomes more challenging to sustain in a voluntary care setting.

Chapter 7. Findings: Shore hub

Setting and History

Shore Hub is based in a relatively deprived coastal city in Southern England, while also working across a wider regional catchment. It provides city-based drop-in advice and guidance for young people aged 11 to 25, alongside school-based programmes across the broader area and counselling provision extending beyond the city into surrounding coastal and island communities. The organisation also runs youth workers based in accident and emergency departments, drug and alcohol support services, a sexual health clinic once a fortnight, and employment support programmes. It therefore spans a broad spectrum of youth support, combining city-centre drop-in, regional therapeutic and school-based work, health partnerships, and practical assistance for young people navigating housing, education, and employment. The city itself is relatively deprived, with significant inequalities across neighbourhoods and high levels of deprivation affecting children and young people

The organisation began as a drop-in centre offering information, advice and guidance for young people aged 13 to 25 in 1993. Over time the service expanded as further funding allowed the development of counselling services. This funding reduced the age range for counselling to five years old and extended provision across two surrounding local authorities. In 2019 the organisation formed a partnership with the NHS, placing youth workers in accident and emergency departments across four regions, including one island community. The number of drop-in services has varied over time, ranging from three locations across the city to a single central Shore City hub. During the period of fieldwork, a second age specific and neurodiversity friendly hub for children aged 11 to 17 opened in a suburban area.

The central Shore City hub is loud and busy. Brightly coloured chairs surround circular wooden tables, and the entrance area is adorned with green hanging plants. Young people move constantly through the space. Some stop for a cup of tea. Others stay longer, talking with youth workers or sitting quietly on their phones. The space performs multiple functions simultaneously. Young people arrive to seek advice, wash clothes, charge phones, or simply sit somewhere warm.

As one staff member explained, the hub deliberately provides basic facilities that allow young people to stabilise before seeking further support:

> "Having the sofa bed, the laundry, the shower with toiletries, and our food… especially for the street homeless young people." (S3-ST-019).

The school aged hub is in a quieter suburban area. It sits close to several primary and secondary schools and was designed specifically for younger adolescents. The interior differs markedly from the central city site. The layout is softer and sensory aware, with carpeted floors, soft furnishings, and sensory toys designed to reduce noise and stimulation. The aim is to create a space that feels safe for younger or more developmentally vulnerable young people. Staff reported early positive engagement, although the service was still building visibility during the observation period. Young people in school uniform often arrived in pairs, speaking briefly with youth workers about their experiences before leaving again and saying they would tell their friends. One care leaver who had just turned eighteen attended the service. She had recently been moved from her foster family to accommodation forty minutes away, did not know anyone in the new area, and was looking for work. Although she was technically above the age range for that drop-in service, the senior youth worker spent forty minutes discussing her job plans and an upcoming interview for work as a child carer. The worker then encouraged her to visit the adult drop-in centre in town on days when she herself would be working there. The quieter space facilitated first contact, building trust and creating the possibility of ongoing support in the busier and more stimulating central hub.

In an interview with two senior managers of the Shore City central drop-in, they emphasised the importance of geography in shaping who accesses the service. As one manager explained,

> "Geography really matters… if you're based within their community, you are going to get a different group." (S3-ST-016/017).

The location of a hub determines who encounters it. A second manager described the trade-offs involved in deciding where services should locate themselves.

> "There is a trade-off in which type of accessibility do you want… multiple local centres, or one consistent central one… What road you are on makes a difference… being near a school, or on the high street, changes who will walk in." (S3-ST-016/017).

Opening hours also shape accessibility. Following consultation with young people about when they most needed support, Shore Hub extended its opening hours to around forty hours per week, including evenings until 8 pm on several weeknights and Saturday mornings. Staff described these hours as essential for reaching young people who work, are in education, or whose crises occur outside traditional office schedules.

One experienced youth worker explained that young people sometimes encounter the service and come in when the alternative may have been less fruitful:

> "Young people might be out thinking about doing something more negative… and they walk past and see we're open. (S3-ST-020).

Young people described the hub as filling a broader social role in their lives. One young person described Shore Hub as a third place between work and home,

> "It's a place where you can form connections… not a pub, not a café, but a safe space." They continued by reflecting on the disappearance of youth spaces across the city.

They went on to talk about the decline of youth clubs and other spaces for young people:

> "These places are dying out… youth clubs are a thing of the past… but here, you can get that." (S3-YP-001).

Table 7.1 summarises the fieldwork dates, observation settings, interview sample and broad participant roles (without compromising participant anonymity and privacy) informing this case study chapter.

Figure 7.1 Shore Hub case summary

Feature	Summary
Case site	Shore Hub
Fieldwork dates and structure	Two intensive one-week fieldwork blocks: • 2-6 June 2025 • 30 June-4 July 2025. Semi-structured observation took place primarily at the main Shore Hub drop-in centre between 10.30am and 5pm, with two after-hours evenings to 7pm and community outreach observation to 6pm.
Direct observation hours	67 hours
Main observation settings	City-centre drop-in, reception and triage spaces, practical support areas, after-hours drop-in sessions, youth work outreach in community settings, drug and alcohol provision, safeguarding, management and multidisciplinary discussions where permitted.
Formal staff interviews	6 formal staff interviews, representing 7 individual staff participants
Types of staff and roles interviewed	Drug and alcohol service manager, drug and alcohol youth worker, drop-in lead, operations managers, senior youth worker and single point of access lead, and therapeutic lead with responsibility for counselling, therapeutic leadership and clinical governance.
Young person interviews	2 young person interviews
Broad young person involvement represented	Therapy, youth groups, youth participation, cultural inclusion, practical support, housing support, harm reduction, sexual health, peer support and survival resources.

Vignette: Arriving at Shore Hub

The central drop-in sits on a busy high street in Shore City. I arrive into a space that is loud and in constant motion. Brightly coloured chairs sit beneath hanging plants, and young people drift in and out throughout the day. Some stop for a cup of tea. Others sit quietly on their phones. Youth workers move between conversations, pausing to greet young people by name. The atmosphere is informal but purposeful. People know why they are here.

The practical infrastructure of the space becomes immediately visible. A small laundry area sits behind the main room. Young people linger to wash clothes. One young man asks if he can use the shower. Another sits at a table charging his phone and eating biscuits. These functions sit alongside advice work and emotional support. Staff move smoothly between tasks. Some workers are discussing housing applications with young people in colourful open booths; another is helping someone find clean socks.

Within hours of my arriving at Shore Hub, a young person is asked to leave after smoking crack cocaine in the bathroom. The request is delivered calmly by a youth worker who has clearly set boundaries like this before. I observe the conversation, but the young person has quietly left before I am aware this event that prompted his one-month suspension from visiting Shore Hub. The space returns quickly to its usual rhythm.

Later that afternoon I help a young man collect a toothbrush and toothpaste from the shared cupboard, and load clothes into the washing machine. He tells me he has been sleeping on different sofas since leaving a hostel the week before. The laundry cycle takes nearly an hour. During that time, he stays in the centre, moving between the sofa and the kitchen area, occasionally joining conversations with youth workers. The practical task of washing clothes becomes a reason to remain in the space.

By the end of the day a staff member quietly mentions that faeces have been found smeared in the laundry area. The discovery is met with weary pragmatism and allocation of clean up.

Throughout the day the flow of conversation reveals the complexity of the young people's lives. A group of young men talk about someone who has been arrested the night before. Another declares to the room that he is hiding from someone, while wearing a high visibility work vest that adds humour and lightness to his claim. A different young man casually jokes about robbing a bank before laughing and saying "nah, I would never actually do it". Youth workers listen in from the sidelines while making tea or typing, occasionally interrupting to change the tone or steer the conversation towards more fruitful topics.

The atmosphere is busy, organised, welcoming and warm. Staff juggle constant interruptions while maintaining long conversations with young people who return day after day. The hub operates with a locked front door policy for safety but has glass frontage, so staff and young people see one another. On the walls there is bolted colourful signage explaining youth rights. The space is functional rather than decorative. It is designed to withstand heavy daily use. The work here involves holding space for young people whose lives rarely unfold in orderly ways. The first day makes this clear. Shore Hub is a unique environment where crisis and continuity of care occur simultaneously in the same space.

Organising Care

Shore Hub offers a wide range of services including drop-in advice and guidance, counselling, drug and alcohol support, employment support, a sexual health clinic, outreach work in accident and emergency departments, and practical survival resources such as showers, laundry facilities and food. The complexity and variety of young people's needs means that the organisation often plays a coordinating role across multiple domains of their lives. One drop-in staff member said:

> "We have to become a jack of all trades very quickly." (S3-ST-021)

Young people arrive with overlapping needs that require a mix of listening, empathy, untangling problems, advocacy, information and guidance.

> "Young people come with multiple complex needs – housing, trauma, neurodivergence, exploitation – and services bounce them around." (S3-ST-021)

Shore Hub staff clarified during confirmation checking that all staff receive a minimum baseline of Level 2 mental health training, alongside suicide prevention, self-harm, and mental health first aid training. This baseline training supports Shore Hub's model because their service requires a wide range of workers being able to recognise distress, respond safely, and escalate concerns, even where their primary role is not clinical.

Counselling is a core component of the service and provides care across a wide geographic area. Shore Hub counsellors have a range of skills and modalities to meet the needs of young people. The head of therapeutic services described the approach as intentionally pluralistic, flexible, and able to be offered on either a short- or long-term basis.

> "We've got integrative therapists, CBT therapists, a family therapist… it's just very broad… We've also got some youth work trained, and social work trained practitioners, so we can adapt." (S3-ST-018)

Given the range of modalities and the complexity of issues being seen, supervision plays a particularly important role in maintaining professional standards and supporting staff. The therapeutic lead had previously worked as a lead teacher in a high school and brought a strong emphasis on formal oversight and supervision structures.

> "Some of it is operational, some clinical… external supervision as well." (S3-ST-018)

This structure responded directly to the complexity of young people's needs and the responsibility carried by staff managing risk.

> "We've got an enormous amount of supervision, more than you'd get in statutory services… it's important because we carry an enormous amount of risk." (S3-ST-018)

While supervision structures were strong and there was a wide range of therapeutic modalities available, demand continued to exceed capacity. Counselling waiting lists were present across services, and staff described ongoing attempts to mitigate delays by offering brief interventions and encouraging continued engagement with the drop-in while young people waited.

> "Some young people are waiting months, and that's still too long." (S3-ST-018)

The therapeutic lead also reflected on differences between the audit culture of schools and the way quality is monitored in counselling practice.

> "With counselling, unlike teaching, there's no observation… so it's harder to measure quality… you rely on supervision and feedback loops." (S3-ST-018)

Quality assurance therefore occurred through professional accreditation with the British Association for Counselling and Psychotherapy, continuing professional development requirements, and feedback from young people receiving support.

The drug and alcohol service worked with young people aged 11 to 25 presenting with a wide spectrum of substance use, ranging from recreational use to alcohol dependency and long-term injecting drug use. Practitioners prioritised engagement rather than strict eligibility criteria.

> "If you're within our age range and you consent and want to work with us, we'll work with you… we don't have much of a criteria which is good. We'll work with anyone." (S3-ST-002)

Practitioners described the importance of relational authenticity while maintaining professional boundaries.

> "Young people can tell if you're not being real… you don't have to be relatable, just authentic." (S3-ST-022)

Staff described recurring themes among young people presenting to the service, including mental health diagnoses, self-harm, suicidal ideation, homelessness and unstable housing. Social disconnection was particularly prominent.

> "A running theme is low self-esteem, a lack of connection, and not knowing who they are." (S3-ST-002)

Young people who had disengaged from school were often particularly vulnerable to exploitation. Staff described their work as supporting young people to reconnect with education and stabilise their circumstances.

The drug and alcohol team emphasised a holistic understanding of recovery, recognising that substance use rarely occurred in isolation from other aspects of life.

> "An analogy I used was air in the tyres of a car… if only one tyre is full and the rest are flat, you'll struggle or go in circles." (S3-ST-002)

At the same time, practitioners were careful to recognise the limits of their role.

> "There is definitely a therapeutic aspect to what we do, but we're careful in recognising we're not trained therapists." (S3-ST-002)

Employment support formed another part of Shore Hub's work. During fieldwork, a new youth worker joined to administer an Individual Placement Support programme designed to support young people into work. Much of this activity already existed informally within the service through youth workers helping young people write CVs, prepare for interviews, and explore employment opportunities. The formal programme therefore made visible work that had previously been occurring in more informal ways.

For some young people, employment represented more than income. It marked legitimacy, routine, dignity, and the possibility for a shift away from lives shaped by material insecurity. One adult young man, who had been intermittently street homeless, spoke with excitement about being offered window-cleaning work.

> "I just got a job… I was begging outside Tescos… two people come up to me… gave me a coffee and picked me up the next morning and took me to work. It's my second legitimate job… the boss literally pays me every day. That's so good…How am I feeling? Fantastic. Feel like a million pounds." (S3-ST-002)

Shore Hub had not found him the job, but staff shared in his delight and supported him to remain engaged through practical encouragement and emotional support. This account illustrates how employment entered Shore Hub's practice as part of a wider relational and moral project of helping young people move towards stability.

The hub also hosted a fortnightly sexual health clinic run by a specialist nurse. Staff noted that the presence of different services could shape how the organisation was perceived by the community.

> "For a period there was this thing of 'oh, you're the sex people' because of sexual health displays and clinics… now we're probably more known as the mental health people, but that perception can still be a barrier." (S3-ST-016/017)

Alongside structured services, the hub provided essential practical support for young people experiencing unstable housing or homelessness. Showers, laundry facilities, clothing and food were used frequently.

> "At the moment I'm using [Shore Hub] for resources… showers, kitchen, washing machines, dryer… sometimes they have clothes here. I use their sexual health clinic as well… to be fair there's not much they don't do. They're helping me with housing. That's so good they do. They're amazing." (S3-YP-002)

Most young people attended the drop-in service for advice relating to housing, rent, debt or mental health concerns. However, a smaller group of approximately ten to twelve young people attended very frequently, often daily, presenting with high levels of complexity and risk. Two overlapping groups were particularly visible. One consisted of young people experiencing combinations of long-term mental health difficulties, homelessness, substance use and criminal justice involvement. The second consisted of young people diagnosed with emotionally unstable personality disorder who sometimes spent several hours a day in the centre and regularly interacted with crisis services.

Safeguarding formed a central component of organisational practice given the complex needs of young people attending Shore Hub. For the counselling group risk is shared collectively:

> "We hold risk carefully as a team… nobody holds it on their own." (S3-ST-018)

During fieldwork in the drop-in central site, I observed safeguarding practice in action. A junior staff member documented suicidal ideation disclosed by a young person with known emotionally unstable personality disorder who attended the service daily. The disclosure was immediately escalated to a manager for guidance. The young person's concerns were taken seriously, and support was put in place without unnecessary escalation to crisis services, including contact with the young person's usual CAMHS mental health case worker. Staff described this ability to maintain continuity of care while managing risk as a core strength of the hub.

> "It's the million dollar question… we have so many young people coming in that feel suicidal on a daily basis… sometimes they just needed some company and to be able to talk things through… that is the beauty of what this hub does." (S3-ST-020)

Later, staff reflected on how local emergency services interacted with the hub.

> "Services across [Shore City] cannot speak highly enough of [Shore Hub]… they just can't thank us enough for preventing escalation." (S3-ST-020)

Another significant safeguarding discussion occurred when a young person attending for housing support disclosed, they had been carrying a concealed knife but had not injured anyone with it. I observed staff debating the balance between maintaining trust with the young person and the potential risk posed to others. The issue was escalated to the manager on duty and then further escalated to the drop-in manager, who discussed this at a safeguarding meeting with the head of therapeutic services. The outcome was an immediate report to community policing, with the young person informed beforehand. The senior youth worker overseeing the case reflected:

> "My experience is that when they tell us something, it's because they want us to do something about it… we are going to take action and ensure the safety of that young person." (S3-ST-020)

The youth worker went on to reflected on the limits of the hub's role.

> "We really do try and make them know there is a safe space… but there is always a big 'but' with that." (S3-ST-020)

The young person continued to attend the service after the incident. Maintaining both safeguarding responsibilities and long-term relationships required considerable professional judgement. Drawing on my previous experience as a GP in a community with high levels of criminal justice involvement and family violence, I recognised the difficulty of sustaining these relationships while navigating legal and ethical obligations. What I observed in these interactions appeared both skilled and nuanced.

Senior staff were reflective about their safeguarding practices. Safeguarding reports were regularly audited and reviewed. In one discussion two managers reflected on gender differences in the pattern of reports.

> "In the safeguarding report, the number of women we complete reports for, especially around mental health, is about 70% [of women compared] to 30% of males. But we also know that suicide is more prevalent in young men… so what can we do better to engage them?" (S3-ST-016/017)

These reflections demonstrated that Shore Hub was not only managing complex safeguarding demands but also maintaining an ongoing process of professional critique and improvement in its practices.

An additional component of Shore Hub's work is its youth work presence in accident and emergency departments across two counties. I did not observe this service directly, as it operated within NHS emergency department spaces and was beyond the scope of my ethics approval. However, I was able to review four de-identified case studies prepared by Alice, a community support worker who had previously worked in this role and was now based in the drop-in centre. These case studies covered the period from December 2024 to the end of March 2025, within the same broader twelve-month period as my fieldwork. They illustrated the relational and practical role of the service in supporting young people aged 15 to 25 presenting in crisis.

In one case, a school aged young person with a history of trauma, sexual abuse, school non-attendance, self-harm and overdose who had previously declined CAMHS support. The youth worker spent time in A&E establishing the young person's needs, preferences and long-term goals, including hopes to work in dramatic arts, then met them again in the advice centre after discharge to support housing and school re-engagement. Over the following two months, their case study findings showed that the young person did not re-attend the emergency department, began engaging with CAMHS for trauma counselling, engaged with social prescribing and a referral to a youth social group, and returned to school with minimal absences. Other case studies included support for a neurodiverse young person assaulted at school who disclosed self-harm thoughts, a homeless young adult with major trauma requiring temporary wheelchair use, and a young woman presenting after domestic violence. These examples suggest that the A&E youth work role functioned as a bridge between emergency presentation and longer-term relational support.

Routine outcome measurement was present within Shore Hub, although it was not a dominant feature of everyday discussions about practice. In the drop-in service, young people completed a short, youth-friendly feedback form at first contact. The front page recorded basic identifying details, followed by a brief explanation of confidentiality and safeguarding responsibilities. It then used a colourful, picture-based Likert scale to ask whether young people felt listened to, whether they were able to talk about what they wanted to talk about, whether they understood what was said, whether the meeting gave them ideas about what to do next, and how satisfied they were with the service. The reverse side collected population-level information, including gender, sexuality, ethnicity, GP registration, disability status, employment and education, housing status, eligibility for free school meals, care experience, and other agencies involved in the young person's support. These forms were completed alongside a Shore Hub worker, so that young people had time, explanation, and support if needed.

Different service streams used different measures. The drug and alcohol team frequently referred to goal-based outcomes in their work with young people. Counselling services used routine measures at appropriate clinical intervals, including CORE-10 and goal-based outcomes. During confirmation checking, staff clarified that Shore Hub had tried to map the different outcome measures used across service areas and develop a more coherent system, but found variation difficult to resolve, even within service streams. The organisation was also working with CORC to develop a logic model for how outcomes could better capture impact, supported by a growing impact and evaluation function. This suggests a service moving towards a more developed outcomes culture, rather than one in which measurement was absent.

During fieldwork, measurement was rarely central in staff accounts of everyday practice. Greater emphasis was placed on youth work, therapeutic relationships, crisis response, and practical support. Client interactions were documented in internal digital systems, and safeguarding concerns or complex cases were discussed within weekly multidisciplinary and clinical team meetings. Outcome measurement therefore sat alongside the work of the hub rather than organising it. Its role was

developing, but the dominant account of impact remained grounded in whether young people were safe, connected, supported, and able to return.

Vignette: Balancing continuity with open access

Once a week the drop-in team holds an internal meeting to review complex cases. I was invited to observe, sitting in one of the colourful booths while staff formed a circle of chairs in the centre of the room. These meetings are attended by all drop-in staff and take place in person before the centre opens, with the hub deliberately delaying opening hours to create protected time where no young people are present. No external agencies or young people attend. The discussion focuses on the young people the team is currently supporting and how risk and care are being managed across the service and communicated with other supporting services in Shore City.

The discussion centred on five street homeless young people who attended the hub almost daily, often arriving in acute distress. All were known to have complex trauma histories or a diagnosis of emotionally unstable personality disorder. Staff spoke candidly about the challenges of supporting them within a drop-in environment not built for intensive daily case work. The team reflected on the escalation of risk behaviours including suicidality, drug use and emotional volatility, and the limits of what the service could realistically contain.

The tone of the conversation remained compassionate but conflicted. Staff questioned whether their presence was helping or inadvertently sustaining crisis patterns. One worker said, “We’re not mental health professionals. They need to seek support from mental health professionals.” Another asked the group, “Are we helping them in any way?… we’re not feeding into their good mental health.” The lead worker eventually voiced what many in the room seemed to be feeling: “We are at breaking point.”

Staff discussed whether regular service users should have more structured contact with the hub rather than remaining in the space for many hours at a time. One senior staff member reflected, “We can’t control how they use the service, but we

can control the time here… sitting here for hours trying to guess what their drawings mean is not effective use of our time."

The conversation widened to the broader system around them. Staff described how other services had increasingly withdrawn from working with the same young people, leaving the hub holding risk for individuals with significant mental health needs. One worker said bluntly, "Other services are stepping back. They need to pick up the slack." The young people were discussed in detail, each with an informal care plan managed by the team. Staff noted that the number of homeless young people presenting to the hub appeared to be increasing over time.

By the end of the meeting the team agreed to trial a more structured approach for several of the highest need young people. Each would be assigned a named worker and offered a one-hour time slot when they could attend the service, rather than remaining in the centre throughout the day. Staff described the approach as reminiscent of an earlier programme known as Shore Hub Extra, which had previously provided more intensive support before the programme funding had ended.

When I returned to observe the meeting one month later, staff reflected on the impact of the new structure. Four of the five young people had accepted the boundaries and continued engaging with the service. One had told a staff member, "I would not be alive without this place." The fifth young person found the new arrangement distressing and had stopped attending, although they remained in contact with external mental health services. The team considered the approach successful, describing it as a way of offering containment without excluding young people from the space.

Ethics of Care and Youth Participation

Care within Shore Hub was strongly shaped by youth work principles emphasising long term relationships, partnership, participation and equity. Staff frequently described the service as an environment where young people could return repeatedly over time as their needs changed. The hub for some young people is a

central point of continuity within otherwise unstable lives. One young person who attended the service regularly during my fieldwork reflected on its importance.

> "Honestly,… I don't think I'd be the person I am today… [Shore Hub] has been such a lifesaver for me… every single one of the staff care about you a lot." (S3-YP-002)

Staff emphasised the importance of this open-ended model of engagement.

> "One of the strengths is the ability for young people to dip in and out over years. Even when they leave a project, they still know they can use the drop-in. For some, this is the longest-lasting relationship they've had." (S3-ST-016/017)

One young person who had spent significant time at the hub described hopes of returning to work there after further study.

> "My plan is to study psychology, come back here, and apply to work at [Shore Hub]." (S3-YP-001)

I observed the ethics of care underpinning this work was often visible in small, responsive moments. One young woman with a history of trauma, drug use, and exploitation with service involvement from acute mental health team and criminal justice attended the hub almost daily. She often spent hours resting, showering, or listening to music through headphones while dancing in the corner of the room. On one occasion her singing became louder, disturbing advice sessions taking place in nearby booths. Rather than confronting her directly, the lead youth worker gently interrupted by offering to charge her vape. The young woman paused, handed over her vape, and then back her singing and dancing in a much quieter and less elevated way. Afterwards the worker explained to me that small redirections often helped regulate her behaviour before escalation. The interaction demonstrated a subtle form of care and relational knowledge built over time that balanced attentiveness to the young woman's needs with awareness of the wider environment and other service users.

Staff often described success not in terms of solving problems immediately, but in establishing relationships that enabled young people to return.

> "A good interaction might be that the issue wasn't really solved, but the young person really liked it and came back." (S3-ST-016/017)

Trust also played a central role in safeguarding in the drop-in environment:

> "Most safeguarding doesn't come out of someone walking in saying something… it comes out of a conversation that for them is just a chat. Young people are evaluating us all the time… how managers talk to staff, how staff treat each other." (S3-ST-016/017)

One example which unfolded over three months was shared with me by a youth worker supporting a young woman who initially sought advice about housing. Over six interactions across this period, some of which were in person and some over the phone, the young woman gradually disclosed that she was experiencing honour-based abuse within her household. The youth worker showed me the digital case notes describing how trust had developed incrementally across these encounters. Each interaction focused initially on practical concerns and provided non-judgemental communication and offers of ongoing help long term. Eventually the young woman was supported to relocate safely to live with a female relative in a nearby city. The case illustrated how continuity with a youth worker could create the conditions for disclosure of risks that might otherwise remain hidden.

Staff also spoke openly about the need to maintain professional boundaries while working relationally with young people. Practitioners in the drug and alcohol service described boundaries as flexible but purposeful.

> "If goals feel vague… it maybe does feel quite casual and confusing… but if you bring the conversation back to what you're working towards, that grounds it in professionalism." (S3-ST-022)

Staff also emphasised the need to adapt services to young people rather than expecting young people to adapt to existing institutional systems. The therapeutic services lead compared school environments with Shore Hub's approach:

> "Kids don't all fit into this box that school has in place. We have to adapt to them, not the other way around. Ultimately, what matters is that young people feel safe, feel heard, and feel supported." (S3-ST-018)

Youth participation was structured within Shore Hub through a youth advisory council composed of current and former service users. Several members had previously been involved in the national Fund the Hubs campaign advocating for youth mental health hubs across the UK. One participant, who had arrived in the UK as a refugee, described the importance of the group in his own recovery.

> "For me, part of the process of healing is doing things." (S3-YP-001)

He explained that being asked to contribute to decisions about service design and recruitment had strengthened his sense of purpose and belonging.

> "It made me feel like I'm not only wanted, my advice is actually acted upon." (S3-YP-001)

Young people within the group were also able to propose and lead initiatives that influenced the wider organisation. The same young person reflected on how their conversations about within the advisory board had impacted the service as a whole.

> "I'm the only non-white person in [the youth advisory council]. [Shore Hub] came to me, asked how can we have more people of colour… and they acted on it. They started celebrating Eid Mubarak, Hanukkah, Diwali… it sends out a message." (S3-YP-001)

Shore Hub reflects the ethics of care principles in how staff members maintain continuity of care, show attentiveness and responsiveness to the young people who visit, how they invest in youth participation structures, and maintain limits on their professional capabilities and responsibilities.

Professional Cultures

Professional culture within Shore Hub was strongly shaped by youth work values and identities. Youth work was considered central to the ethos of the organisation, and staff emphasised relational skills and the ability to build informal trust with young people as more important than technical advisory expertise. Many staff members had first encountered the service as volunteers before joining in paid roles, creating a workforce that had developed familiarity with the organisational culture and the young people who used the hub. As one manager explained:

> "The youth work side is more important to us than the advice side… it's harder to teach those skills. An ability to talk in a relaxed way that appears to be about nothing, but isn't about nothing. Most of our team started as volunteers… they've seen the culture, seen the young people, and they're the ones that stay." (S3-ST-016/017)

Unlike some youth mental health hubs that seek alignment with clinical systems, Shore Hub did not present itself as a clinical service. Instead, professional identity centred on youth work practice and relational engagement, with counselling, drug and alcohol support and other services embedded within this broader youth work framework.

Staff consistently described the team culture as collaborative and mutually supportive. The emotional demands of working with high levels of trauma, crisis and deprivation were openly acknowledged within the team, and staff emphasised the importance of collective responsibility for wellbeing and sustainability.

> "The caseloads are heavy, but the team support each other enormously. We're constantly talking about vicarious trauma. I always say to staff, you have to take breaks, you have to take annual leave." (S3-ST-018)

Members of the drug and alcohol team similarly described the importance of strong internal relationships.

> "Here we are a very close-knit team… we come through crisis together. Managers care about us as people – they check in, they give us time, they support us." (S3-ST-002)

Several staff reflected that this sense of collective support was a key factor in enabling them to remain in demanding roles over long periods of time.

At the same time, one senior staff member opened up about the challenges involved in supporting a workforce where many of the employees themselves had lived experience of mental or physical health difficulties.

> "Sometimes you feel like you're walking on glass… if you talk about how it's impacting performance, you might impact their mental health more. If some of the team are continuously picking up the slack, then what are the young people getting?" (S3-ST-019)

The informal nature of the service was also reflected in the way staff presented themselves. Clothing was casual and comfortable, with little emphasis on formal professional appearance. Staff described this as intentional, allowing them to relate more easily to young people and to bring their authentic selves into the work.

> "At Shore Hub I feel like I don't have to pretend… I can be myself. If a workplace makes staff feel they can be themselves, then they're more likely to build trusting, meaningful, supportive and professional relationships with young people." (S3-ST-002)

The professional culture observed within Shore Hub was team-oriented, supportive and strongly oriented around youth work values. Staff identity was shaped less by clinical hierarchies and more by relational practice, shared responsibility and flexibility in responding to young people's needs. These characteristics appeared to contribute both to the sustainability of staff working in a high demand environment and to the relational style of care delivered within the hub.

System Integration

Shore Hub operated within a network of local health, social care, education, and

community services. Its patterns of integration varied across sectors. Some partnerships were established and collaborative. Others appeared more strained, reflecting broader pressures across housing, health, and social care systems.

Several areas of integration appeared robust and embedded. The Accident and Emergency youth work service described earlier provided one example of close collaboration between Shore Hub staff and NHS services. Strong working relationships were also reported with youth justice services and substance use services. The manager of the drug and alcohol programme described the value of these relationships:

> "I sit on the youth justice service joint decision-making panel. It's very rare to get all those specialists in a room – it's really good multi-agency working." (S3-ST-022)

This quote shows that Shore Hub was not working at the margins of youth justice partnership but was actively involved in multi-agency decision-making around young people with overlapping needs.

Shore Hub's integration with statutory services was more developed than I initially understood during fieldwork. In confirmation checking, senior staff reported that my understanding of their logics of care were "spot on" but clarified several additional structures I had not observed or discussed.

Shore Hub participates in weekly MDT meetings through an Integrated Care Board partnership involving CAMHS and adult mental health services. It also has a worker sitting within CAMHS Single Point of Access triage, giving the organisation a direct role at the point where referrals are assessed and routed. A separate Shore Hub role supports 111 young people's mental health referrals through a social prescribing pathway, with referrals coming from a mental health nurse. These arrangements show that Shore Hub was not only receiving referrals from statutory systems but was also positioned within some of the triage and coordination infrastructure that shapes how young people move through local mental health pathways.

This altered my interpretation of Shore Hub's system position. During fieldwork, its integration appeared most visible at the crisis and outreach edge of the system: A&E youth work, youth justice, substance use work, housing advocacy, and evening street outreach. These remain distinctive features of the organisation, moving between early intervention and crisis support. However, the confirmation checking process showed a broader set of system connections, including CAMHS triage, 111 mental health referral pathways, weekly MDTs, and school-based provision. Shore Hub is interconnected with statutory systems in more ways than were visible to me during fieldwork. Its integration still appeared less conceptually consolidated at whole-organisation level than Dock Hub's, but it was more extensive than the fieldwork data alone had suggested.

Relationships with NHS child and adolescent mental health services were not absent, but they were still experienced as inconsistent in some areas of everyday practice. Staff described variation in referral acceptance and differing thresholds for engagement:

> "There's inconsistency… sometimes referrals are pushed back, other times not." (S3-ST-002)

This inconsistency affected Shore Hub, as an open access service their staff remained involved and attempted to provide ongoing support when referral pathways into specialist services were uncertain, delayed, or contested.

School-based provision was also more developed than I observed directly. Shore Hub delivers open-access drop-in sessions in local high schools focused on health, mental health, emotional wellbeing, and wider support needs. It had also appointed a Head of Alternative Provision just after my fieldwork concluded to work with secondary schools to develop school-based packages for young people who are struggling to remain in education, return after absence, change schools, or need bridging support. This indicated a developing school-facing strand within Shore Hub's model, extending its work beyond the city-centre drop-in and crisis-facing provision into earlier intervention within education settings.

Housing services emerged as the most frequently discussed structural challenge across interviews and observations. When I asked staff what they would prioritise if significant new funding were available, the answer was almost always housing rather than expansion of the hub itself. Staff repeatedly identified unstable housing as a key driver of many young people's difficulties. One drug and alcohol worker described the frustration of trying to secure accommodation for vulnerable young people:

> "It's not a nice system… sometimes it feels like signing someone's death warrant when housing refuses." (S3-ST-021)

The force of this statement reflects the level of risk staff associated with housing decisions. For Shore Hub, housing was core condition shaping safety, mental health, substance use, exploitation risk, and crisis presentation.

Staff also described increasing numbers of refugee and asylum-seeking young people attending the hub. Senior staff reflected that they were considering why this group of young people often sought practical support rather than mental health services:

> "Is that because of the perception of what we offer, or language, or that they go to churches, mosques, whatever, for that support?" (S3-ST-016/017)

This reflection shows staff trying to interpret patterns of access rather than assuming that the absence of mental health help-seeking meant the absence of distress. Another staff member described the difficulties faced by young people granted refugee status but given limited time to secure employment and housing, often resulting in crisis homelessness.

Recognition from multi-agency partners had also created new pressures. One staff member who had worked at Shore Hub for more than five years reflected that the service had previously been dismissed by some statutory organisations as "too soft" in its approach to young people. More recently, this relationship had shifted in a paradoxical way. The same systems that had once dismissed the service were now referring substantially more young people to it, often with minimal information and

no accompanying resources. This increased pressure on the organisation without any parallel increase in funding or capacity. A junior drop-in worker described receiving referrals for housing advice even after the hub had lost specific funding to support housing applications. Senior managers were acutely aware of the risks of absorbing unmet need within the wider system:

> "We're always aware we might just be propping up the system… but the young people would suffer in the short term if we didn't." (S3-ST-016/017)

This captures one of Shore Hub's central system tensions: staff recognised the danger of compensating for wider service failure, but also knew that withdrawing support would have immediate consequences for young people.

I observed little direct engagement between Shore Hub and local general practice services. Several participants described difficulties accessing GP appointments. One young person compared the unpredictability of primary care access with the reliability of the hub:

> "You never know when you're going to get the appointment with a GP… they tell you, we'll call you on Thursday between 11am and 6pm." (S3-YP-001)

The problem here was not only waiting time, but the loss of control and predictability built into the appointment system. He contrasted this with the accessibility of Shore Hub:

> "I decide when I go… the door is always going to be open… that already does something good before we've even stepped into care." (S3-YP-001)

For this young person, open access itself had a therapeutic quality. The possibility of choosing when to seek help created reassurance before any formal intervention occurred. He suggested that closer collaboration between hubs and general practice might reduce pressure on both services:

> "GPs don't have the time or energy… collaboration between GPs and hubs would reduce the burden." (S3-YP-001)

This comment reflects a young person's own system analysis: that hub provision and general practice could function more effectively if they were connected rather than operating as separate routes into care.

Staff similarly reflected on the difficulties young people experienced navigating NHS systems:

> "Trying to get any sort of appointment… don't even think about seeing them face to face. If I myself feel like giving up sometimes, what must it be like for a young person from a disadvantaged background? Emergency departments have become the only real drop-in other than us… and that's wholly unsuitable for most young people." (S3-ST-020)

This quote links access barriers in routine care to inappropriate use of emergency departments. It also explains why Shore Hub's open-access model matters locally: it provides one of the few places where young people can still seek help without navigating a complex appointment system first.

Alongside these formal systems, Shore Hub worked closely with local community organisations. Partnerships existed with arts and music groups that offered creative opportunities for young people, as well as with employment services such as the Individual Placement Support programme:

> "We work alongside the IPS team… employment is crucial for recovery." (S3-ST-022)

This reflects Shore Hub's broader understanding of recovery as social and practical as well as clinical. Employment, housing, safety, relationships, and community connection were treated as part of the wider conditions for mental health.

Vignette: Youth Worker Outreach in Shore City

I accompany two youth workers, Dave and Adam (pseudonyms), on an evening outreach walk to an area of Shore City identified through community policing as a hotspot for youth antisocial behaviour. Dave previously worked as a substitute teacher and ran a mixed martial arts gym. As we walk the twenty minutes toward the square, he talks about the confidence young men gain from structured physical activity and shared discipline. One older boy from the neighbourhood had recently begun competing in local martial arts tournaments, and Dave described how that success had inspired younger boys to train with him. Adam works for the local authority and has been a youth worker in the area for decades. Their approach is relaxed and conversational, moving easily between humour and confident quiet observation.

Along the walk several young people recognise them. A few offer cautious nods or brief greetings as we pass. Dave explains that the area has been experiencing minor incidents of antisocial behaviour, mostly theft of snack items from local grocery shops and occasional broken windows after closing hours. Adam tells me the local authority are planning small community activities over the summer, including repairing a broken mobile pizza oven and bringing it into the nearby park to provide food and informal contact with young people who gather there.

When we reach the square, a group of teenagers are standing near a low wall, with two uniformed police officers watching from a visible distance. The atmosphere is not tense but highly performative. Several young people greet Dave and Adam loudly. One couple, who Dave and Adam know by name, begin joking, shouting playfully, wrestling and leaning into exaggerated displays of affection. Their behaviour appears partly playful and partly theatrical. When they approach the youth workers the tone softens a bit, and conversation becomes more relaxed. I introduce myself briefly as a researcher observing the outreach session, though my presence seems to attract little interest. One quieter girl standing on the rim of the group, visibly shifts her posture once invited into conversation by Dave, stepping closer to the group and speaking more confidently.

Watching these interactions, I am struck by how public space becomes a stage on which young people assert presence and recognition. The playful confrontational energy of the group sits alongside moments of quieter engagement with the youth workers. Youth presence in public space here appears both expressive and strategic.

On the walk back toward the hub we encounter four school aged boys riding bicycles. One of them immediately recognises Dave and calls out his old teacher's name with delight before jumping off his bike to hug him. The boys gather around for several minutes, talking easily. The other three relax as the conversation unfolds and begin to ask questions of their own. Dave invites them to visit the gym and reminds them that Shore Hub is always open if they need somewhere to go. The boys thank him and ride off.

The moment lingers with me as we continue walking. Across the week I have observed young people repeatedly performing versions of themselves in Shore Hub and in public spaces around Shore City, sometimes through humour, bravado or conflict. Yet the sudden joy of the younger boy being recognised by Dave suggests a different dimension. In both the square and the street corner encounter, the common thread is young people being seen. The outreach work, like the hub itself, appears to create moments where young people's presence is acknowledged rather than ignored or policed. The question that stays with me is who young people believe is watching, and what forms of recognition they are seeking in these shared spaces.

Shore Hub is positioned as both a connector within local service networks and a buffer absorbing unmet need when other parts of the system were inaccessible or overwhelmed. Confirmation checking made clear that its statutory integration was more extensive than I had initially seen, particularly through CAMHS triage, 111 referral pathways, weekly MDTs, and school provision. At the same time, the fieldwork data showed that integration did not remove the pressure of system gaps. Shore Hub's role was shaped by its ability to stay close to young people at the points where housing, health, education, crisis care, and community support failed to meet need cleanly.

Logics of Care

Shore Hub's dominant logic of care is organised around presence, containment and providing for practical needs. The long opening hours and outreach services, the laundry, the shower, the food, the sustained availability of adults who will remain engaged: these are the primary conditions through which care becomes possible. Everything else, advice, therapeutic work, employment support, harm reduction, unfolds from that prior condition of being somewhere safe with a support person who will not turn you away.

Youth work is foundational to this logic. Staff identity is organised around relational practice, and the capacity to build informal trust over time is understood as more consequential than technical advisory expertise. The counselling service is embedded within a wider youth work framework rather than the other way around, and this shapes how the organisation understands its own purpose. Shore Hub does not primarily understand itself as delivering clinical intervention. It understands itself as providing consistent human presence Ito young people for whom that is often unavailable elsewhere. One young person described the hub as a safe space where connections can form, distinct from any commercially or institutionally driven environment. For some, it is also the longest-lasting relationship they have had.

Meeting young people’s basic needs is the starting point care in the Shore Hub drop-in. Showers, laundry, food and phone charging are not welfare concessions at the margins of a therapeutic service, they are the infrastructure through which young people stabilise enough to engage with anything else. The young person who had been sleeping on different sofas and spent the hour waiting for his clothes in the centre illustrates this precisely. Nothing was resolved. The next step became available.

Harm minimisation defines the therapeutic orientation across the drug and alcohol service and shapes the hub's wider practice. The analogy of the car with three flat tyres going in circles regardless of one full tyre, captures how Shore Hub understands the relationship between substance use and the rest of a young person's

life. Change is understood as distributed and non-linear, occurring across multiple domains simultaneously. This logic extends beyond the drug and alcohol service into everyday youth work. A good interaction might be that the issue was not resolved but the young person returned. Return is itself is an early measure of success.

Shore Hub serves young people who have passed through statutory thresholds and been discharged, refused or directed elsewhere. Many have already encountered CAMHS, emergency departments, housing services and criminal justice. The hub holds them because it will not refuse them, and because that refusal, in this environment, has consequences that staff have no wish to produce. This is a different structural position from services that describe themselves as sitting below statutory thresholds. Shore Hub sits beyond them, at the endpoint of referral chains that have already exhausted the formal system's willingness to engage.

This creates a tension that runs through the organisation's identity. Shore Hub was founded on the principle of helping young people help themselves: a rights-based commitment to self-efficacy and agency. In practice, the management of open access in a high-acuity environment means that some young people develop patterns of attendance that look less like progressive independence and more like sustained reliance on the hub as their primary stable structure. Staff asked whether their presence was helping or inadvertently sustaining crisis patterns, and the question was not rhetorical. The structured intervention trialled with the five highest-need young people, named workers and time-limited contact, was an attempt to honour both commitments simultaneously: to remain present without becoming the only thing that holds a young person's life together. That four of five accepted the structure and continued engaging, with one reporting they would not be alive without the service, shows how close those two things can sit.

Shore Hub's rights-based identity is embedded in the physical space and the founding commitment rather than generating a broader theoretical analysis. The bolted signage on the walls, the language of rights in staff accounts, the mission to help young people help themselves: these shape what the hub will hold and who it will refuse to turn away. The system critique at Shore Hub is enacted in daily

practice more than theorised in staff discourse, and this distinguishes it from Heath Hub's more explicitly political orientation.

Shore Hub demonstrates that a logic of care can organise around presence, containment and practical survival, holding young people at the far edge of what organised care systems will typically claim as their remit. The organisation provides the longest-lasting relationships some young people have, defines effectiveness in terms of return rather than resolution, and maintains an open door to those other services have discharged or refused. Its youth work logic is an alternative form of expertise, grounded in relational trust and the prior conditions of safety rather than in accredited intervention. At Shore Hub, the founding commitment to helping young people help themselves and the reality of holding those whose lives are most precarious exist in productive tension. Shore Hub shows that at the boundary of the early support hub model, care must be organised first around presence. Everything else becomes possible only from there.

Summary

The case study findings for Shore Hub shows how care is organised around presence, containment, and practical support for young people whose lives are often marked by instability, crisis, and repeated exclusion from other services. Across the chapter, I have shown that its distinctive contribution lies in providing an open and sustained relational space where advice, youth work, counselling, harm reduction, and survival resources can coexist. Care begins with food, showers, laundry, warmth, and trusted adults who remain available, and from there extends into safeguarding, therapeutic work, employment support, outreach, and system navigation. Youth work is the organising professional culture through which this care is delivered, and the hub's effectiveness is often measured less by immediate resolution than by whether young people return, stay connected, and remain safe enough for further support to become possible. At the same time, the case exposes the tensions at the edge of the hub model: between open access and the containment of very high acuity need, between helping young people help themselves and becoming a last stable structure in lives marked by profound precarity, and between acting as an integrated local partner and absorbing the unmet demand created by wider system failure.

In the next chapter, I bring Dock Hub, Heath Hub and Shore Hub into direct comparison. The comparison of the three cases shows that there is no single standardised Early Support Hub model. Instead, they reveal a recognisable but variable service form, shaped by shared commitments to accessibility, relational continuity, and care for young people in context, but enacted differently according to organisational history, professional culture, geography, and system position. Comparing the three cases allows me to identify both the common logics of care that connect hub models and the important differences that shape how hub care is organised and experienced in practice.

Chapter 8. Case comparison

This chapter brings the three case studies into direct comparison to answer the central question of this thesis: what model of care is enacted by Early Support Hubs in England, and what logics of care underpin it? In the previous chapters, I examined Dock Hub, Heath Hub, and Shore Hub as individual case studies. In this chapter I compare them across my chosen six dimensions: settings and histories, organising care, ethics of care and youth participation, professional cultures, system integration, and logics of care. The purpose is to show what is shared across the cases, where they differ, and what those similarities and differences reveal about the model of care enacted by Early Support Hubs.

Drawing on my findings from these three cases, I conclude that is no single early support hub model in England in the sense of a tightly standardised intervention that could simply be copied from one site to another. The three organisations differed in organisational history, therapeutic orientation, professional identity, and relationship to statutory systems. Across the three sites, I found common logics of care built around open access, relational continuity, mixed workforce teams, and an understanding of distress as shaped by social and material conditions as much as by the presence or absence of symptoms relating to mental ill-health. These common features were supported through different routines, infrastructures, and understandings of the role of an Early Support Hub.

This matters because one of the recurring questions in policy and service development is whether Early Support Hubs represent a coherent model of care or simply a loose family of voluntary sector services gathered under a convenient label. My findings suggest that the three Early Support Hubs were not interchangeable, but nor were they merely unrelated services with shared 'hub' terminology. They expressed a common orientation to youth mental health and wellbeing, but they enacted that orientation differently according to place, population, workforce, and system position.

In this chapter, I show first that the three organisations shared a common historical lineage rooted in youth work and advice rather than specialist mental health care. I then compare how care was organised in practice, including safeguarding, counselling, supervision, outcome measurement, and the handling of complexity. I

go on to examine ethics of care and youth participation, before turning to differences in professional culture and system integration. I end by drawing the comparison through the logics of care enacted at each site and the different forms of outcome each organisation treated as meaningful.

Settings and histories

The three hubs shared a similar historical lineage. All three were mature voluntary sector organisations that had existed for more than twenty years. All three operated across multiple physical hub sites. All three offered combinations of advice and guidance, counselling, youth work, and other forms of support. Most importantly, none of them began as a narrowly clinical response to mental illness. Their origins lay in broader traditions of youth support, advice, participation, and community response to the difficulties young people faced in everyday life. Mental health was central to their present identity, but it had entered through a wider concern with poverty, instability, relationships, schooling, housing, identity, and transitions into adulthood.

This shared history shaped how each organisation understood its work. In all three sites, staff spoke about distress in social terms. They did not reduce young people's problems to symptoms alone. Housing, debt, school exclusion, family conflict, trauma, discrimination, loneliness, immigration status, and the insecurity of early adulthood were treated as part of the rationale for the service. This was visible not only in interviews but in the structure of the organisations themselves. Counselling, advice and guidance, and youth groups were all understood as contributing to mental health care. Staff moved readily between talking about anxiety or depression and talking about benefits, employment, school, relationships, and where a young person was going to sleep.

The material environment of the hubs also expressed this lineage. All three used some form of controlled entry, balancing welcome with safety. All three registered young people on arrival at drop-in or other open-access provision. None framed this as surveillance. It functioned instead as a routine of oversight and shared responsibility. Tea, food, and snacks were present at all three sites. These were small details, but they affected the tone and sense of welcome hubs offered. They helped establish the hub as a place where bodily comfort and social ease were part of

support. Food was practical, but it also signalled care, belonging, and a slowing of pace. These gestures were modest and ordinary, yet they distinguished the hubs from services organised purely around appointments, symptoms, or risk triage.

The similarities in history and ethos were important, but so were the differences in place and population. Dock Hub was based in a large city and operated within a dense urban ecology of schools, general practices, statutory services, and long-standing professional relationships. Heath Hub and Shore Hub both worked across wider geographies for counselling provision, with more dispersed populations and longer travel distances. This shaped the practicalities of access and partnership. Rurality and coastal geography mattered. Transport affected how easily young people could reach the service. The availability of other local services also shaped what each hub could realistically offer itself and what it could refer on to.

The three hubs also served somewhat different populations. Shore Hub carried the highest visible level of material deprivation. Showers, laundry, homelessness support, and practical survival resources were built into the physical design and everyday work of the service. Heath Hub worked with a distinct refugee and asylum-seeking population shaped by local accommodation policy, alongside other young people facing precarity and poor mental health. Dock Hub served a broad urban population through a large and differentiated organisation, with patterns of need shaped by poverty, school pressure, neurodiversity, local identity, and long-standing inequalities across the city. The age ranges differed slightly too, which mattered for the feel of different spaces, the tone of youth group work, and the mix of developmental needs present within each site.

Even the way my own access was managed on the first day at each site revealed something about organisational culture. Dock Hub was structured and formal on my arrival. My access was carefully managed, introductions were organised, and the institution presented itself with clarity and confidence. Heath Hub and Shore Hub were more flexible in the way observation began, though in different ways. These first encounters were fleeting, but they foreshadowed broader differences in how each organisation related to structure, control, and professional presentation.

What emerged from this section was a common inheritance shaped by local divergence. All three hubs came from a tradition of youth-centred, socially situated support rather than specialist psychiatric treatment. But they developed in different service landscapes and in response to different forms of local need. Those differences shaped not only what they offered, but how they understood what a young person might need from a hub in the first place.

Organising care

The three hubs shared several organisational features that gave care its practical form. All three had clear safeguarding pathways and escalation structures. All three used supervision as a core mechanism for quality assurance, staff support, and collective risk management. All three employed accredited counsellors to deliver the clinical or therapeutic strand of the work, usually through some combination of NHS and Integrated Care Board funding. All three operated group-based provision alongside individual support. All three described their young people as presenting with overlapping needs spanning mental health, trauma, neurodiversity, housing, instability, and family difficulty. None of the services dealt with isolated categories of need.

All three also faced waiting lists for counselling. These waits were always longer than several months. This was a shared structural reality across the cases and an important one, because it showed that the counselling function of hubs remained constrained by the wider shortage of therapeutic provision. Yet none of the hubs simply placed a young person on a waiting list and withdrew; each offered interim routes of support through drop-in, advice, group work, wellbeing activity, or practical help. This interim work was central to the model of care. It meant that the organisation could remain in relationship with a young person while more intensive or specialised support was pending. It also reflected a broader understanding that waiting itself is part of the care pathway and should not be treated as empty time.

Safeguarding was another area of strong similarity. In all three organisations, safeguarding was held as a team responsibility rather than as the burden of a single practitioner left alone with a difficult disclosure or complex presentation above their skill level. Staff described pathways of escalation, informal checking-in, use of

designated leads, and collective discussion. This mattered for safety, but it also mattered for staff morale and sustainability. Staff working with high levels of need on a daily basis were supported by structures that distributed judgement and responsibility.

Despite these similarities, the organisation of care varied substantially across the three sites. One major difference lay in therapeutic orientation. Dock Hub's wellbeing and counselling work used more clinical language and was more strongly shaped by CBT-informed and brief intervention approaches. Heath Hub's counselling was predominantly humanistic, drawing on person-centred, integrative, and Gestalt traditions. Shore Hub described itself as pluralistic, combining integrative counselling, CBT, family therapy, and practitioners who also brought backgrounds in youth work and social work. These differences shaped the language of the organisation, the kind of practitioner it employed, the forms of expertise that carried most authority, and the kinds of change for young people that it focused on.

A second area of difference lay in the use of outcome measurement. All three hubs used paired (before and after) outcome measures, particularly in counselling, and all three expressed some version of the concern that formal measures did not capture the full value of their work across a young person's journey or in the relational and environmental qualities of care. The difference between case studies was what place measurement occupied in organisational processes, what kinds of work it was used to validate, and what other work remained harder to make visible. Dock Hub had the most developed measurement culture. Measurement was embedded in how the organisation understood quality, improvement, and external credibility. Staff used a wide range of measures and feedback tools across counselling, wellbeing, youth work, and drop-in activity, including CORE-10, YP-CORE, goal-based outcomes, and brief feedback forms, alongside national recognition through the Child Outcomes Research Consortium. Non-clinical support was valued internally as wellbeing work in its own right, and long-standing youth groups were positioned as a source of pride by senior leadership, described as important spaces of belonging, identity safety, confidence, and continuity.

Outcome measures helped make this broader work visible in terms that could be recognised within clinical and commissioning systems. Heath Hub and Shore Hub

also measured outcomes, but with less organisational centrality. Heath Hub. used CORE-10, goal-based outcomes, and additional research measures through the Fund the Hubs project. Shore Hub used a youth-friendly demographics and feedback form at first contact in the drop-in, goal-based outcomes in drug and alcohol work, and several other routine outcomes measures in the counselling and outreach components of their service. In both sites, staff spoke less about the everyday benefits and daily practices of outcome measurement than staff at Dock Hub, and more about the pressure created by the gap between measurable change and the value of relational, practical, and developmental support.

Power's account of audit culture helps explain how this pressure develops[185]. Public services are increasingly organised around formalised practices of checking, verification, and evidence production, which require complex work to be translated into forms that can be inspected, compared, and ranked. I am not arguing against measurement. For any health service but particularly in an emerging model of care, hubs need ways to learn, improve, and demonstrate value. Outcome measures can support reflection, help young people see change, and give staff a shared language for progress. But they also created pressure to privilege what was easiest to count. Maltby's critique of Power cautions against treating audit culture as a single force imposed uniformly from outside[186]. In all these three cases, audit practices were locally negotiated. At Dock Hub, measurement was part of organisational maturity and system legitimacy. At Heath Hub, it was useful when it supported therapeutic reflection, but burdensome when external research requirements disrupted counselling sessions. At Shore Hub, it was present but much less central to the practical work of keeping young people safe, housed, fed, and connected. The comparison therefore suggests that outcome measurement should not be rejected but designed and interpreted with care. Early Support Hubs need ways to evidence their value, especially in a policy environment where prevention, relational work, and non-clinical support are difficult to fund without demonstrable outcomes. Yet the work most central to the hub model is often the hardest to make auditable. Measures need to support learning and accountability without displacing the relational, material, and developmental forms of care that make hubs distinctive.

The management of complex health and social care needs also differed. Shore Hub held by far the broadest service range within a single organisation. It offered drug

and alcohol support, sexual health work, A&E outreach, employment support, school programmes, and practical resources alongside counselling and youth work. It also carried the highest visible complexity of presentation. During fieldwork, I observed young people experiencing street homelessness, emotionally unstable personality disorder, criminal justice involvement, severe relational instability, and substance use. Shore Hub made very few exclusions within its age range beyond consent and basic service limits. This gave the service a breadth of response from prevention and early intervention to crisis response. It stayed available to young people whom other services often struggled to hold long term.

Dock Hub organised care and responded to complex care needs through a large, differentiated structure with strong internal pathways and unusually broad reach into external services, especially schools and GP practices. This gave the organisation a wide span across the local system and allowed different forms of need to be identified, routed, and managed through multiple access points. It also had a formal training function. Trainees contributed significantly to service delivery, which brought both capacity and limitation. They could not work with moderate or high-acuity presentations, which restricted flexibility in the most demanding areas of service. Complexity was therefore managed through role differentiation, clearer boundaries around who could hold what, and stronger internal routing.

Heath Hub managed risk and complexity differently to other hubs. Its physical layout was layered, moving from open booths and informal space through to more private rooms used for counselling and deeper work. The building itself enacted a movement from accessibility towards containment. Heath Hub also formalised intuitive awareness of risk through a distinct practice: the "gut feelings" question asked at each pre-drop-in handover. This small organisational routine turned tacit risk sensing into something discussable. It gave staff permission to speak about discomfort, unease, or concern before these had hardened into fully articulated incidents. That was a subtle but important feature of how care was organised.

These organisational differences shaped what levels of complexity and risk each hub could absorb, what it could measure, and how it connected young people to different types of care beyond the hub. The comparison showed a common set of commitments organised through markedly different infrastructures. The hubs all

combined counselling, advice, and relational support, but the authority of measurement, the handling of complexity, and the place of clinical work varied in important ways.

Ethics of care and youth participation

Across the three cases, an ethics of care was visible within everyday pattern of practice. Staff in all three hubs valued attentiveness, responsiveness, non-judgement, and relational continuity of care. Young people were often given time and flexibility in how support unfolded. Care extended beyond formal appointments into reception exchanges, brief corridor conversations, follow-up calls, drop-in moments, and practical acts of support. In all three hubs, the emotional tone of support mattered. Young people were expected to feel welcome, known, and treated as whole people rather than as problems to be processed.

Competence was also important across the sites. None of the hubs treated warmth or the expressions of care ethics as sufficient on its own. Staff spoke about the need to know what each part of the service could and could not provide. This included appropriate referral, clear safeguarding, calibrated offers of care, and the ability to contain difficult disclosures without opening therapeutic work that could not be held safely. Staff advocated with schools, contacted other agencies, helped young people navigate fragmented systems, and often remained involved beyond what a strict interpretation of remit might require.

Youth participation was a clear area of alignment with values and practice. In all three hubs, youth voice extended beyond one-off consultation. Young people informed governance, recruitment, programme design, and service development. There were examples in all three cases of young people moving from service users to contributors, volunteers, peer researchers, or staff. This was understood as part of the purpose of the service and what gave the work ethical legitimacy. The trajectory for young people from receiving care to shaping the service was treated as evidence of positive impact.

Across the cases, participation had multiple functions: improving services, supporting the confidence and development of some young people, and at times

contributing to advocacy. Funding constraints, staffing pressures, adult responsibility, service risk, and the emotional labour of participation all shaped what youth voice could reasonably achieve. This prevented participation from becoming an empty moral slogan or an unqualified good. Across the cases, it was taken seriously, but its value depended on clarity of purpose, appropriate support, and whether the circumstances for contributing where within control of the hub.

The biggest difference between the sites lay in how they managed the tension between continuity and dependency. All three wanted to offer continuity and trusting relationships with staff. All three were alert to the possibility that young people who had experienced abandonment, trauma, or chronic instability might come to rely heavily on individual workers or on the service itself. Yet they all handled this differently in practice.

Dock Hub managed boundaries through structured programmes, differentiated spaces, and clear limits around drop-in spaces and how peer socialising occurred. Continuity existed, but it was often carried through organisational processes and programme design rather than left to ongoing relationships with individual staff. This was especially visible in the administrative infrastructure around long waits, including regular checking calls and clinical admin teams who maintained organisational memory across periods when a young person might otherwise have fallen out of contact. Trust in this model was supported by system and routine as much as by individual attachment to staff.

Heath Hub was the most explicit in articulating boundaries as therapeutic. Senior leaders and therapeutic staff described limits not as a regrettable necessity but as part of what a young person needs to experience safe and sustainable care. Rotation of mental health advisors was deliberate. Sessions and access had explicit time limits. The drop-in staff made efforts to reinforce that the relationship was with the organisation rather than a single worker, and to model forms of sustainable and bounded relating. The distinction between being responsible to a young person and responsible for them was articulated directly. Heath Hub practiced boundaries with a conceptual clarity I did not hear expressed as explicitly at the other two sites. This may reflect the particular mix of staff backgrounds and organisational values at Heath Hub, where therapeutic practice, social justice commitments, and concern

with sustainability combined to make boundaries more explicitly considered and discussed.

Shore Hub faced the most acute pressure in this area. During fieldwork, a small group of highly vulnerable young people attended daily, often for several hours at a time. For some of them, the service had become one of the longest-lasting relationships in their lives. Staff spoke openly about the emotional weight of this. Shore Hub's ethos of open access and staying available to young people at the margins produced a difficult tension when the service risked becoming a daily holding environment for a small group whose needs exceeded what the organisation could sustainably provide. By the time of my fieldwork, this had reached a point of collective strain and required a more structured response through time-slot arrangements for some regular attenders. In Shore Hub, the tension between openness and containment was being experienced as moral pressure and practical overload for staff.

Youth group provision highlighted another shared element of care. Across the three cases, groups were valued as providing something important and distinct from one-to-one work. They offered belonging, peer recognition, identity formation, and a sense of being among others without needing to arrive ready for one-on-one counselling. This was especially clear in LGBTQ+ and identity-based groups.

Youth participation differed in reach and emphasis. Dock Hub's participation structures extended into recruitment panels, programme design, and peer research with services beyond Dock Hub. Heath Hub's youth councils reached more clearly into civic and local authority spaces beyond the organisation itself. Shore Hub's advisory board produced concrete cultural shifts inside the service, including around religious celebration and recognition. These were all meaningful, but they highlighted partially different understandings of what youth voice was for within a hub.

This section showed that ethics of care was built into the structure of hub practice. It shaped how boundaries were drawn, how continuity was held, how safeguarding was enacted, and how young people were invited into organisational life. The main differences lay in where each hub placed the limit point between support and over-

holding, and in how youth participation linked the internal life of the organisation to wider forms of social and civic action.

Professional cultures

The three hubs shared strong supervisory cultures and clear hierarchies of escalation. This was important because all three employed relatively junior staff or staff in training in emotionally demanding frontline roles within youth mental health provision. Supervision, safeguarding support, and team culture made that work possible and helped it function safely and effectively. Across the cases, staff described the work as emotionally taxing, and the organisational response was collective rather than individualised. This contrasted with the more familiar pattern in medicine, where staff wellbeing is often addressed through support directed at the individual. In the hubs, vicarious trauma was acknowledged openly and staff sustainability was treated as an organisational responsibility. In each site, I observed supportive and collaborative work cultures in which difficult cases, ethical tension, and staff distress could be brought into shared conversation.

Freidson's account of professionalism as a "third logic" can provide a framework for interpreting these differences[187]. He distinguishes professional logic from market and bureaucratic logics, emphasising specialised knowledge, judgement, training, standards, and responsibility for complex work. Dock Hub drew most explicitly on this logic through formal titles, accredited pathways, outcome infrastructure, and NHS-facing professional presentation. Heath Hub also used professional judgement and supervision, but located authority more strongly in relational skill, therapeutic boundaries, and social justice commitments. Shore Hub placed greatest emphasis on youth work expertise, practical responsiveness, and long-standing community knowledge. To complement Freidson, MacIntyre's account of practices and their internal goods in *After Virtue* suggests that professionalism in these hubs was not only about formal authority or credentialed expertise, but about the pursuit of goods internal to caring practice itself, including trustworthy, attentive, and relationally skilled support[188]. Across the three hubs, professionalism was present in non-clinical care, but it was enacted through different forms of expertise and different claims to legitimacy.

The workforces at all three sites were mixed rather than defined by a single professional route. Counsellors, youth workers, wellbeing practitioners, advisors, outreach staff, and more specialist practitioners worked alongside each other sometimes in overlapping roles. This gave each hub a hybrid character. It also meant that questions of professional identity and clinical hierarchies were present. Across the three cases, there was tension between clinical and non-clinical forms of authority, though this tension was handled very differently in each site.

Dock Hub presented professionalism most formally. Staff were dressed in smart business casual clothing. Roles were clearly titled. Clinical and quasi-clinical language was common. The organisation projected maturity, competence, and legitimacy within statutory systems. This presentation aligned with the hub's broader position as a large, city-wide organisation deeply embedded in schools, general practice, and NHS-facing structures. Professional presentation helped Dock speak the language of the systems around it. Yet this did not mean wellbeing was confined to clinical intervention. Non-clinical support was also valued, and long-standing youth groups were a source of organisational pride, described as important spaces of belonging and continuity. Outcome measures then helped render this broader wellbeing work visible in forms that could be recognised and validated within clinical and commissioning systems.

Heath Hub and Shore Hub looked more similar to one another than Dock Hub. Staff dressed casually and informally. Tattoos, colourful clothing, and a lack of formal dress expectations were part of the atmosphere. This was a different presentation of professionalism where youth work values or relatability and accessibility were prioritised. The message to young people was that this was not an institutional setting in which they needed to perform compliance to be granted access. Staff could still be highly skilled and providing long-term high-quality care while presenting themselves in ways that softened hierarchy and signalled proximity.

The hubs also differed in how they positioned themselves in relation to clinical identity. Dock Hub aligned most strongly with clinical professionalism. It used NHS-facing titles, outcome infrastructures, brief intervention language, and structured training pathways. Shore Hub was the clearest in refusing clinical identity as the core description of what it did. Youth work framed the organisation.

Counselling was part of the service, but the organisation did not present itself as a clinical mental health provider. Heath Hub occupied a middle position. It used clinical structures where helpful and employed staff with significant prior clinical experience, but the culture remained strongly relational and non-clinical in tone.

Staff experience and values also differed across the sites. At Heath Hub and Shore Hub, staff spoke openly about their own experiences of mental health difficulty as shaping their relational practice and moral commitments. At Dock Hub, staff were more likely to describe common ground with young people through local identity, working-class experience, care-leaving, or other forms of socioeconomic similarity. In none of the hubs was lived experience formalised as a delivery model or hiring criterion in the way seen in some peer support systems. It worked more implicitly through values, empathy, and style of relating.

Heath Hub and Shore Hub staff were also more likely to speak openly about the operational tensions that arise when a workforce includes people with ongoing health-related needs of their own. This included uneven workload distribution and the need for teams to absorb fluctuation. These were named honestly and without resentment, but this issue did not arise in the same way at Dock Hub during my fieldwork.

Workforce trajectory also differed across the three hubs. Dock Hub was more clearly oriented towards early-career development. It employed many recent graduates and trainees within clear supervision structures, though some frontline advice roles were held by people who had arrived from prior careers in social work or statutory mental health services, and senior supervising staff in counselling and wellbeing brought decades of experience. Dock Hub also interpreted staff movement into NHS roles partly as a success. Staff leaving for statutory systems were seen as carrying the organisation's ethos and ways of working outward. Heath Hub and Shore Hub did not frame movement in this way. Both placed greater emphasis on retention as the basis for continuity and trusted relationships. Heath Hub's workforce included a mix of early, mid, and later-career practitioners, many with backgrounds in teaching, medicine, or other statutory roles. Shore Hub's workforce was more strongly mid-career and more culturally home-grown. Many staff had long-standing familiarity

with the service and the local community, and several had first entered the organisation as volunteers before training as youth workers through it.

Heath Hub stood out most sharply in political culture. Across all three hubs, staff recognised social determinants, poverty, and state failure as part of what shaped young people's lives. At Heath Hub, social justice was named explicitly and frequently as an organisational value and shaped how staff understood both their role and the purpose of the hub. This was visible in leadership language and in everyday informal discussion about austerity, housing, asylum policy, transport, and school exclusion. Distress was more likely to be interpreted through unequal social conditions than through individual pathology alone.

This political culture also seemed to shape recruitment and, through recruitment, the service logics of the organisation. Staff were hired not only for formal competence but for value alignment: their capacity to work relationally, tolerate complexity, and respond to young people in ways that were non-judgemental and attentive to structural disadvantage. This helped reproduce a model of care in which advocacy, accompaniment, and practical support sat alongside emotional and therapeutic work. Heath Hub's social justice orientation was one of the mechanisms through which the hub reproduced its model of care.

Professional culture shaped how credibility was displayed, how expertise was defined, how workers related to young people, and what kinds of legitimacy each organisation sought from external funding and governance structures. The three hubs all relied on relationally skilled, supported teams. But the style and self-understanding of those teams differed in ways that fed directly into the model of care each hub enacted.

System integration

All three hubs operated within complex local systems of health, education, local authority, and voluntary provision. No hub worked in isolation, yet their position within those systems differed considerably. These differences shaped not only access and referral patterns, but also legitimacy, language, and the forms of presentation, risk, and complexity each service was expected to hold.

Dock Hub had the most formal and settled system integration. Staff were embedded across schools and general practices throughout the city. The organisation was deeply woven into local health and education infrastructures, drawing on relationships built over decades. It participated in interagency forums and had a confident understanding of where it sat within statutory systems.

Dock Hub used role translation strategically. In NHS-facing settings such as multi-disciplinary team meetings, staff adopted dual titles such as "Senior Clinical Lead", to secure parity of esteem within statutory hierarchies. This was a practical form of boundary work. Gieryn uses 'boundary work' to describe how groups draw, defend, and negotiate the boundaries of legitimate knowledge, authority, and professional jurisdiction[189]. Langley and colleagues extend this account beyond professions to organisations, showing that boundary work can also involve aligning boundaries to enable collaboration[190]. This is useful here because Dock Hub staff were not asserting a separate professional jurisdiction so much as translating their roles into NHS-recognisable terms. Dual titles allowed them to enter statutory spaces as credible contributors without becoming an NHS service or abandoning the wider youth work, wellbeing, counselling, and relational meanings of their internal roles.

Dock Hub's MDTs also functioned as a practical response to system fragmentation. Where data systems were poorly integrated, professionals often entered the meeting with access only to their own records and organisational vantage points. The MDT created a space in which these partial views could be assembled into a usable account of the young person's care needs. A recent ethnographic study of long COVID clinics describes this as the production of "working knowledge" in MDTs, built through shared practices, distributed cognition, mutual trust, and relational knowledge of what was at stake for the patient[191, p. 1882]. That formulation fits this case well, where integration was achieved without connected digital infrastructure through relational work: professionals reading from their own systems, verbally sharing relevant information, and translating that material into coordinated action across organisational boundaries.

I did not observe this kind of explicit role translation in Heath Hub or Shore Hub. Both engaged with statutory systems, but neither appeared to use dual titles in the

same strategic way. That difference speaks to Dock Hub's more embedded position within local health systems. It had enough proximity to NHS structures to need this translation, and enough organisational confidence to use it without losing its own identity.

Dock Hub's settled position did not remove all tension; place-based commissioning still produced hard geographic boundaries that could feel arbitrary, including young people living on different sides of the same street having different access routes. But overall, Dock Hub's integration was embedded and functioning smoothly day to day.

Heath Hub occupied a more complementary and less embedded position in relating to statutory services. Its integration with schools and primary care was less formalised than Dock Hub, and it did not have embedded workers in general practice or emergency departments. Yet it had developed strong interagency meeting structures, including a second layer of multi-agency coordination for young people whose needs were too complex for standard thresholds or who were not ready for therapy but still needed coordinated support. These meetings reached beyond standard referral forums and could include social work and less conventional routes of care such as equine therapy. Heath Hub therefore had a distinctive coordinating function in relation to complexity.

Across the three hubs, there was a spectrum in how staff connected young people's distress to the wider system and to the political forces shaping it. Heath Hub was the most explicit in its structural analysis. Staff through their informal conversations with me most clearly linked young people's distress to austerity, exclusionary school practices, inadequate social housing provision, asylum seeker and refugee policies, and wider failures of the state. The organisation understood itself not only as helping young people navigate these conditions, but as offering a partial corrective to them. Advocacy and navigation were framed as expressions of social justice rather than optional extras. The phrase "island of sanctuary" captured this stance well: a bounded space of refuge and dignity within a wider system experienced by some as unequal, punitive, or neglectful. Dock Hub, by contrast, consistently recognised poverty, deprivation, and adverse childhood experiences as shaping young people's lives, but this did not often develop into an explicit critique of the broader policy or

institutional order. Its response was more pragmatic and embedded, using its position inside schools, primary care, and NHS-facing structures to improve support for individual young people. Shore Hub sat somewhere in between. Staff expressed strong frustration with local service failures, especially around housing, transitions, and gaps in statutory provision, but this critique was usually directed at proximate institutions and broken pathways rather than at government or policy settings more broadly. Heath Hub did not aim to become the whole system for young people, but it more explicitly named the system failures it was responding to and, in doing so, positioned itself as both complementary to and critical of it.

Shore Hub's system integration within particular programmes was strong, but less settled and embedded at the level of the organisation. Its links with youth justice, substance use services, and NHS emergency departments were well developed. Its A&E youth worker presence across two counties was a distinctive form of co-location within acute health settings. This integration at the crisis edge of the system set Shore Hub apart from the other two sites. Shore Hub also conducted evening street outreach, moving through identified public spaces to build relationships with young people where they were. That kind of integration into community geography did not appear at Dock Hub or Heath Hub in the same way. Across Shore Hub, integration appeared more as a cluster of well-connected programmes, coordinated through the Single Point of Access referral route and the drop-in hub, than as a single organisation-wide settlement that was immediately legible to an external observer.

Shore Hub's integration with primary care was much more limited. Its relationship with housing was often advocacy-based rather than partnership-based, with staff challenging decisions and pushing for young people whose needs were poorly met. Its reputation with statutory services had also shifted over time. Staff described an earlier period in which the hub was dismissed as "too soft" on young people or insufficiently credible as a youth mental health service provider. More recently, this relationship had shifted in a paradoxical way, where the same systems that had once dismissed the service were now referring substantially more young people to it, often with minimal information and no accompanying resources. This increased pressure on the organisation without any parallel increase in funding or capacity.

Heath Hub had one additional feature worth noting here. Its workforce included an NHS-trained doctor with psychiatric experience working as a mental health advisor. This meant that part of the organisation's capacity to recognise and hold complexity rested on the prior clinical background of a particular worker, rather than on a formally clinical infrastructure. It was, in this sense, another form of boundary spanning: psychiatric expertise was folded into the hub without requiring the organisation to define itself as a medical or psychiatric service. This gave the team extra confidence in recognising complex presentations, including possible early psychosis, and supported staff in managing risk while retaining the hub's broader relational and non-clinical identity.

A further safety implication concerns how hubs define the scope of mental health work at every level of the organisation. Across the three cases, staff were often working with young people whose needs were complex, fluctuating, and difficult to separate from safeguarding, housing, family conflict, neurodiversity, trauma, and poverty. This made the boundary between early support, advice, emotional containment, safeguarding, and clinical mental health work a live and evolving organisational issue based on community circumstances and the young people attending the hub.

This was most visible at Heath Hub, where non-clinical mental health advisors played an important role in helping young people make sense of distress, access support, and navigate the wider system. Their work was deemed valuable by young people as shown through their informal feedback and interview data and strongly aligned with the hub's relational ethos. However, the role also raised questions about scalability and governance. The training threshold for this kind of mental health advice was not always clearly specified, and specialist clinical guidance relied partly on local relationships and historical arrangements, including access to general guidance from a previously medically trained but no longer practicing mental health advisor. In a mature, local, and small organisation, these arrangements could function through real time relational advice between staff and collective organisational memory. If the model were scaled or replicated elsewhere, however, reliance on informal expertise and localised workarounds would become more likely to create gaps in care.

This does not mean that all hub mental health work should become clinically professionalised. That would risk weakening the accessibility, flexibility, and relational quality that make hubs distinctive. Rather, it means that the scope of mental health work, safeguarding responsibility, escalation thresholds, supervision arrangements, and access to timely clinical advice need to be explicit, and appropriately resourced and funded, at each level of the organisation. As hubs serve more young people, and as the model is potentially scaled beyond locally adapted services, clinical governance cannot depend only on tacit knowledge, longstanding relationships, or individual judgement. It must be built into the organisational infrastructure of the model.

These differences in system integration shaped the model each hub could enact. Dock Hub's service form was built partly through strong formal embedding and role translation. Heath Hub's grew through coordination, advocacy, and a politically conscious acceptance of limit. Shore Hub's developed through crisis-linked partnerships, street-level presence, and the practical absorption of complexity at the edge of system failure.

Logics of care

The comparison across the three cases showed a shared underlying orientation to care. In all three hubs, mental health was understood as emerging from social, relational, and material conditions rather than as a discrete clinical category detached from context. Care was organised around the circumstances of a young person's life, not only around their symptoms. In all three sites, support unfolded iteratively. Needs changed over time. The path through the organisation was rarely linear. A young person might move between drop-in, advice, groups, counselling, re-engagement after absence, and practical help. The organisation itself provided the continuity within which those engagement patterns made sense.

Open access had a shared significance across the cases. It was expressed as an ethical principle; young people should not need a diagnosis, a referral, or a crisis of sufficient seriousness before they could seek support. Youth participation had a similarly central place. It was not an optional extra but part of what made the organisation recognisably credible as an Early Support Hub.

Within this shared orientation, the three hubs enacted care differently.

At Dock Hub, care was enacted within and alongside statutory systems. Clinical language, formal outcome measures, and structured professional roles formed the infrastructure through which an ethics of care was sustained and made visible. Distress was understood in relation to disadvantage, adversity, and social difficulty, but support was often organised through clinically legible frameworks. A good outcome at Dock Hub included functional and symptom improvement, movement into education or employment, and onward developmental trajectory. It could also include a young person returning later as a participation member, volunteer, or staff member.

At Heath Hub, care was enacted more as support for development and self-formation in an unequal world. Distress was understood as bound up with adolescence, identity, and structural injustice. The aim was not simply to reduce symptoms, but to help young people feel valued, understand themselves more clearly, and develop strategies for moving through difficult systems. Empowerment was central. A good outcome at Heath Hub was one in which a young person left with stronger self-knowledge, greater capacity to understand their rights and advocate for themselves, and a clearer sense of belonging in community life.

At Shore Hub, care was enacted as sustained presence for young people living closest to abandonment and exclusion. For many, support began before any formal intervention, with food, washing facilities, warmth, safety, and a place to sit. Counselling and outreach sat within a broader ethic of staying with young people whom other services often found too hard, too chaotic, or too resource-intensive to hold. A good outcome at Shore Hub was flexible and often materially grounded: a period of stability, fewer A&E attendances, temporary accommodation, reduced crisis, or enough trust built for a young person to return after a period of instability.

The comparison shows that the three hubs were responding to a common problem of youth distress and service fragmentation through different organisational logics of care. All three treated distress as socially situated, relational, and unfolding over time. All three prioritised trust, continuity, and access. But they organised these

commitments differently. Dock Hub translated relational care into a form that was legible to statutory systems through formal roles, outcome infrastructures, and clinically recognisable pathways. Heath Hub organised care around young people's development in context, with greater emphasis on identity, rights, belonging, and learning to navigate an unequal world. Shore Hub organised care around proximity to crisis and exclusion, making practical support, sustained presence, and tolerance of instability central to what care meant. The comparison demonstrates that there was no single hub model, but nor was there complete variation in the logics that underpinned them. What united the cases was a shared commitment to relational, socially situated support; what differed was the organisational answer each hub gave to the question of how that support should be structured, bounded, and made effective in its local setting.

Summary and conclusion

Across these six dimensions, the comparison showed that Early Support Hubs shared a recognisable service form but enacted it through different organisational settlements. Each hub combined counselling, advice, youth work, and open-access support within a voluntary sector model that understood young people's distress in social and developmental context. Each relied on relational continuity, mixed professional teams, and organisational structures that could hold risk collectively rather than leaving it to individual workers. Yet the cases also revealed clear variation in how these commitments were stabilised. Dock Hub was the most formally embedded and clinically legible, using stronger measurement systems, professional role differentiation, and close statutory integration. Heath Hub placed greater emphasis on developmental support, social justice, and therapeutic boundary-setting. Shore Hub worked closest to crisis, exclusion, and material deprivation, organising care around practical support, sustained presence, and tolerance of instability. The case comparison highlights the coherence and the variation of the hub field: a common orientation to care was present across all three sites, but it took different institutional forms depending on local history, population, workforce, and system position.

What unites these cases is not a standardised programme but shared logics: that young people's distress is social as much as clinical, that relationships are the

medium through which care becomes effective, and that organisations sustaining that kind of care over time require particular forms of infrastructure, workforce culture, and system positioning to do so safely and at scale. These are the features a model of care needs to name and protect, even as the organisational form varies.

This finding helps explain why the category of an Early Support Hub has been both useful and unstable in policy and practice. It has been broad enough to gather a field, but not yet specific enough to define a model of care. The next chapter turns to the Youth Access Quality Framework process, examining how a national evaluation sought to make this field more legible by naming shared principles, foundations, and service components while preserving local variation.

Chapter 9: National Evaluation: The Youth Access Quality Framework

Introduction

This chapter presents the findings and outputs of the national evaluation I led to develop the Youth Access Quality Framework for hubs.

The chapter is organised in four sections. Section 1 presents findings from the evaluation process, including the outcomes of youth workshops, hub engagement, stakeholder consultation, and public consultation. Section 2 describes the contents of the Youth Access Quality Framework as the principal output of the evaluation. Section 3 examines the areas of broad consensus and productive disagreement that emerged through the process. Section 4 considers implementation and impact. The methods underpinning this work are revisited briefly here for context and were described in full in Chapter 4.

Youth Access commissioned this evaluation through competitive tender and funded it as part of its wider work to strengthen quality across youth information, advice and counselling services and related hub models in England. Youth Access holds the intellectual property for the Youth Access Quality Framework, and I was commissioned independently to lead the programme between April and November 2025. The work was overseen by the Youth Access Chief Executive and policy team, alongside a Steering Group comprising hub leaders, youth work academics, and non-profit sector leaders, and was co-designed throughout with three paid Youth Engagement Co-designers. Youth Access were aware of my doctoral work from the outset and gave permission for the Youth Access Quality Framework to be included as a component of this doctoral study. A full copy of the Quality Framework is provided in Appendix A.

The evaluation drew on utilisation-focused evaluation[150] and youth participatory co-design methods[192], [193] and Cooperrider's appreciate inquiry[152]. The methods for the Youth Access Quality Framework have been covered in detail in Chapter 4 Methods. The project combined scoping interviews with hub leaders, weekly work with Youth Engagement Co-designers, creative arts workshops with

young people, a national workshop with hubs, a national workshop with funders and commissioners, consultations with standards bodies and government, monthly Steering Group meetings, and a three-week public consultation. I designed this approach in partnership with Youth Access to develop an account of quality that would be usable and legitimate across a varied field of hub practice.

Two brief notes on terminology are needed here. Firstly, the principal output of the evaluation was the Youth Access Quality Framework, which I refer to throughout as the Quality Framework. When I use Quality Framework in capitals, I mean the specific Youth Access document produced through this evaluation. By contrast, when I use lower-case quality framework or framework, I am referring more broadly to the category of quality frameworks as an evaluative instrument, or to the process of developing and using such a tool.

Secondly, in Youth Access usage, "hubs" refers to the wider family of community-based, open-access advice and counselling services for young people aged 11 to 25, including services also described as YIACS, Early Support Hubs, youth mental health hubs, drop-in services, integrated health and wellbeing models, and one-stop-shops (Appendix A, p. 5). In this thesis, I use Early Support Hubs as my main term to reflect the specific boundaries of my case studies, but the Quality Framework was designed to support this broader field of hub services rather than only the 24 services involved in the government funding programme that could be considered Early Support Hubs. The terminology in this area is still evolving, and I have tried to be clear in each term and its meaning without overexplaining each instance of use.

The final Quality Framework is organised into three overarching categories: Principles, Foundations, and Services. Principles addressed the ethos and relational commitments of hub practice. Foundations addressed the organisational conditions required for safe and effective delivery. Services addressed the different forms of support that hubs might provide and coordinate. I introduce these domains briefly here and examine them in more detail in Section 2.

From the outset, the project was guided by an explicit theory of change developed by Youth Access to inform the direction of the work. This held that the framework should:

- enable hubs to demonstrate the breadth, depth, and impact of their work using a nationally recognised model
- support continuous improvement and service development in ways that were locally responsive and meaningful to young people
- provide government and system leaders with a clearer tool to inform policy, commissioning, and oversight
- preserve the youth work ethos and relational strengths of existing hubs
- help aspiring hubs develop models in underserved communities.

These ambitions positioned the Quality Framework as a practical and field-shaping intervention designed to do several kinds of work at once: internal improvement, external demonstration, policy clarification, and support for the development of Early Support Hubs and related hub models in England.

Through this process, I sought to translate a diverse and evolving field of hub practice into a more explicit quality architecture, making visible a set of commitments, tensions, and standards that had previously existed largely in the tacit knowledge of practitioners and organisations. This chapter is therefore about both the Quality Framework as a product and the wider questions its development surfaced: what counts as evidence of quality, who gets to define it, and what happens when a voluntary instrument is asked to satisfy the simultaneous demands of hubs, funders, standards bodies, and government.

Findings from the evaluation process

Youth co-design and creative arts workshop findings

Youth co-design materially shaped the language, priorities, ordering, and legitimacy of the Quality Framework. Three paid Youth Engagement Co-designers, Amy from 42nd Street in Manchester, Kyra-Sky from No5 Young People in Reading, and Charlotte from the Isle of Wight Youth Trust, were recruited in April 2025 and worked alongside the project team across the full lifecycle of the evaluation. All three gave permission to be named and for their photographs to be used in connection with this work. We met weekly for an hour across the duration of the

project. Every iteration of the Quality Framework was shared with them as it developed. They contributed to the literature review, facilitated small group discussions in the national hubs workshop, and reviewed the Quality Framework line by line before finalisation.

At the conclusion of the project, the co-designers presented their analysis to the Steering Group in a synthesis drawn from all three workshops. Their account of what they determined young people wanted from hubs is quoted in full in their words:

> We are working to amplify quality of care, and improving service attributes as well as fostering a supportive environment for young people. Some consistent themes and findings across our analyses include the following.
>
> A need for:
>
> - clear and consistent communication
> - respect and collaboration in delivery of care
> - recognition of cultural, religious and/or spiritual beliefs
> - understanding with regard to social or economic barriers (e.g., race, gender identity, sexuality, neurodivergence, income etc.)
> - acknowledgment of support needs and disabilities
> - willingness to learn from service providers
> - shorter referral waiting times
> - concise explanations of support that can be offered and what to expect from service providers

This synthesis illustrates the analytic clarity and confidence the co-designers brought to the project. But it does not capture the totality of their influence, as this cannot be reduced to a single output or moment. Amy, Kyra-Sky, and Charlotte shaped the Quality Framework week by week, through discussion, reflection, questions that reframed how I was thinking, and comments on successive drafts that changed what I wrote and how it was expressed. Their contribution is threaded throughout the work and as a result, cannot be pulled out as a discrete example of co-design impact. The Quality Framework is their work, as it is the work of every young person who gave their time to the workshops, and every hub that engaged with the process.

At the close of the project, the co-designers completed an anonymous evaluation of their experience for Youth Access. All three strongly agreed that it had been a positive experience, and all agreed or strongly agreed that they had gained new skills, felt heard and included, and grown in confidence. Their written feedback pointed to four recurring strengths of the process: warm and respectful working relationships, flexibility around access needs, the meaningfulness of contributing to service improvement for young people, and personal growth through participation.

One co-designer wrote, "I have never really spoken about accessibility needs, or felt comfortable to, but this has changed for me after this experience, given the positive reception I was given when I honestly spoke about my difficulties." Another reflected, "Isabel has been incredible throughout, the most amazing person to work alongside, calm, caring and composed all the time."

For me, these reflections were instructive in shaping my own practice in co-design. As someone relatively new to this way of working, I was struck by how closely the conditions the co-designers described as enabling their participation mirrored the ethics of care I had been observing in hub practice across this doctoral study. Attending to those conditions in the co-design process was a deliberate attempt to enact, rather than merely describe, what relational and ethical practice looks like when working alongside young people.

The workshop findings, summarised by the co-designers in a feedback zine, were organised under three headings: Emotional, Logistical, and Physical Space of Hub available in Appendix B. As mentioned in the methods chapter, a zine is a short, accessible, visually designed booklet used to communicate ideas in a creative and reader-friendly way, and it was design to captured what young people experienced in services and what they wanted more of.

Emotionally, they wanted active listening rather than solution-driven responses, affirmation of their identities, and trusted relationships with hub workers that did not assume what was needed. Logistically, they wanted in-person and remote access options, community-based information and advice, and youth voice participation processes that paid them without tax implications and covered food and travel. In terms of physical space, they wanted environments that felt welcoming rather than

clinical, accessible for disabled and neurodivergent users, and shaped by young people themselves. These themes are traceable in the Youth Voice, Trusted Relationships, Safe and Welcoming Spaces, Accessibility and Anti-Oppressive Practice and Service categories of the Quality Framework.

Youth Voice is the first and arguably most important organising principle of the Quality Framework, and hubs hold it as central to their identity and practice. Having young people engaged as co-designers throughout the process, making analytical decisions, shaping the workshops, and reviewing the framework line by line, gave the Quality Framework an authenticity that mattered to the sector. Hubs could see that the commitment to youth voice in the Quality Framework had been enacted in the process that produced it. That alignment between the framework's stated values and the way it was built was a source of trust that shaped how hubs engaged with everything that followed.

Hubs as end users and feedback cycles

Engagement with hubs was the central focus of the utilisation-focused evaluation approach[150], as hubs were the primary end users of the Quality Framework. This engagement spanned the full project: eight scoping interviews at the outset; a national workshop with 38 practitioners in June 2025; and Steering Group governance with five hub chief executives and youth work experts throughout. A three-week public consultation in July 2025 received 36 organisational and individual responses from hubs, funders, academics, and young people. By the later stages of this process, feedback had shifted in character in a way that indicated the Quality Framework was landing well. Early responses engaged with structure and content, critiquing areas of focus, language, and the relative priority of different sections. Responses gathered around the time of public consultation focused instead on implementation support and resourcing, a shift that suggested broad agreement on the Quality Framework's areas and approach had been reached.

Feedback from hubs sharpened several areas of focus. Practitioners pressed for greater clarity on the scope and accreditation of counselling provision, seeking explicit recognition of a range of modalities including creative therapies and person-centred approaches alongside CBT-based models. Safeguarding and supervision

were identified as needing stronger specification, particularly given the increasing complexity of need in open-access settings and the rapid expansion of new services in an emerging field working with some of the most vulnerable young people. The integration of clinical and social-cultural practice, often referred to in the sector as "non-clinical" practice, was the point on which hub practitioners spoke with the greatest confidence. They did not frame clinical rigour and social and emotional responsiveness as competing values. They argued that the combination of the two was precisely what made their services distinctive and effective: the best hubs were those that combined clinical safeguards with social meaning-making, tailored to the identities and communities they served.

A second contribution of hub feedback was to press the Quality Framework towards greater usability across services of different size, geography, and maturity. Smaller, rural, and early-stage hubs raised concerns about proportionality: whether the Quality Framework would be accessible to their capacity, whether there would be flexible entry points, and whether engaging with it would generate improvement value or simply administrative burden. These concerns directly informed the decision to define quality by depth of delivery rather than breadth of service offer, and to build tiered engagement options into the planned digital tool.

Stakeholder feedback from funders, commissioners, standards bodies, and government

Consultation with stakeholders beyond hubs was necessary because the Quality Framework was designed to function not only within services but across commissioning, funding, standards, and policy environments. Each group brought distinct institutional priorities, and their combined input made visible the different ways in which quality frameworks gain legitimacy and authority in different arenas.

Funders and commissioners broadly welcomed the Quality Framework as a potential shared national reference point, but they encouraged further attention on outcomes, quality assurance, and comparability between hubs. The workshop with trusts, foundations, local authority commissioners, and Integrated Care Boards identified a significant gap in current practice: quality assurance in this space often relied on waitlist reduction times and the absence of complaints as proxies for

quality. Funders and commissioners also emphasised that quality should be framed as continuous improvement rather than as a pass/fail threshold, and that "good enough" was, if hubs met a robust safety standard, a legitimate starting point, recognising that services were at different stages of maturity. The same group raised concerns about self-assessment credibility and favoured in the long term for there to be additional peer review or other forms of external validation rather than mandatory inspections and audits of an already resource-pressed voluntary sector.

Engagement with standards bodies helped locate the Quality Framework within an existing ecology of professional regulation and accreditation rather than positioning it as a replacement for these systems. Discussions with the British Association for Counselling and Psychotherapy (BACP), the Advice Services Alliance, and the National Youth Agency clarified what alignment and passporting opportunities might look like in practice, and where the Quality Framework made a contribution that existing standards did not: its integration of clinical governance with youth work principles, its placement of ethos before infrastructure in the quality architecture, and its explicit attention to the relational and community-based dimensions of quality.

Government engagement tested the Quality Framework's policy applicability and made visible the different institutional lenses through which hubs are viewed across departments. An area I was interested in was how different departments asked different questions to explore the robustness of the framework. One senior policy official asked detailed methodological rigour and theoretical grounding, while another focused on clinical governance and safeguarding in non-clinical settings. Their engagement and feedback strengthen areas of the Quality Framework include Workforce Development, Safeguarding, Clinical Governance, and Outcomes and Impact. I perceived from these discussions that some of the differences in questions reflected the distinct ways senior policy officials consider evidence and the efficacy of quality systems, shaped by the regulatory and accountability frameworks within which each department operates.

Stakeholder engagement strengthened the Quality Framework's legitimacy while making visible the difficulty of designing a single quality instrument that could satisfy the distinct priorities of hubs, funders, standards bodies, and government.

The Quality Framework did not resolve all these tensions. What it offered was a shared structure for working with them, and a positioning of itself as the start of a continuing conversation rather than the end of one.

Public consultation

Between 14 July and 4 August 2025, Youth Access conducted a national consultation on the draft Quality Framework. Thirty-six organisational and individual responses were received from hub staff, young people, funders, researchers, policy professionals, and counselling regulators including the British Association for Counselling and Psychotherapy (BACP). For hub staff and funders, over 90 per cent of respondents reported they were likely or very likely to use the Quality Framework. That headline figure provided endorsement, and the substance of the responses shaped the direction of the project.

Respondents described the Principles, Foundations, and Services architecture as clear, comprehensive, and sector-relevant, with youth voice authentically embedded throughout. The Quality Framework was valued for holding both principles and measurable indicators within a single instrument, and for recognising relational and practical dimensions of quality as equally legitimate. Stakeholders identified multiple uses: reflective practice, funding applications, commissioning conversations, and policy advocacy. The sense that the Quality Framework was less administratively burdensome than other existing accreditation schemes, while still meaningful and reflective of what hubs actually do, was a recurring observation. Respondents described it as making invisible work visible, particularly the relational and cultural dimensions of hub practice that tend to disappear in conventional quality metrics.

The consultation also surfaced areas which the Quality Framework had not yet fully addressed. Respondents identified several areas for development within existing areas: continuity and transitions for young people moving through and beyond services, particularly at eighteen; sustainable funding as an enabling condition for quality; commissioner relationships as a dimension of quality in themselves; and emerging questions around data governance and artificial intelligence. Feedback on the final version of the Quality Framework called for expanded counselling scope,

clearer definitions of clinical and non-clinical competencies, and separate safeguarding guidance for children and at-risk adults, reflecting both the breadth of the sector and the specificity of existing professional standards.

The Youth Access Quality Framework

The principal output of the national evaluation was the Youth Access Quality Framework, provided in Appendix A. The framework is voluntary and was developed using Cooperider's principles of appreciative inquiry[152] to be orientated towards development and improvement rather than audit or critique. It was designed for multiple audiences: hubs seeking to reflect on and strengthen their practice; emerging services building provision in underserved areas; commissioners and funders assessing quality and making investment decisions; and policy actors seeking a nationally recognised account of what good looks like in this space.

The Quality Framework responded to a sector and policy context in which demand for youth mental health services was rising, service models varied considerably across geography, size, and workforce composition, and there was no agreed national account of what quality in an Early Support Hub should mean. Prior to this, hubs had reported their work to commissioners and funders through a patchwork of different outcomes metrics and narrative evidence. Without a shared structure, demonstrating quality consistently was difficult, and the field's relational and developmental strengths were often invisible in the language of accountability frameworks designed for other settings.

The framework was developed at a moment of political and policy convergence, resembling what Kingdon describes as a policy window, in which a recognised problem, an available policy solution, and heightened political attention align to make institutional change more possible[194]. In England, community and political interest in early intervention and prevention in young people's mental health was strengthening, reflected in the Fund the Hubs campaign's advocacy for sustained national investment in community-based youth mental health services, the Lancet Psychiatry Commission's identification of hub models as a leading approach to youth mental health service reform[9], and the development of the government's Young Futures Hubs programme under the Department for Culture, Media and

Sport. The Quality Framework arrived at this intersection: a field with growing political and policy interest, and no shared national standard for quality.

The final structure of the Quality Framework

The Quality Framework organised quality into three overarching domains: Principles, Foundations, and Services. These are not hierarchical tiers but mutually reinforcing categories, each addressing a different dimension of what it means to run a high-quality hub. The combination of these three categories produce an account of quality that is layered, contextual, and difficult to reduce to a single score or compliance threshold. The principles domain defined the ethos and what the Steering Group referred to as the "youth work orientation" of a high-quality hub. It has six areas of focus:

- Youth Voice
- Trusted Relationships
- Accessibility and Anti-Oppressive Practice
- Sustained Community Presence
- Safe and Welcoming Spaces
- Values and Culture

These Principles articulate the underpinning values for how a hub operates, not just in its policy documents but in its everyday practice and relationships. Positioning these as Principles rather than aspirations placed ethos before governance in the architecture of quality, a structural decision with real consequences for how the Quality Framework reads and how hubs are expected to engage with it.

The Foundations domain specified the organisational conditions required for safe, effective, and sustainable delivery. It has seven areas:

- Safeguarding
- Clinical Governance and Risk Management
- Workforce Development
- Outcomes and Impact
- Service Learning and Improvement

- Internal Coordination
- External Integration and Collaboration

These Foundations address the infrastructure within which principles are enacted. This domain carries detailed guidance on safeguarding practice in open-access settings, clinical governance in non-clinical environments, and the integration of quantitative and qualitative outcome evidence.

The Services domain articulated the areas of support that a Youth Access hub might provide and coordinate. Five service areas are described:

- Counselling
- Wellbeing
- Drop-in and Information, Advice and Guidance
- Youth Work and Outreach
- Physical Health

The Services domain is explicitly non-prescriptive about scope: quality is defined by how well each area is delivered in response to local need, not by how many service areas a hub offers. A smaller hub delivering counselling and information, advice and guidance with depth and integrity meets the Quality Framework's expectations as fully as a larger hub with a broader service offer.

This chapter analyses the process and impact of the Quality Framework rather than restating its content in detail. The full text, including definitions, evidence indicators, and the challenges and tensions identified within each of the eighteen areas of focus, is set out in Appendix A. Each of the eighteen areas of focus includes a definition of what good practice looks like, illustrative examples of how quality might be evidenced, and a section on challenges, tensions, and variations.

An improvement-oriented framework is only useful if it is honest about why improvement is hard. By combining the national evaluation with insights from the case study findings reported in earlier chapters, it was possible to articulate not just what quality should look like but why it so often proves difficult to sustain: the structural tension between relational continuity and short-term commissioning of

projects in the Trusted Relationships domain; the mismatch between what matters to young people and practitioners at the level of the individual and what funders need to demonstrate value at system level in Outcomes and Impact; the competing demands on open access physical spaces in Safe and Welcoming Spaces.

Consensus and Productive Disagreements

Areas of broad consensus

Several areas of broad consensus emerged across the evaluation, despite the diversity of participants and settings involved. These convergences were not produced by the consultation design: they surfaced independently across hub practitioners, co-designers, young people, funders, and government, which gave them a quality of authority that findings from any single stakeholder group could not carry alone.

The strongest consensus was that youth voice should be treated as foundational to quality rather than as an optional participation exercise. Hub practitioners argued that youth voice should shape governance, recruitment, service design, and accountability. Co-designers and young people articulated what this looked like from the inside: it meant clear communication, respect in delivery, recognition of identity and background, and willingness on the part of services to learn from those they served. Funders and government agreed that youth-centred environments and direct youth voice were features of quality, not ornaments to it. That youth voice is the leading Principle of the Quality Framework reflects this consensus: it was not a design preference but a finding.

A second area of strong agreement was that trusted relationships lie at the centre of hub quality and distinctiveness. This convergence extended the argument developed through the case study ethnography in earlier chapters, where the ethics of care within hubs was shown to underpin staff practice and young people's willingness to seek and sustain support. The national evaluation confirmed that finding at scale. Practitioners described relational quality in terms of attunement, continuity, and the slow work of becoming a reliable presence. Young people named it directly: trusting relationships with hub workers were described as essential, long-term, and qualitatively different from the transactional encounters common elsewhere in

health and welfare services. Funders and commissioners, who might be expected to focus on outputs, acknowledged that relational trust was a real and meaningful dimension of what hubs did, even where it remained difficult to evidence through quantitative means.

Participants also converged around the idea that the quality of the physical and social environment is part of care itself, not a peripheral condition for it. Young people described wanting spaces that felt welcoming rather than clinical, that indicated through their design that others had been there before them and found support. Hub practitioners spoke about the detailed work involved in creating these environments: sensory-accessible layouts, the presence of snacks and art materials, the management of front doors in ways that balanced security with dignity. The Quality Framework's Safe and Welcoming Spaces area gave formal recognition to what many in the field had long understood: that space holds people, and that its quality is inseparable from the quality of the care conducted within it.

Across the process, quality was repeatedly defined as both relational and practical, combining principles, infrastructure, and service delivery rather than privileging one dimension alone. That synthesis was itself an outcome of the evaluation. The field has often debated whether quality resides in values or in systems. The evaluation suggested the answer is neither in isolation: values without systems are enacted inconsistently, and systems without values become compliance machinery.

Areas of productive disagreements

The evaluation also surfaced several productive disagreements. I frame them as productive because in complex environments, tensions are not merely obstacles to implementation but productive resources, because making disagreements explicit and working through them can strengthen, refine, and legitimise collective action rather than weaken it[195].

One major tension concerned how impact should be evidenced in a model that values trust, continuity, and non-linear change. Funders and commissioners showed mixed preferences: some favoured standardised quantitative evidence; others valued system-level and relational outcomes. Hubs wanted tools that could hold narrative,

qualitative, and co-designed evidence alongside quantitative indicators, capturing change in young people's own voices as well as in validated outcome measures. The Quality Framework's Outcomes and Impact area attempted to hold both, but the tension between what can be counted and what matters is not resolvable by a framework document. What the evaluation made clear was that the current default, relying on quantitative outcome measures alone, or using waitlist reduction and the absence of complaints as proxies for quality, was widely regarded as inadequate. Moving beyond it required investment in new evidence infrastructure, not just a better framework.

A second tension lay between the desire for shared national standards and the need to preserve local identity, flexibility, and proportionality. Larger, established hubs could engage with the Quality Framework's full scope. Smaller and newer services were concerned about being held against a standard designed for a more mature organisational form. The Quality Framework's response, defining quality by depth of delivery rather than breadth of service offer, was broadly welcomed, but the tension between national coherence and local diversity remained live and will continue to shape how the Quality Framework is used in practice.

A third area of productive disagreement concerned the relationship between clinical and non-clinical approaches to care. The hub workshop produced clarity through productive discussion: practitioners argued that clinical rigour and social and relational responsiveness were not in tension but complementary components of what made hub care effective. The Quality Framework adopted this position, treating counselling, wellbeing support, youth work, and advice as complementary and interacting layers of support rather than a hierarchy.

Dialogue with hubs and wider stakeholders also identified a corresponding structural risk: that non-clinical settings require particular attention to risk management, supervision, and escalation precisely because they operate outside the governance structures that ordinarily provide safety assurance in clinical environments. Ethnographic observation across the case study sites, reported in earlier chapters, showed how robust safeguarding protocols, clinical governance structures, and supervision arrangements supported non-clinical staff to hold risk without compromising the relational and open-access character of their work. That

evidence informed how the Quality Framework articulated this boundary, holding the tension between clinical accountability and non-clinical presence as a productive feature of hub practice rather than a problem to be resolved.

A fourth tension centred on the credibility of self-assessment. The "marking your own homework" concern surfaced independently across hubs, commissioners, funders, and government, each with a different inflection. Funders and commissioners favoured peer review as a lighter-touch alternative to formal external audit. Government reflected that an external validation process would build confidence in the Quality Framework. Hubs recognised the concern but were clear that mandatory external inspection would undermine the developmental character of the Quality Framework. The evaluation did not resolve this. It documented the options, outlined two evaluation models for consideration in 2026, and positioned the question as one to be worked through in implementation rather than settled in the framework document itself.

These disagreements are not problems to be resolved, they are inherent tensions to be managed. They reflect an engaged hub sector working within a complex system, where quality must be negotiated across different values, accountabilities, and service forms. In that context, tensions are productive. They generate reflection, sharpen the framework, and support improvement by making assumptions and trade-offs visible. The task of the Quality Framework was not to eliminate these tensions, but to help the sector work with them more clearly and more thoughtfully.

Implementation and emerging impact

The next phase requires investment in the implementation infrastructure around it: practical tools, accessible formats, peer learning mechanisms, and continued policy engagement. Youth Access has begun this work; a digital self-assessment tool has been developed based on the Quality Framework, which will allow hubs to work through the eighteen areas of focus, gather and upload evidence, and track their progress across Bronze, Silver, Gold, and Developing levels. I contributed to drafting the content for those levels and provided implementation planning input for 2026. My formal consultancy role with Youth Access concluded in November 2025. I remain informed about implementation but am not leading it.

Even at this early stage, the Youth Access Quality Framework is being applied within the sector. Youth Access reports that hubs are using it to structure internal quality improvement discussions and evidence gathering and is commissioning further tools to support services in identifying priority areas and undertaking structured improvement work.

At commissioning level, the Prudence Trust, a national funder of youth mental health services providing grants of up to eight million pounds per year, has confirmed that it is using the Quality Framework as a benchmark in current grant funding decisions. That a major national funder moved to embed the Quality Framework in its processes within months of publication suggests the field had been waiting for this kind of shared standard to drive investment.

The early use of the Quality Framework in funding and improvement decisions also makes validation and careful implementation important. The framework was developed as a developmental quality improvement tool for hubs. Its intended logic is to help hubs reflect on practice, identify areas for improvement, gather proportionate evidence, and communicate the quality of their model to funders, commissioners, policymakers, and young people. However, as Bonell and colleagues argue in their work on "dark logic models", interventions and evaluation tools can produce unintended harms when their potential adverse mechanisms are not explicitly considered[196]. For the Quality Framework, the dark logic could be that a tool designed to protect relational, locally adaptive and youth-centred care could instead incentivise superficial compliance, excessive documentation, performative evidence production, or standardisation that weakens the areas of quality that it was designed to support.

A further risk concerns how the Quality Framework is used within a sector marked by wide variation in service size, funding stability, administrative capacity, and organisational maturity. Larger, established hubs may be better able to evidence quality across all eighteen areas of focus, while smaller or emerging services may struggle to demonstrate the same level of documentation even when their relational practice is strong. If applied without attention to context, funding, workforce capacity, organisational maturity, and local need, the framework could

unintentionally reproduce inequity across the sector. It could also shift attention from learning to performance management, encouraging services to prioritise what can be evidenced most easily rather than what matters most to young people.

Several features of the framework were designed to reduce this risk. The self-assessment structure is developmental, with Developing, Bronze, Silver, and Gold levels intended to support staged improvement rather than pass-fail judgement. Evidence expectations are deliberately broad, allowing services to draw on youth voice, reflective practice, qualitative feedback, case examples, staff learning, partnership work, and routine data, rather than relying only on narrow performance metrics. The framework also places Youth Voice and Safeguarding as essential domains, meaning that quality cannot be claimed without attention to both young people's influence and organisational safety. These design choices reflect the values underpinning the framework: proportionality, learning, relational care, equity, and accountability.

Nevertheless, further external validation and evaluation of the quality framework's ongoing use is required. Future evaluations should examine whether the framework is interpreted consistently across hubs, whether its levels distinguish meaningfully between stages of organisational development, whether young people and staff recognise its descriptions of quality, and whether use of the framework leads to improvement rather than compliance activity alone. Validation should also test for unintended effects, including increased administrative burden, gaming of evidence, exclusion of smaller services, over-standardisation, or weakening of local adaptation. In this sense, validation should include both the framework's intended logic and its possible dark logic. The framework will be most useful if it remains a tool for reflective improvement and shared learning, rather than becoming a blunt instrument of audit, funding control, or reputational ranking that benefits large and established services over small community-based models.

At policy level, the reach of the Quality Framework extended further than I had anticipated. Following publication, I have been contacted independently by a senior official at the Department of Health and Social Care seeking advice on safeguarding and clinical governance in connection with their commissioned research for the Shared Outcomes Fund, and by a senior civil servant at the Department for Culture,

Media and Sport requesting a detailed briefing on workforce arrangements, training levels, and accreditation standards for hub models, in connection with the National Youth Strategy and governance of the Young Futures Hubs programme. The specificity of their questions suggested that the Quality Framework was being read and considered in the context of policy development.

Beyond England, through a kind introduction from my DPhil supervisor Professor Michael Kidd, who also serves as Chief Medical Officer of Australia, I was invited to present my doctoral research findings to Dr Sophie Davidson, Chief Psychiatrist of Australia, and her colleagues. While my presentation focused on the broader evaluation questions and the literature review findings, the Quality Framework was central to discussions about workforce, safeguarding, and the design of welcoming, non-clinical environments for young people, and it offered a practical reference point for thinking about how Australia might develop quality standards for its own community-based youth mental health services.

Conclusion

The national evaluation produced a shared standard for quality across a diverse range of hub services that, despite their differences in size, geography, and model, share common principles, foundations, and service commitments. The utilisation-focused evaluation approach ensured that the people who would use the Quality Framework helped to shape it and determine whether it was fit for purpose. The Quality Framework entered the sector with broad endorsement and is already functioning as shared structure for evaluating quality: used by hubs for internal improvement, by funders to benchmark grant decisions, and by government officials working on the design and governance of future national hub programmes.

The most important finding was that quality in Early Support Hubs cannot be reduced to a list of interventions or a compliance checklist. Principles, foundations, and services are inseparable in how hubs deliver care: ethos without infrastructure is enacted inconsistently, and infrastructure without ethos becomes compliance machinery. Quality emerged across every consultation strand as relational, organisational, political, and infrastructural. It resided in the trust a young person felt when they walked through a door, the reflective capacity of the staff who met

them, the governance structures that held risk without displacing care, and the policy environment that either supported or undermined the service's ability to sustain its presence in a community. The tensions the evaluation surfaced, between measurable and relational evidence, national standards and local flexibility, clinical accountability and non-clinical character, are the conditions from which high-quality hub services emerge in this field and naming them with clarity was itself an analytical contribution.

The Quality Framework is the product of many people's work. It belongs to Youth Access, to the hubs that engaged throughout, and to Amy, Kyra-Sky, Charlotte, and the thirty-eight young people who gave their time to the youth engagement workshops. Translating doctoral research into something of practical use during the research process itself, rather than after it, was an opportunity I had not anticipated, and for which I am enormously grateful. That the Quality Framework is already being used to improve services for young people, and is informing policy conversations in England and beyond, reflects a conviction that has run through this doctoral study from the beginning: that rigorous research and system impact are compatible and mutually reinforcing.

Chapter 10: Discussion & Conclusion

Early Support Hubs are community-based services for young people with emerging mental health difficulties, offering open-access and practical support outside statutory mental health provision. They sit in a complex and layered system of youth mental health care in England, working alongside GPs, CAMHS, schools, and voluntary sector organisations to reach young people who are struggling but have not been able to access specialist services. Interest in Early Support Hub models is growing among mental health advocates and policy makers, driven by a conviction that accessible early intervention and preventative support can make a meaningful difference to young people's mental health and wellbeing.

The research question guiding this thesis was: what is the model of care enacted by Early Support Hubs in England, and what logics of care underpin this model? When I began this doctoral study in 2023, that question did not have a settled answer. The field was conceptually varied and terminologically messy. Services operated under different names, with different workforces and service arrangements, united by a recognisable orientation to what care should be rather than by any agreed specification of what it must include. I found that there was no single hub model, and the sector had not yet developed shared language for what one would look like. I hope that the development of this doctoral study and the Youth Access Quality Framework help to provide it. This aspiration is the starting point for this chapter, and the contributions section at its close reflects on how far the field has progressed in the three years of doctoral research.

The chapter summarises the findings of three comparative case studies of Early Support Hubs in England, integrated with analysis from a parallel national Quality Framework evaluation process. I describe three central findings:

First, that what connects Early Support Hubs as a model was a set of shared logics of care: a contextual understanding of young people's distress, a relational and iterative approach to support, open access as an ethical commitment rather than an operational feature, and youth voice as foundational to what a hub is. These logics were enacted differently across the three case study sites, reflecting distinct organisational histories, professional cultures, and statutory relationships. Through

this research, and in combination with the Quality Framework process, I have traced how the field has moved, partly through this work, from a family of related services towards a more explicit and usable model of care.

Second, that trust is one of the mechanisms through which these logics of care become real for young people. An ethics of care, embedded in how hubs are designed and how staff are trained and supported, generates the conditions under which young people can engage with support, disclose what is actually happening in their lives, and return after difficulty or absence. In many healthcare organisations, relational work is deprioritised in favour of throughput, efficiency, and episodic care. As a GP, I have worked in settings where the pressure to see more patients in less time makes sustained, trust-based relationships difficult to maintain, however much individual clinicians and patients value them. Hubs aim to overcome this, by building time, relational continuity, and an ethics of care into service design itself. The trust young people have in hubs is a component of organisational infrastructure, produced through relationships between staff and young people and sustained by the culture, values, and workforce structures of the hub as a whole, rather than left to the discretion and effort of individual workers. Trust is difficult to codify, measure, and assign value to, which makes it challenging to specify in models of care, evaluate meaningfully, and sustain when services are adopted in new organisational contexts.

Third, that hubs operate in an ongoing struggle for legitimacy within systems that privilege clinical and statutory forms of care and measurable indicators of success. The politics of evidence is an expression of that struggle. Evidence debates in this field have been distorted by developing measures for outcomes without a clear understanding of the model generating those outcomes.

The Youth Access Quality Framework, developed collaboratively with young people and hub services, is integrated throughout this analysis. It served as a mechanism of translation: converting the shared logics identified through comparative case study research into a practical structure that services, funders, and government could use both formatively (to guide reflection and improvement efforts) and in summation (to judge achievement). This national evaluation process also contributed to the analytic

depth of the thesis, bringing insights into challenges across the sector that the case studies alone could not provide.

This chapter proceeds as follows. The first section examines the movement from a diffuse field of related services towards a more coherent model of care, introducing the shared logics that underpin hub practice and showing how they were enacted across three distinct sites. The second section examines trust as organisational infrastructure: how it is built, what it makes possible, and why it is fragile. The third section examines how hubs operate within and alongside statutory systems, and why the politics of outcomes measurement have become contested. The chapter concludes with reflections on the strengths and limitations of the research, contributions to research, policy, and practice, and priorities for the field as Early Support Hubs begin to be adopted nationally.

A model of care for Early Support Hubs

Early Support Hubs did not begin as a single model of care. When I began this doctoral study in 2023, the field was conceptually varied and terminologically messy. Services were described as YIACS (Youth Information Advice and Counselling Services), youth mental health hubs, Early Support Hubs, drop-in services, integrated health and wellbeing models, one-stop-shops, and sometimes simply as hubs or youth hubs. These labels pointed to a recognisable family of services, but not to a clearly specified intervention with agreed components, boundaries, or minimum requirements. The category was real and useful, but it was not yet settled.

Early Support Hubs in this period functioned as a boundary concept in Star and Griesemer's sense: coherent enough to organise advocacy, funding claims, and service development across groups who did not fully agree, without requiring those groups to resolve their disagreements first[14]. The productive ambiguity of the hub category allowed different services to recognise themselves within it and helped build a broad coalition around the need for community-based, youth-centred early support. For some stakeholders this was a strength. For others it created category uncertainty: services could identify with the hub movement while differing substantially in workforce, service mix, governance, and threshold for inclusion. The

Quality Framework process made this visible in practice: some services which identified as hubs were closer to counselling services with a youth participation group attached, and the question was raised more than once in the process whether a youth drama or arts programme with no other services attached could count as a hub at all.

Star later clarified that boundary object status is not simply a property of any concept that is used flexibly across contexts[15]. The category requires enough internal structure to coordinate work across social worlds, and it is always under pressure from two directions at once. Standardisation pulls towards collapse, as administrative and regulatory processes attempt to fix the category by resolving its productive ambiguity into defined components, membership criteria, and governance requirements. Against this, boundary objects generate residual categories: the services and practices that do not quite fit the emerging standard, and that may coalesce into new alliances or new boundary objects of their own. What this pressure looks like in practice, however, depends on who is doing the brokering and to what end.

Kimble and Grenier's analysis of boundary objects in professional networks shows that brokers select and deploy boundary objects politically, either towards collective goals that open up information and widen participation, or towards individually oriented ones that control the direction of a joint enterprise and limit who belongs[197]. The Quality Framework represented a collectively oriented brokerage: developed through co-design with young people, services, funders, and government, it was explicitly designed to construct shared understanding rather than concentrate definitional authority. The outcome it has produced is nevertheless a significant standardising move. Services that cannot demonstrate a working combination of advice and guidance, counselling, and a meaningful youth voice and participation structure are now positioned as aspiring hubs, acknowledged as part of the broader field but understood as requiring further development before they meet the model's minimum conditions. That is a substantial shift. For years, the hub category had no floor. It now has one.

Logics of care in Early Support Hubs

What connected Early Support Hubs was a common orientation to what care should be. Across all three case studies and the Quality Framework process, hubs understood distress as contextual, organised support as relational and revisable over time, treated access as a moral question, and placed young people's views at the centre of what made a hub meaningful. Annemarie Mol's concept of a logic of care gives this orientation analytical precision: care, in Mol's account, is an ongoing, practical, and revisable process in which needs, possibilities, and responses are worked out relationally and experimentally, rather than a transaction in which a fully autonomous consumer selects from a menu of options[16]. Applied to hubs, this framing shifts attention away from what services offer and towards how they understand the work of caring at all. Four shared logics emerge from the case study data and Quality Framework process, each revealing something distinct about what hubs do and why the model is difficult to reproduce elsewhere.

Distress as social, relational, and material

Hubs began from a broader and contextual account of distress than most clinical settings. Across all three case studies, young people's mental health difficulty was understood as emerging within social, relational, and material conditions, shaped by the practical circumstances of a young person's life: family instability, poverty, housing difficulty, school exclusion, loneliness, safeguarding concerns, bullying, questions of identity and belonging, the overlap between neurodiversity and mental health difficulties, and the cumulative effects of adversity. Hubs responded to a wider ecology of distress, attending to crisis and formally diagnosed disorder alongside the social and material conditions that surrounded and often produced them. They actively provided support to respond to it, integrating practical, relational, and emotional help within the same service rather than treating social complexity as background to a clinical problem.

Clinicians working in medical settings are often acutely aware that a young person's mental health cannot be separated from their housing, relationships, finances, or sense of belonging. The gap lies in what systems are designed to do in response. Clinical encounters tend to categorise difficulties into defined medical problems with likely diagnoses, and to respond within the frameworks those diagnoses make available. Social prescribing represents a movement towards broader response, and

it has real value, but it remains a referral and an adjunct to treatment rather than a core element of care.

Relational and social support sits alongside the clinical encounter rather than inside it. Many GPs, psychiatrists, and other doctors work hard to maintain relational continuity in constrained systems. I have worked alongside exceptional clinicians for whom continuity and relationship were core therapeutic commitments, and some of these people shaped how I learned to practise. In medicine, relational work depends heavily on individual effort: remunerated and measured inconsistently and rarely built into system design as a central element of care. Hubs have made that ethics of care and relational continuity a design feature, which changes what the service can offer and who can make use of it.

Hubs being primarily non-clinical spaces makes a different sequence of care possible. For the young people I observed visiting the hubs, support often began well before difficulties had become stable enough to fit a diagnostic or treatment pathway. It started with housing advice, help with benefits, a conversation about school, a place to sit quietly, a safe space to question identity and belonging, or contact with a trusted worker. The direction of travel was frequently the reverse of a conventional clinical pathway: beginning with the material, relational, and social environment, and building towards more formal or specialised responses where needed.

There were multiple examples of young people in interviews across the hub-based case studies describing how they could not make effective use of counselling or therapeutic support until more immediate instability had first been addressed. A young person frightened about debt, struggling to attend school because of bullying, trying to understand their own neurodivergence or changing identity, or navigating a period of acute family conflict may not be able to benefit from reflective therapy at that time, however valuable that therapy may eventually become. Hub support played a stabilising role: it created the practical and emotional conditions in which psychological work could later become possible. When distress is understood this way, the sequence of care inverts: the social and material environment must be sufficiently stabilised before formal therapeutic work can take hold. That inversion has direct consequences for how hub care should be measured.

Care as unfolding over time

Mol's account of care as a practical and revisable process is useful here: rather than being delivered once to a stable problem, care is reworked in relation to one that is itself changing, adjusted as situations shift, new constraints become visible, and trusting relationships deepen[16]. Across all three case studies, young people's situations shifted across time, often unpredictably. Crises intensified and then receded. Young people returned after absences of weeks or months. Practical difficulties emerged that made a previous plan unworkable. Staff described staying alongside young people, revising support, trying something, pausing, holding contact, and working with what was possible at a given moment. Hub care was iterative: it required attentiveness, responsiveness, and a willingness to rework support rather than insisting that young people adapt themselves to the service's original plan.

Continuity of care has long been recognised as important in primary care, with associations with lower mortality[198] and improved patient outcomes[199]. In general practice and hub settings alike, relational continuity changes what becomes knowable, how risk can be held over time, and from this what forms of help can be offered. In general practice, continuity is often held by one clinician across years of contact. In hubs, continuity tends to be carried more organisationally, across a team and a setting, so that a young person's relationship with the hub itself becomes the thread that makes successive forms of support meaningful. That is a different form of continuity, and it places different demands on the organisation: stable staffing, low turnover, shared culture, and institutional memory matter as much as the skill of any individual worker.

Episodic models of service delivery, organised around bounded encounters, throughput targets, and linear outcome trajectories, implicitly assume that care can be made discrete and complete. For many young people, especially those living with instability, complexity, or recurring social adversity, that assumption does not hold. Care was valuable in hubs precisely because it could remain open, responsive, and willing to begin again. That orientation has a direct implication for evaluation. A young person who returns to a hub after a six-month absence is not a case of attrition. Being provided counselling and returning a year later for further support is

not seen as failure. Young people are using the hub in the way the service was designed to be used.

Open access as an ethical principle

Across all three case studies, there was a strong underlying proposition that young people should not have to become sufficiently ill, at-risk, or legible to bureaucratic thresholds before they were considered eligible for support. Young people themselves were clear on this point: in research interviews and Quality Framework workshops, they described constrained appointment availability, high referral thresholds, and the clinical orientation of many NHS consultations as active barriers to getting help early. Open access was their answer to a system that had often already failed them by the time they arrived.

Open access is commonly used in the hubs and youth mental health literature to describe services that young people can enter with low formal barriers, typically through self-referral, rapid or flexible access, and youth-friendly community settings rather than conventional clinical pathways[1], [2], [29]. In practice the case study comparison suggests that this definition is overly simple and requires further explanation. Access depended not only on referral route, but on where a service was located, what hours it was open, how young people were received at the door, who else was in the space, whether the environment felt calm or chaotic, how risk was managed, and whether staffing and governance could sustain low-threshold support over time. It also depended on how relationships were organised. Young people did not always build trust with a single worker alone; in some sites, staff actively worked to build continuity with the service as a whole, so that support remained accessible even when individual workers changed or interventions ended. Open access, in this sense, was not a single service feature but an ethical, relational, and organisational accomplishment. All three hubs enacted it as a shared principle, but each did so differently.

Open access is also an aspirational principle constrained by resources in practice, and hubs managed this tension through deliberate design. The boundary-making that shaped access was subtle but consequential: opening hours, front-desk processes, check-in systems, open- and closed-door arrangements, layout, décor, artwork, sensory environment, and choices about which groups a space was made

accessible for all determined, in practice, who could walk through the door and who could not. All three hubs also discussed the need for longer opening hours outside school and working hours, recognising that access was constrained as much by when young people were available as by whether the door was technically open.

Shore Hub illustrates this principle particularly clearly. Open access for vulnerable street-homeless young adults created a loud and chaotic environment in the main drop-in that was less suitable for younger neurodiverse teenagers with anxiety. The service responded by creating a distinct physical space with different access criteria for school-age young people. Meaningful open access therefore required active reflection on who the current design was and was not reaching, and a willingness to reorganise the service in response.

Openness also required safeguarding governance capable of holding complexity without reverting to exclusion. This emerged as a strong area of consensus in the Quality Framework process precisely because open-access, relationship-centred, longitudinal provision risk emerges in distinctive ways: safeguarding concerns might surface gradually through a worker's accumulated knowledge of a young person, rather than through a single disclosure in a contained clinical encounter. That kind of longitudinal, relational, safeguarding depended on the same conditions that made hub care possible at all: continuity, trust, and time. Open access, properly understood, was not a posture of unlimited availability. It was a commitment that placed real demands on governance, workforce, and organisational design, and that carried practical limits on the numbers of young people who could be seen and the levels of complexity that could be safely held.

Youth voice as a defining feature of Early Support Hubs

In the Quality Framework process, youth voice was consistently named as the first foundational principle of high-quality hub practice. It was also consistently broad: widely invoked, valued and prioritised, but less settled in its meaning than its prominence suggested. Understanding what youth voice contributes requires distinguishing between its different functions, because they carry different implications for how participation should be designed, supported, remunerated, and evaluated.

At its most practical, youth voice was used to improve services. All three case study hubs had youth advisory councils made up of young people who had previously used the service, meeting regularly with support from a dedicated staff member to contribute to questions on how the hub operated. Hubs also got feedback from current service users through different mechanisms: Dock Hub used a QR code displayed on the walls linking to a brief online survey, Heath Hub used paper-based surveys, and Shore Hub gathered feedback through ongoing dialogue with youth workers. Across all three, young people provided views on whether spaces felt welcoming and what kinds of support should be offered differently. In some settings, young people sat on interview panels or contributed to recruitment decisions. This functional role produced tangible changes to hub design and practice: adjustments to physical environments, shifts in opening hours, new programme offers, and changes to how services communicated with young people.

Youth voice also had a developmental and therapeutic function that went beyond service improvement. Participation in groups, panels, and co-design activities enabled some young people to build confidence, practise communication, and form connections with peers. Five out of six young people interviewed for this research were members of youth advisory councils. They described this participation as part of their recovery and sense of life purpose. Participation, in these accounts, was a form of care.

Youth participation sometimes carried an explicitly political dimension, with young people speaking to decision-makers at local and national levels about the value of hub provision. All the young people I spoke to believe in the value of hubs and were energised by the opportunity to contribute to national conversations about youth mental health. That enthusiasm was real and advocacy through sharing their personal narratives was often powerful. The question worth holding alongside it is whose agenda structures these opportunities. When young people are mobilised to speak about the value of the service that supports them, the interests of the young person and the interests of the organisation are aligned, but not always identical. How opportunities are framed, who selects participants, whether young people are paid, and what support they receive before and after public-facing roles all shape whether political participation functions as empowerment for young people or as a

resource the service draws on for its own legitimacy. Naming this tension is not a critique of youth advocacy but calling attention towards doing it well.

Youth voice can also function as an ethical good in itself; a marker of moral seriousness for hub staff and researchers that risks becoming an end in itself rather than a means. During the Quality Framework process, a hub staff member challenged my involvement on the grounds that the Youth Engagement Co-designers had not been appointed before I was, and that this sequencing had compromised the participatory integrity of the work. I took this provocation seriously, and it opened extended conversations with the Youth Engagement Co-designers, Youth Access, the Steering Group, and senior colleagues at the National Youth Agency about what authentic participation requires and where the appropriate limits lie.

A balanced account also requires naming the costs and limits of youth voice. Meaningful participation is time and resource intensive. It requires clear communication, defined roles, flexible opportunities for engagement, remuneration where feasible, and access to debriefing and emotional support[161]. Without these structures, participation can slide into overcommitment, burnout, or tokenism rather than empowerment[200]. It also does not work equally well for all young people[201]. More confident, articulate, or already-engaged young people are often easier to recruit and retain, while under-representation persists among those facing structural disadvantage, disability, language barriers, or ongoing instability. In mental health settings there are also specific welfare concerns. Young people involved in service improvement have described the emotional challenge of revisiting difficult experiences, feeling responsible for peers, and worrying about the impact of participation on others in the group[202]. These are not arguments against youth voice, but are reasons to design it carefully, support it properly, and resist treating it as universally beneficial.

For hubs, there are domains of service operation, including complex safeguarding deliberations, confidential staffing matters, and detailed financial administration, where it is neither appropriate nor fair to expect young people to provide advice or bear responsibility. A challenge for Early Support Hubs and participatory researchers alike is to distinguish between meaningful participation that is respectful

to young people's skills and experiences, and an ideological insistence that more youth voice is always better regardless of function or fit[203], [204].

Youth voice in Early Support Hubs can redistribute power within services, improve fit between provision and the people it is meant to serve, and support the development and recovery of some participating young people. When achieved these can be meaningful and valuable contributions. But participation is not self-justifying, its value depends on how well it is matched to function, bounded ethically, and supported in practice. Meaningful involvement requires clarity of purpose, careful communication, explicit attention to power, diversity, reimbursement, and exit, and specific welfare consideration in mental health settings where revisiting difficult experiences or bearing responsibility for peers carries real emotional cost[205]. The analysis here has attended to what youth voice is contributing to in each hub, and at what cost, precisely because the question of how youth voice is embedded and supported matters more than how prominently it features in a service's self-description.

From family resemblance to a model of care

In the case studies these shared logics were enacted differently across the three sites. Dock Hub translated shared logics through a professionally formalised integrated with, and recognisable to, other clinical and statutory services. Heath Hub held shared logics within a focus on advice and guidance, with a developmental and social justice ethos, offering an alternative way of working to statutory services while coordinating with them. Shore Hub enacted shared logics through long term open-ended support for some of the most vulnerable young people in its locality, where early intervention, prevention, and crisis response often sat alongside one another in the same space.

The case studies thus illustrate how three Early Support Hubs were united by a family resemblance: a similar orientation to young people's needs, while building different organisational arrangements that reflected the history, context, and values of the people who worked there.

The Quality Framework co-designed as part of this DPhil helped move this field from family resemblance towards greater specification. It did not simply describe what hubs were already doing. It also helped organise the field by naming domains, clarifying what counts as quality, and giving services, funders, and government a more stable shared language for talking about hub care. The framework set out eighteen areas across principles, foundations, and services, while still recognising that hubs vary by local context and do not all offer the same mix of provision. A senior leader from an Early Support Hub emailed me at the end of the project to say that even those who had championed hub development for years had doubted that sufficient coherence was achievable across services with staff and leaders as independently minded as these.

This is the first contribution of the thesis. The Quality Framework clarified and gave greater conceptual coherence to the hub category without flattening local difference. It has given practical form to a model that had previously been widely invoked but only partially articulated. Early Support Hubs have moved from a boundary concept closer towards being a model of care. This contribution sits within a wider field that has been moving simultaneously through multiple channels: continued sector advocacy, growing parliamentary attention to hub funding and policy, and emerging national research evidence including Appleton and colleagues' qualitative work with staff and young people for the Shared Outcomes Fund[2], [26], with quantitative findings forthcoming.

The shared logics emerged consistently across all three case studies, but the findings suggest they may not be self-sustaining. Across the sites, they appeared to be more robustly enacted where there was mature leadership, stable staffing, strong local embedding, and accumulated organisational memory. Where those conditions seemed thinner or patchy, the orientation remained present in aspiration but appeared harder to maintain in practice, though further research with a wider range of sites, including hubs under greater organisational strain, would be needed to test this observation more rigorously. What the case studies consistently suggested, across all three sites, was that a central mechanism sustaining the logics of care was trust: between young people and workers, between workers and the organisation, and between the organisation and its community. In the next section, I explore this theme in more depth.

How trust is sustained, and why it is hard to reproduce

Trust in Early Support Hubs is built through the design of the service itself: through continuity, accessibility, atmosphere, boundaries, follow-up, confidentiality, an ethics of care embedded in how staff are trained and support young people. This section examines how trust is built, what it makes possible, why it is fragile, and what understanding it as organisational infrastructure means for how the hub model can be adopted and sustained elsewhere.

Trust as a condition of engagement

Trust is important factor for young people accessing mental health care. Appleton and colleagues' systematic review of young people's experiences of mental health support in primary care identifies a trusting relationship, empathy, being taken seriously, enough time, and the absence of barriers as the conditions under which support becomes usable[206]. Young people described trust as a gateway: without it, sensitive matters could not be raised at all. Feeling judged, rushed, or dismissed inhibited disclosure. Feeling listened to and taken seriously made it possible.

Trust shapes whether a young person will speak, whether they will return, and whether they will risk bringing more difficult material into the encounter. In youth mental health, what is being disclosed can be overwhelming, shame-laden, or difficult to narrate within a clinical formulation. A service that lacks trust may be technically available and remain practically unreachable for the young people who most need it. Many young people interviewed in the research and in Quality Framework workshops described how they could not engage meaningfully with formal support until the social and relational pressures around them had first been stabilised. Trust was what made that possible: a young person could name what was happening in their life because they felt safe enough to do so.

Trust in the organisation, as well as the worker

Trust in hubs is carried by organisational form as well as by individual workers. Drawing on Goffman's original account of facework in social encounters[207], and Giddens' later reformulation of facework as part of trust in expert systems such as medicine[208], Kroeger defines facework as the process through which interpersonal

trust becomes attached to an institutional system[209]. In his account, trust in the person and trust in the organisation are related but not the same. Staff become the access points through which the service acquires a face. Through repeated encounters, young people learn not only whether a particular worker is trustworthy, but also what kind of institution this is and whether it can be relied upon.

Young people encounter the hub through people, but also through waiting rooms, reception practices, drop-in thresholds, follow-up, confidentiality, flexibility, and safeguarding responses. These repeated encounters create what Kroeger calls situational coherence: a stable, intelligible, and socially readable encounter in which trust-signalling actions can be understood[209]. A young person may trust a youth worker because she is calm, non-judgemental, and reliable. They may also come to trust the hub because the wider service has shown itself to be consistent, respectful, and likely to remain available over time. These are related but not identical forms of trust. Organisational inconsistency can erode interpersonal trust. A warm worker cannot compensate indefinitely for a service that repeatedly loses continuity, responds unpredictably, or fails to follow through.

This dynamic was visible in all hubs, but particularly at Dock Hub, where the drop-in team were acutely aware of a local culture in which speaking to any health professional could be seen as a betrayal of community trust. Staff had worked to build a reputation as a service that sat at some distance from more official statutory structures, and that could therefore be trusted precisely because it did not feel like an extension of the government system. Trusted relationships in hubs are not only assets within individual therapeutic or support encounters. They are also mechanisms through which the organisation itself becomes credible, usable, and safe to return to over time.

Trust, boundaries, and ethical containment

Trusted relationships in hubs depended on boundaries, themselves a form of care. Michel and Billingham's account of relational practice in adolescent safeguarding describes high-quality work as requiring both attunement and analysis[210]. Attunement involves emotional connectedness and responsiveness to a young person's lived experience. Analysis involves the capacity to step back and think carefully about needs, risk, context, and what a safer direction might require. They

describe the ethical work of containment: maintaining relationships that are warm enough to be trusted and bounded enough to remain safe.

This was particularly visible at Shore Hub and Heath Hub. At Shore Hub, staff described setting firmer boundaries around time and engagement for some young people with emotionally unstable personality disorder, precisely because unlimited relational availability could deepen dependency and delay other productive activities such as work, study, volunteering or social engagement that might support growth. At Heath Hub, staff sometimes deliberately rotated workers when one young person began attending very frequently, to reduce attachment to a single individual and avoid acute distress when that worker was absent. These practices could feel less intuitively caring than continuity with one trusted adult, but they reflected a different aspect of care: the ethical work of containment. Boundaries are part of how trust is built and sustained across an organisation over time.

The tension between hub relational and clinical logics of care is a tension between different ethical priorities. Clinical ethics includes a strong commitment to the fair allocation of limited resources. The four principles of Beauchamp and Childress' biomedical ethics include a specific commitment to the just distribution of care across a population[211]. Shorter appointments and efficient use of clinical time can reflect an ethical commitment to serving more patients fairly within constrained resources. As a GP, I have seen how the best systems allow some flexibility: double appointments at patient or clinician discretion, extra time for complex presentations, and careful prioritisation by front desk administrative staff. A focus on delivering quality care for as many people as possible is also a commitment to access and equity. Throughput pressure in primary care is real, and it reflects tensions about fair allocation. Hubs were less explicitly organised by system-level efficiency logics. Hub staff were more likely to respond to whoever came through the door on a given day, and trust and long-term relationship-building often took precedence over throughput. This reflects a different ethical priority, one adapted from their nonprofit and charitable origins and more appropriate to early support and preventive care for young people where time and empathetic listening are essential to establishing trust. Local systems benefit from containing different kinds of care settings operating under different logics rather than converging on a single model.

Trust as organisational infrastructure

Trust in Early Support Hubs can therefore be understood as part of the relational infrastructure of care. It is not only a trusted relationship between a young person and an individual worker. It is also produced through repeated organisational practices, routines, and access points that make the service appear reliable, respectful, and safe to use over time. I use infrastructure here in a relational sense drawn from Susan Leigh Star's work where infrastructure is embedded in organised practice, built into conventions and standards, usually backgrounded in everyday work, and noticed most clearly when it breaks down[13]. Greenhalgh and colleagues extend this argument in healthcare, showing that infrastructure includes not only hardware, software, and buildings, but also the collectively developed practical knowledge through which organisational work becomes possible[212]. In complex services, staff must come to a shared understanding of what actions are feasible and legitimate to provide as forms of care. That understanding is built through repeated interaction and collective sensemaking, and becomes sedimented in both formal mechanisms, such as protocols and systems, and informal ones, such as routines, habits, norms, and tacit expectations.

Understanding trust as infrastructure makes visible something that interpersonal accounts of trust tend to miss: that trust in hubs is structural as well as relational, and is built and communicated through the ordinary contact points a young person encounters when they interact with the service. The receptionist who remembers a name, the worker who (perhaps prompted by technology) follows up after an absence, the service that maintains confidentiality under pressure: these moments are simultaneously personal interactions and institutional signals. Each one either reinforces or erodes the sense that this is an organisation that can be relied upon. Trust accumulates through these small and repeated exchanges and becomes a property of the service itself, not only of relationships within it. Young people often arrive distressed, wary, or tired of repeating painful accounts of themselves. Care becomes more usable when the service as a whole can be approached as reliable, respectful, and able to hold complexity without moving quickly into categorisation or throughput logic.

Trust is not enacted in an institution through explicit claims about values or reliability, as Kroeger argues, facework that builds trust often functions best when it

remains tacit[209]. It is conveyed through a practical and ordinary way of acting, in which staff draw on organisational norms and expectations without needing to articulate them. In hubs, facework links a worker's professional identity to institutional ethos. Hub staff do not perform isolated enactments of ethics of care; they embody a recognisable way of working that signals what kind of organisation this is. This was visible in the way hubs describe their work; providing "the right support" at Dock Hub and the social justice focus in the Heath Hub way of working. In both, trust rested not primarily on formal statements of principle. When these expressions were evoked no further definition was provided for these commonly used expressions, the implicit understanding was there is an assumed and shared style of practice: how young people were welcomed, how their complex lived experiences were interpreted, when flexibility was offered, and what sort of follow-through could be expected. Organisational trust was built through the tacit enactment of organisational logics in everyday work.

Trust is also fragile and cumulative. Tarrant and colleagues' study of trust and continuity in primary care shows that trust develops through repeated interactions, with both a backward dimension (what has already happened) and a forward dimension (the expectation that the relationship will continue)[213]. More secure trust develops through a history in which competence, motivation, and concern have been tested over time. This helps explain why some of the most important conditions of trust in hubs are also some of the hardest to codify or transfer: low turnover, enough time, stable staffing, informal repair after rupture, continuity across thresholds, and a service culture that allows workers to act with steadiness and discretion.

The young people with the most complex needs often reveal most clearly what trust infrastructure in hubs is built to hold. Young people facing homelessness, exploitation, substance use, family rupture, severe emotional distress, or repeated crisis test what kinds of disruption and uncertainty a service is willing to sustain over time. This matters not only because their lives are more precarious, but because those shaped by trauma, instability, and repeated institutional disappointment may be less able to navigate systems strategically. Archer's concept of fractured reflexivity describes how sustained adversity can disrupt a person's capacity to reflect on their predicament, narrate it coherently, and act purposively in their own

interests[214]. Rybczynska-Bunt and colleagues apply this directly to complex health and social need, showing how some people struggle to advocate for themselves within increasingly demanding service environments[215]. In healthcare, the capacities that fractured reflexivity erodes, coherent self-presentation, strategic help-seeking, tolerance of uncertainty, are often precisely those that triage systems, appointment structures, and time-bounded encounters quietly require.

Hubs began from a different premise: that complexity should not itself become grounds for exclusion. At Shore Hub, staff described it as unethical to stop serving a young person simply because they were highly distressed, struggled with emotional regulation, or had verbally abusive or emotional outbursts. The underlying premise was that those most shaped by trauma, chaos, and repeated abandonment may be least able to meet the behavioural and reflexive expectations on which more bounded services depend. That premise is only sustainable where organisational trust is already in place. The ethics of care and a meaningful offer of practical and emotional support are all necessary, but they are not sufficient without the accumulated credibility that allows a service to hold difficulty over time without moving away from it.

Understanding trust in this way has direct implications for how a model of care for Early Support Hubs can be specified and adopted elsewhere. The logics of care described in the previous section can be named, taught, and written into standards, as they have been in the Quality Framework. The organisational conditions through which those logics generate trust in practice are harder to codify. Low turnover, stable leadership, accumulated community relationships, informal cultures of repair, and the institutional memory that allows a worker to notice when something has shifted in a young person they have known for two years are not incidental features of good hubs. They are among the conditions under which hub care becomes possible at all. A service can adopt the principles, workforce mix, and service components of the hub model and still fail to generate the organisational trust on which those components depend. This is partly because trust rests on forms of practical knowledge and discretionary judgement that are collectively learned and enacted rather than fully captured in explicit rules.

This matters for evaluation as much as for adoption and scale. What makes hubs work for young people is also what is hardest to see from the outside. Funders, commissioners, and government are understandably drawn to what can be counted: referral numbers, waiting times, throughput, and outcome scores. But Star's account of infrastructure suggests that the solution is not always simply to make tacit work fully visible[13]. Writing of nurses' attempts to classify and record their labour, she notes a tension between invisibility and surveillance: leave the work tacit and it fades into the wallpaper but make it fully explicit and it becomes vulnerable to managerial scrutiny, standardisation, and labour substitution. The challenge, she suggests, is to make work visible enough for legitimation while preserving an area of discretion.

Trust, continuity, and the slow accumulation of organisational credibility in a community requires recognition and investment. But once translated into narrow indicators they risk exposure to the wrong kinds of pressure: quantification without adequate conceptualisation, overly simplified proxies for relational work, and throughput logics that reward what is easy to record rather than what makes care usable. The next section examines how this tension between legitimation and distortion has shaped the politics of evidence in the hub field, and what it means for how hub care is funded, evaluated, and sustained.

Legitimacy, evidence, and the politics of recognition

Hubs must constantly communicate their value into forms that systems can recognise, without losing the relational practices that make them effective. Legitimacy in health and social care is granted through clinical status, proximity to the NHS, measurable outcomes, governance language, standardised evidence, and commissioner-friendly impact narratives. What hubs do best is relational, slow, practical, developmental, and context specific. It does not translate neatly into those forms, and the effort of translation shapes everything: how services present themselves to funders, how they design their evaluation, how they manage their workforce, and how they position themselves in relation to statutory partners

Hubs sought legitimacy at two levels. At the organisational level, hubs were attempting to establish themselves as credible services in the eyes of integrated care

boards, charitable funders, NHS partners, and local authorities. This required demonstrating governance, clinical safety, and measurable outcomes in forms those bodies could recognise and fund. At the political level, advocacy groups, including young people from hub participation councils who spoke directly to ministers and civil servants, were attempting to establish the case for early intervention with government. Young people who had experienced hub care were among the most powerful advocates for the model, bringing first-person testimony to parliamentary discussions, select committee consultations, and departmental briefings. These two forms of legitimacy-seeking reinforced one another but also created different pressures. Organisational legitimacy required working within existing commissioning and clinical frameworks. Political legitimacy required demonstrating that the hub model represented something new and distinctively valuable. The tension between consolidation and distinctiveness shaped how hubs presented themselves, and it continues to shape the field.

The politics of evidence and outcomes

The politics of evidence in Early Support Hubs reflects a broader dynamic in health policy: the pressure to demonstrate outcomes before models are sufficiently understood and established. Across the development of this field, commissioners, funders, and government have repeatedly asked whether hubs work before achieving sufficient clarity about what the hub model consists of, what logics underpin it, and what kinds of value it is designed to produce. Once a service purpose has been identified, questions of model clarity and measurement are not separate stages but mutually reinforcing tasks. Clarifying what the service is for helps determine what should be measured, while thinking carefully about measurement can sharpen understanding of the model itself. Without sufficient clarity on what the intervention consists of, what logics drive it, and what it is trying to achieve, it is difficult to know which outcomes to measure, how to attribute change, or what would constitute a fair comparison.

A proposed Department of Health and Social Care funding structure from the early period of this study illustrates this tendency concretely. During the first year of the DPhil, as I was trying to understand the national policy and research landscape around hubs, I had a series of conversations with academic and policy researchers working within Department of Health and Social Care research networks. Through

those conversations I became aware of a public three-part tender that had been offered previously covering three distinct questions: what the model of Early Support Hubs consisted of, who used them, with particular attention to young people from marginalised communities, and what outcomes they produced. The outcomes strand was funded and became the Shared Outcomes Fund research led by University College London's mental health policy team. The first two strands were tendered, went unfilled, and to date have not been retendered. I reflected on this afterwards, and I find it difficult not to read it as revealing something about how legitimacy is constructed in this field. It was one of the reasons I chose to focus this thesis where I did.

Goodhart's Law helps explain what follows when outcomes become the primary route through which hub care is recognised, funded, and judged. In the 1970s, British economist Charles Goodhart observed the pitfalls of using monetary targets as measures of fiscal policy effectiveness, an insight later generalised by anthropologist Marilyn Strathern: when a measure becomes a target, it ceases to be a good measure[216]. Crawford and colleagues have applied this logic directly to routine outcome measurement in mental health services, showing that using outcome data to assess and pay for services can paradoxically reduce its value as an indicator of quality[217].

In youth mental health, the problem is not only that standardised outcome metrics may fail to describe what matters most to young people, including trust, continuity, relational safety, practical help, and willingness to return. The deeper problem is that, once tied to performance management, commissioning, or organisational legitimacy, those measures may begin to shape the work itself. Services may be pulled towards producing measurable improvement rather than sustaining the relational, developmental, and preventive conditions through which meaningful improvement becomes possible. As shown in the case comparison, staff were concerned that outcome measures could influence how practice was organised and how young people's progress was interpreted. In this way, measurement does not sit outside care as a neutral assessment of benefit, it can become part of the intervention environment. Measurement can shape what is noticed, prioritised, funded, and ultimately, the quality of care received by young people.

A foundational problem with routine outcome measurement is that the quality of administration shapes the quality of the data collected. Validation of a measure does not remove the practical work of implementation. In my case studies, staff were alert to the fact that young people did not always understand items in the way measure developers appeared to assume. One counsellor at Heath Hub put this bluntly: "Young people don't know what the words mean… the data would be skewed if we just left them to it" (S2-ST-011). At Dock Hub, "checking calls" every ten weeks gathered YP-CORE or CORE-10 data by the clinical admin team outside a therapeutic encounter, using brief scripted contact with an administrator whom the young person contacted had no prior relationship. Across fieldwork, I found myself wondering what kind of data is produced when a young person completes a distress scale alone on an iPad or printed sheet of paper, with a counsellor who explains terms carefully, or over a brief checking-in call with an admin person they have never seen. I also wondered where these young people were at the time of answering the questions from administrators: at the shops, with friends, in front of parents, or somewhere private enough to answer honestly?

Research on patient-reported outcome measures suggests that the way outcomes data are collected affects the data produced. Focusing on the PHQ-9, a measure used in Early Support Hubs and in primary care, Malpass and colleagues show that patients do not always interpret questionnaire items in the way intended, and may struggle to fit their lived experience into the wording and response categories provided[218]. Ford and colleagues demonstrate that even when the same PHQ-9 is used, the way clinicians ask the questions, reformulate wording, or steer responses can shape the answers that are produced[219]. Chang and colleagues argue, in a wider review of patient-reported outcomes, that truthfulness and data quality are affected by context, embarrassment, wording, mode of administration, and interpersonal dynamics[220]. In mental health especially, where items are often abstract, emotionally loaded, and context dependent, the quality of explanation and mode of administration is inseparable from the quality of the data produced.

Armstrong and Byrom extend this critique by drawing on anthropology and lived experience to argue that psychiatric rating scales are not inert or harmless tools[126]. They carry assumptions about what distress is, how it should be described, and what aspects of experience should count. Using the PHQ-9 as their example, they

argue that its development for time-efficient administration in primary care means it should not be treated as a complete account of depressive experience. Leydon and colleagues similarly show, in an interview study with UK GPs, that severity questionnaires can place strain on the doctor-patient relationship when used rigidly, especially if they displace more individualised enquiry[221]. Their account recalled my own discomfort as a GP using outcome measures in mental health work: beginning with an extended narrative interview focused on compassionate listening and presence, then somewhat awkwardly shifting tone to ask a patient to complete outcomes measure paperwork while I arranged referrals and other care. In mental health especially, the data produced by a measure cannot be separated from the context and manner of its administration.

This does not make such scales useless. It does encourage the question of what, and for whom, outcomes measures in youth mental health are for. In mental health research, it has been argued that routine outcome measurement was introduced partly to make the effects of therapeutic work more visible and open to scrutiny: to bring greater transparency, comparability, and accountability to a field in which claims of benefit had often been difficult to examine systematically, and that routine outcome assessment can be justified both ethically and scientifically, as a way of monitoring whether care in ordinary services is actually helping patients[222]. At the same time, studies of implementation show both support for this ambition and ambivalence about the value, burden, and possible misuse of outcome measures in mental health[223]. When I discussed these tensions with the head of counselling at Dock Hub, her view was that it was self-evident that outcome measures could never capture the therapeutic process or experience in full. Even so, she saw them as an imperfect but important move towards a stronger commitment to quality than an earlier position in which counselling outcomes had remained less explicitly examined and more open to contestation.

Many hubs collect high-quality outcome data, and some do so with comparable rigour to their NHS counterparts. A senior leader at Heath Hub noted that despite their relational and values-based approach, the hub reports the same data to regional NHS teams as local NHS trust colleagues on counselling, including volumes and paired routine outcome measures, and that he believed their data quality is equal to or better than local NHS services. The point, as this leader framed it, is that there is

no necessary trade-off between a relational approach and the capacity to demonstrate treatment outcomes. Hubs can and do deliver both.

The problem is what happens when a narrow set of measures becomes the sole test of a service's worth. Outcome data collected within counselling episodes captures change in distress and functioning within a bounded intervention. It does not easily capture the relational, developmental, and preventive work that precedes and surrounds it. Hub care unfolds through return, pause, re-entry, and nonlinear progress. How outcomes are collected, over what timeframe, by whom, and in relation to which components of the service, also shapes what becomes visible and what is obscured. An episodic evaluative model can misclassify return after absence as attrition, and ongoing engagement without a formal episode as non-participation. Evaluation in hubs needs to distinguish between absence as a failure of quality care or a pause as part of the long-term pattern of support.

The Quality Framework offers an alternative approach to understanding quality in Early Support Hubs, one that may illuminate features of the model that narrow outcome metrics obscure. It highlights some of the harder to measure conditions that enable care: trusted relationships, open access, youth voice, workforce, and safeguarding governance. These are the organisational conditions under which good outcomes become more likely. The framework maintains high standards for outcomes measurement and service improvement within this broader structure, setting minimum expectations across eighteen areas of practice while still recognising local variation. It does not replace the question of what outcomes the hubs produce. It insists that question can only be answered well once the conditions producing it are understood. This thesis did not aim to produce a new national outcomes framework for Early Support Hubs. Its contribution comes earlier in the evaluative chain: it clarifies why disagreement about measurement arises and provides a conceptual basis for understanding what counts as value in hubs, what can be measured, and what risks being overlooked.

The challenge of measuring prevention and early intervention

A particularly challenging task is measuring the preventive work that Early Support Hubs may do well. In services of this kind, prevention may not appear first in data on crisis presentations, diagnostic incidence, or hospital use, since these are late

markers and often signs of more advanced need. There is not yet direct evidence establishing the preventive value or cost-effectiveness of hubs specifically. There is, however, a broader literature showing that prevention in mental health is often cost-effective, and that this is especially the case in areas such as early intervention in psychosis. Systematic reviews have found that mental health prevention and promotion interventions are frequently cost-effective or cost-saving[224], especially when targeted, and studies of early intervention in psychosis has also been shown to be cost-effective in comparison with usual care[225].

Hamilton and Holt's review of economic evaluations in youth mental health is useful here because it identifies service attributes likely to support cost-effectiveness, including assessment, prevention, early intervention, family engagement, information provision, and group delivery[226]. Hubs fit many of these features, but the question of measuring prevention remains underdeveloped in the hub literature.

This matters because, in my experience of this doctoral research and interactions with government, current evidence debates often default to hierarchies that privilege randomised controlled trials and formal cost-effectiveness studies as the tests of certainty and impact. These methods were brought to the social sciences from the practices of evidence based medicine[227], [228]. These methods are valuable for measuring targeted and replicable interventions, but they are less well-suited to understanding services such as hubs, which are relational, locally embedded, and enacted differently across complex systems. To hold policy only to this standard would, in my view, also misrepresent medicine. In clinical practice, not everything rests on randomised trial evidence. Much of medicine also proceeds through accumulated practice knowledge, mechanisms, and theories of change. The same principle applies here. For hubs, the evaluative task may be to clarify what the service is expected to interrupt, strengthen, or prevent, and then measure signs along that pathway rather than waiting only for distant endpoints to shift. That was the central argument I was invited to make in my 9 April 2026 presentation to the Department of Health and Social Care on evidence and evaluation in prevention and early intervention: use the right methods for the right questions, engage young people from the start, measure what matters to them, choose a small number of consistent outcomes, evaluate from the beginning, and, above all, learn to measure prevention in ways that fit the model of care.

The three case studies in this thesis offer examples of what this might look like. Shore Hub described young people whose repeated attendance at emergency departments had reduced through sustained support, and others who had moved into work. Dock Hub told stories of young people who had chosen not to take their own lives because of support from a worker or an identity-based group. Heath Hub described young people supported out of financial exploitation, through crisis, and through the uncertainties of seeking asylum.

These are all examples of prevention in practice, but none is easily captured in routine quantitative metrics as impact. Hubs also provide care for what is increasingly described as the missing middle: young people who are too unwell for ordinary primary care support, but do not meet thresholds for CAMHS or are unable to use those services effectively[50], [51]. In theory, this group may sit beyond the remit of early support. In practice, they continue to attend, and the hubs in this study often managed this skilfully through safeguarding, clinical supervision, governance, and multidisciplinary coordination while linking young people to longer-term care. At Shore Hub, this included careful boundary-setting with young people with emotionally unstable personality disorder so that relationships could remain containing without becoming unsustainable.

These examples suggest that hubs are often doing preventive and stabilising work that matters clinically and socially, but which currently sits beyond what most routine outcome systems are set up to see.

Early Support Hubs and the wider system

Early Support Hubs exist within complex systems of mental health and social support, and their position within those systems varies considerably by organisational history and structural arrangement. Dock Hub is formally embedded within a network of statutory and voluntary sector services, maintaining clinical partnerships and referral pathways that give it a degree of institutional legibility, while continuing to navigate its identity as a charitable organisation operating outside NHS governance. Heath Hub and Shore Hub operate in more complementary arrangements, maintaining regular interagency meetings and

participating in complex case discussions with statutory partners. Their position outside statutory structures, however, means they can be simultaneously disregarded and depended upon: not always taken seriously as clinical equals, while receiving referrals from statutory services with an implicit expectation that the hub will manage what those services cannot or will not. Hubs can complement statutory systems, compensate for their gaps, and collide with their underlying logics, often simultaneously.

This threefold relationship helps explain why hubs were praised and marginalised at once. The more they compensate for system failure, the more they risk being treated as informal overflow rather than as services with their own expertise. Staff at both Heath Hub and Shore Hub described a paradox in which their work was not always taken seriously by statutory services, while staff from those same services sometimes referred young people to them with an implicit expectation that the hub would sort out the young person's issue, often without any further plan, shared responsibility, or ongoing support. Their value can therefore be recognised in practice while remaining subordinate in the system.

Workforce and safeguarding are two of the clearest areas where this legitimacy pressure becomes visible in practice. Non-clinical youth mental health roles, including youth mental health workers, mental health advisors, and other front-line roles sitting between counselling and youth work, remain conceptually unclear in their skills, scope, and risk thresholds. This is not a failure of individual services. It is a structural feature of a model operating across professional and institutional boundaries that have not yet developed shared frameworks for these roles.

From my perspective as a GP, I did not observe unsafe practice in any of the three case study sites. I observed high-quality work, sensible safeguarding escalation, and evidence-informed psychoeducation and brief interventions that were tailored to the young person’s needs. The concern is about what happens if these roles remain conceptually unclear as the model expands rapidly to meet national policy ambitions. Safeguarding governance presents a parallel challenge: open-access, relationship-centred, longitudinal provision encounters risk in ways that standard institutional procedures were not designed to hold. Longitudinal relational safeguarding, where concerns emerge gradually through a worker's accumulated

knowledge of a young person rather than through a single disclosure, depends on the same conditions that make hub care possible: continuity, trust, and time. Strong safeguarding governance has become a source of legitimacy with statutory partners precisely because it demonstrates that relational practice and clinical rigour are not in tension.

The supply of care is geographically structured and resource dependent. In England this is shaped heavily by NHS dominance, but also by geography, by the political priority afforded to youth mental health relative to other health demands, and by the wider organisation of the welfare state. These arrangements determine which forms of care are resourced, which are recognised as legitimate, and which are left to voluntary sector organisations to absorb. Hubs have emerged partly in response to the gaps these arrangements produce, occupying the space generated when statutory systems narrow their responsibilities through rationing and categorisation.

Disagreement about the source of hub authority runs through all of these tensions. Some hubs, especially those more closely integrated with local NHS and specialist mental health systems, drew on clinical legitimacy as a source of authority. Clinical alignment offered recognised pathways for commissioning, stronger influence in local systems, and forms of credibility that travelled across professional and funding boundaries.

Other hubs, particularly those with more explicit political values and a more intentional positioning as alternatives to statutory and clinical services, defended non-clinical legitimacy as the basis of their distinctive authority: youth voice, trusted relationships, longitudinal care, open access, and the capacity to stay with young people without forcing them too quickly into bounded treatment frames. The tension remained unresolved across all three sites and the Quality Framework process because it expressed two defensible but competing ambitions: securing recognition within systems that reward and fund clinically legible forms of care, and protecting a mode of relational, longitudinal, and youth-centred practice understood as distinctive precisely because it exceeded clinical frames. How different sources of authority are balanced shapes what hubs can become and what kinds of care they can sustain.

Hubs expose what broader arrangements leave behind. They also risk being drawn into compensating for system failure without the authority or resources to reshape the wider settlement. That risk is most evident at the point of scaling: as Young Futures Hubs expand nationally, the pressure to demonstrate clinical legitimacy, measurable outcomes, and governance compliance will intensify. The question this thesis cannot answer, but which the field must, is whether that pressure can be held without eroding the very features that make hubs worth scaling in the first place.

Strengths and limitations of this DPhil

A strength of this study is its examination of enacted models and logics of care in practice. The comparative case study design made it possible to analyse three hubs with overlapping commitments but distinct institutional forms, and therefore to move beyond generic claims that hubs are relational, youth-centred, or holistic. It allowed closer examination of what the boundary concept of Early Support Hubs meant in practice, how they were stabilised organisationally, what kinds of professional cultures sustained them, and where their tensions lay.

The ethnographic approach enabled a form of access that other methods would not have provided. Observation, fieldnotes, and close attention to ordinary interactions allowed the study to capture aspects of hub care that are difficult to recover through interviews or documents alone: atmosphere, informal threshold work, patterns of access and return, the lived meaning of continuity, professional hierarchies, and the everyday negotiation of risk, belonging, and exclusion. Because these organisations are trust-based, developing trust as a researcher was part of what enabled access to the more difficult and revealing aspects of practice. At Dock Hub, for example, only at the end of the first observation week did a senior leader feel comfortable discussing the more challenging aspects of their open access drop-in service development, following my efforts to show visible appreciation for the quality of the work and a clear willingness to understand tensions rather than produce a superficial account of their work. Short visits or semi-structured interviews alone would likely have missed this depth. This deepened both my case study understanding and my ability to write meaningfully about tensions and variation in the Quality Framework.

The integration of doctoral research with parallel national evaluation and Quality Framework development gave this thesis a distinctive vantage point. Through a pragmatic orientation, I moved between in-depth case study research and policy-facing evaluative work, allowing each to inform the other. The doctoral research generated a detailed understanding of hub models, logics of care, and system positioning that underpinned the wider framework process, while sustained prior engagement with services helped build the trust and sector knowledge that made later dialogue possible. This arrangement also created tensions around autonomy, proximity, and capacity for robust analytic critique, which I discuss in the evaluation and reflexivity sections of the methods chapter. I do not believe this approach can be simplified into a strength or a weakness, but that it represents an orientation to research that is engaged with real-world impact, while working to maintain high standards of methodological rigour, clarity of analysis, and reflective attention to relationships and power dynamics.

This orientation aligns with Nowotny, Scott and Gibbons' account of Mode 2 knowledge production: socially distributed, application-oriented, and accountable to a wider range of stakeholders than the academy alone[229]. I was accountable in this thesis not only to academic supervisors and disciplinary standards, but also to hub staff, young people, and the sector more broadly. Questions arising in the research sharpened later questions in the Quality Framework process, while issues surfaced through national dialogue clarified where deeper analytic attention was needed within the case studies. That mutual shaping is both a methodological strength and a source of the tensions around autonomy and proximity discussed in the reflexivity section of the methods chapter.

There were limitations to my research approach. Three comparative case studies provide the empirical foundation of this research. The cases were selected as a maximum variety sample, chosen to reflect geographic variation across England and different organisational forms, funding arrangements, and statutory relationships. This was a deliberate and appropriate sampling strategy: statistical representation would have been neither feasible nor analytically useful for a study of this type. The study therefore supports heuristic rather than statistical generalisation, as discussed in the methods chapter, I cannot generalise these findings directly to all Early Support Hubs. The contribution of this work is in clarifying concepts, tensions, and

logics of care that extend beyond the three cases while remaining attentive to contextual variation.

The more substantive limitation is that at the level of the three case studies, however varied in geography and population served, are unlikely to have reached data saturation. Through the Quality Framework process I encountered hubs I would have valued including as case studies: a hub in south east London serving an ethnically diverse population and developing innovative approaches to community engagement; a hub in Cambridgeshire with distinctive approaches to demographic and outcomes data collection driving active service improvement; and a hub in south west England with a strong focus on housing support and a history of over seventy years. Had I had additional time and resources, these three sites would have been my next case studies.

It was part of my selection criteria to examine well-established and well-functioning services, to understand hub care at its most developed. A comparison with hubs struggling with funding instability, high workforce turnover, or difficulty maintaining safeguarding and organisational structures would have provided further insight into which features of hub care are most fragile, and under what conditions the logics of care are hardest to sustain. Studying a struggling or failing hub would carry practical and ethical challenges, and it remains an important direction for future research and policy application.

Longer observation at each site would almost certainly have generated richer data and additional insight, particularly around interagency processes, longitudinal relationships with young people, and slower-moving aspects of organisational change. This is, however, one of the trade-offs of conducting focused ethnography within the practical and time constraints of a doctoral thesis, where depth must be balanced against feasibility across multiple sites.

A further limitation concerns the way fieldwork access was organised within each hub. Because these were busy services working with young people in sensitive circumstances, my access was necessarily negotiated and mediated by hub staff. This was both a strength and a limitation of the study.

At Dock Hub, fieldwork was organised through a highly structured programme of activity. Staff and volunteers knew I was coming, and I was scheduled across different services, teams and internal meetings, sometimes from 9.30am until 8pm. This gave me an unusually detailed overview of the organisation. I was able to observe multiple arms of the hub model, including programmes that I might otherwise not have known existed, and to understand how different services related to one another. The structure of the programme also helped establish legitimacy for my presence. By the second week of fieldwork, staff were more familiar with me, and I was able to have more candid conversations about challenges, tensions and areas of change within the organisation.

However, this access was also curated. The structured schedule meant that what I saw was shaped partly by what the organisation considered important, appropriate or feasible to show me. It may have increased my exposure to areas of organisational strength and reduced my exposure to more ordinary, unplanned or difficult aspects of everyday practice. In this sense, the richness of the Dock Hub case was partly produced through organisational mediation. The case gave me a broad and detailed view of the hub system, but not an unfiltered view.

The other two hubs offered a different form of access. Their fieldwork schedules were less tightly structured, and I spent more time observing the routine texture of drop-in spaces, informal interactions, staff conversations and day-to-day pressures. This provided a valuable view of the messier detail of everyday practice. At the same time, less structured access meant that I may have missed some important organisational functions. For example, I observed Dock Hub's multidisciplinary and partnership processes in more detail than I did at the other two sites. During final sense-checking presentations, staff at Heath Hub and Shore Hub described governance, partnership and system-linking functions that were more developed than I had appreciated from observation alone. This suggested that some elements of their hub systems were less visible to me during fieldwork, not necessarily less present in practice.

This has implications for the cross-case comparison. Some apparent differences between hubs may partly reflect differences in what was made observable, not only differences in what organisations did. A highly planned programme of access

increased breadth and organisational visibility but increased the risk of curation. A more open and emergent form of access increased exposure to everyday practice but risked missing less visible governance, partnership and coordination work. I addressed this limitation through interviews, informal conversations, documentary review, follow-up questions and sense-checking with each site. Nonetheless, the study's findings should be read as accounts of what became visible through negotiated ethnographic access and further sense checking with hub managers at the conclusion of my analysis, rather than as exhaustive ethnographic analysis of all functions within each hub.

The policy environment shifted substantially during fieldwork. The transition from Early Support Hubs to Young Futures Hubs, the narrowing of the target age range, and the addition of knife crime reduction as a programme objective all occurred while data collection was underway. Tracking these movements required sustained informal engagement with policy networks that went beyond what is typically possible within a doctoral timetable. The instability of the policy object is itself analytically important, but it created methodological challenge in maintaining a stable and coherent research question while the field continued to move.

My identities as a clinician, doctoral researcher, and as an evaluator has shaped this research in ways that are worth naming explicitly. Coming to this study as a General Practitioner, I brought a clinical lens to what I observed: I attended to safeguarding systems, scope of practice, clinical risk, and the governance structures around complex casework in ways that a youth worker, social worker, or professionally trained ethnographer might not have prioritised in the same way. That attention has strengthened some parts of the analysis, particularly the workforce and legitimacy sections, and the comparison between hub care logics and biomedical ethics frameworks. It may also have directed my gaze away from aspects of hub life that a practitioner from youth work or community development traditions would have seen more readily: the texture of informal youth work relationships, the political dimensions of participation, or the embodied and spatial experience of being a young person in these spaces. I have tried to compensate through close attention to fieldnotes, sustained engagement with youth participation literature, and the final sense-checking process with hubs described in the methods chapter. The limitation

remains, and examiners and readers should interpret my analysis with that positionality in mind.

The doctoral study may also have benefited from a formally constituted youth advisory panel engaged across the whole project, though the value of such a panel is not guaranteed. Structured youth participation panels can produce authentic co-production, or they can also become tokenistic if the conditions for meaningful engagement are not in place. Building those conditions takes time, trust, and clarity in communication and purpose.

In practice, I met several young people through hub events during the early stages of the research and began informal discussions with them about taking on an advisory role. At that point, however, I was still formulating the research questions and developing my understanding of participatory practice and public involvement. I did not yet have the structures in place to fund their time appropriately, support their participation adequately, or ensure the experience would be genuinely worthwhile for them as well as for my research. Bringing young people into a process that was not yet ready to receive them well would have risked exactly the kind of tokenistic participation this thesis has critiqued.

The Quality Framework process provided the structure that the doctoral research alone could not. Youth Access created the conditions under which co-design became possible: employing and paying young people across the project, providing safeguarding training, resourcing workshops, and ensuring that another trusted contact was available when I was on annual leave. That administrative and procedural infrastructure freed me to focus on the relational work itself: building trust with the co-designers, working collaboratively on the substance of the framework, and providing support when they faced challenges in the process. In much the same way that hubs build the organisational conditions under which an ethics of care can be enacted, Youth Access built the conditions under which participatory practice could be authentic and impactful rather than performative. I am grateful to have learned from that experience, and to carry it forward in my future research work.

Not all perspectives were equally visible in the data. Young people were present in the study, but those who were most disengaged or least willing to speak with a researcher are likely to be less visible in the material. Families, carers, and statutory partners were not a major focus of the research design, even though they clearly shape young people's trajectories. Private therapeutic encounters were not observed, and some of the most sensitive work remained inaccessible to ethnographic witnessing. Most significantly, the study says little about young people who never attended a hub, who came once and left without receiving help, or who found the services unwelcoming, irrelevant, or unsafe.

Understanding who does not use hubs, and why, is as analytically important as understanding who does. Had I had an additional six months of fieldwork, I would have sought to connect with local community organisations, schools, youth groups, and peer networks outside the hubs to explore these questions directly: who had heard of the hubs but not attended, what had put them off, and what experiences of other services they were navigating instead. This remains a limitation of scope rather than of method. It points to a future research agenda concerned not only with access but with the active production of non-use, and with the question of which young people the hub model is least equipped to reach. These are the questions that matter most as the model moves from a small number of mature, locally embedded services towards a nationally adopted programme. The contributions and future research sections that follow take these gaps as a starting point.

Finally, I had initially planned to include a comparative case study strand with headspace Australia, contrasting urban hubs in major city centres with regional and remote services serving Aboriginal and Torres Strait Islander populations. This comparison held professional and personal significance. I conduct my general practice work in Australia and had been encouraged by Aboriginal Gamilaroi elder Aunty Beryl Van-Oploo, a friend and mentor for many decades, to understand more about how young Aboriginal and Torres Strait Islander people access and experience mental health support. That comparative strand would have enriched the international dimension of the research and contributed to questions of equity, access, and cultural fit that are only partially addressed by the English case studies. It became clear, however, that this was beyond the scope of a single doctoral project. Adding three further sites in a different country, health system, and cultural context

risked diluting the focused ethnographic approach that gave the English case studies their depth. I made the difficult decision to set that work aside, while remaining committed to contributing to health equity in Australia. I hope to pursue that research in partnership with Aboriginal and Torres Strait Islander people in other ways in the future, and I am grateful to Aunty Beryl for the encouragement and vision that planted the seed of this work.

Contributions to research, policy, and services

Jane Addams argued that knowledge is produced in relationship with communities, not extracted from them. That pragmatist commitment has shaped how I have approached this work. This doctoral study emerged through sustained relationship with hub staff, young people, sector leaders, and co-designers, and whatever influence it carries belongs to that collective as much as to my own work. The contributions described below should be read in that spirit: as the product of a particular kind of engaged, translational scholarship that moves between empirical depth and policy relevance, and that is accountable to more than one kind of audience.

Impact in contested policy fields is rarely attributable to a single source, and this thesis does not claim sole responsibility for the conceptual convergence that has occurred. What it does claim is a concrete and traceable contribution to it. Youth Access now presents the Quality Framework as a shared structure for hubs, funders, and government. The Prudence Trust, which spends approximately £8 million a year on grants, has adopted it as the standard against which hub applications are assessed. I have held multiple meetings with senior policymakers from the Department of Health and Social Care and the Department for Culture, Media and Sport, responsible for the National Youth Strategy, on questions that sit at the heart of this thesis: how hubs should be staffed, how they manage safeguarding, how they relate to CAMHS and other NHS services, and how youth participation is built into decision-making systems. These conversations have occurred because this work gave the field a clearer language for what hubs are, what quality looks like, and what is at stake when services like these are scaled. That is how research impact can occur in a live policy environment: not a single moment of influence, but through

ongoing dialogue and sustained presence in the spaces where the model is being made.

Contribution to research

This thesis contributes to research in three main ways. First, it clarifies the hub model of care in England by identifying the shared logics of care that give Early Support Hubs coherence beneath their geographic and organisational differences. It shows that hubs are more than a cluster of services brought together under one roof, but locally adapted organisational models underpinned by recognisable logics: distress as social, relational, and material; care as unfolding over time; open access as an ethical principle; and youth voice as a defining feature of the model. This contributes conceptual clarity to a field in which policy, practice, and research have often moved faster than model specification.

Second, the thesis argues that ethics of care and trust are not peripheral values or desirable features of youth mental health support, but mechanisms through which hub care becomes possible. Trust enabled young people to disclose need, return after absence, accept support, tolerate uncertainty, and remain engaged long enough for help to take effect. Ethics of care was similarly enacted not only in individual relationships, but through organisational routines, boundaries, safeguarding practices, supervision, and youth participation. This advances trust as an organisational and infrastructural concept in youth mental health services, extending work on relational continuity in primary care into community-based, voluntary-sector and non-clinical settings. It also suggests that future research should examine trust and care ethics as potential mechanisms of engagement, therapeutic benefit, and system effectiveness, rather than treating them only as aspects of acceptability or service experience.

Third, the thesis contributes methodologically by showing how focused ethnography, comparative case study, and applied collaborative evaluation can be combined in a pragmatist research design to generate conceptual clarity in a contested policy field. The case studies made visible how hub care was enacted in everyday practice, while the Quality Framework evaluation showed how quality was defined, debated, and translated into a usable structure across the wider sector. Keeping these strands analytically distinct while allowing them to inform one

another offered a form of engaged scholarship that was rigorous without being detached. This contributes to methodological discussions about how researchers can study complex, relational, place-based services while also producing knowledge that is useful for policy, practice, and future evaluation.

These contributions support a central argument of the thesis: clarity on what and how a model works is logically prior to outcome evaluation. Without understanding what hubs consist of, what logics drive them, and what forms of change they seek to produce, it is not possible to know which outcomes to measure, how to interpret impact, or what a fair comparison would involve. Future evaluations of Early Support Hubs should therefore assess not only short-term symptom change, but also the relational, organisational, and ethical conditions through which young people become able to access, trust, and remain engaged with support.

Contribution to policy

This thesis provides a clearer basis for understanding what the English government is attempting to scale with the Young Futures Hub programme. It shows why evidence debates in this field have been distorted by a premature focus on outcomes before the model generating those outcomes is well specified, and why that sequencing produces evaluative frameworks that miss what matters most about hub care. It offers practical guidance on what can and cannot be reproduced through top-down commissioning: the logics of care, the quality standards, and the service components can be named and spread; the trust, local culture, and organisational memory on which those components depend cannot simply be centrally manufactured.

The thesis makes the case for quality frameworks as a mechanism for raising standards without mandating uniform form, and demonstrates through the development and adoption of the Youth Access Quality Framework that this approach is practically achievable. It is directed at government departments responsible for youth mental health and the National Youth Strategy, NHS England, integrated care boards, local authorities, and the charitable funders who are increasingly shaping how hub provision develops.

Contribution to services and young people

This thesis gives hub services a language for describing and defending the value of what they do to funders, commissioners, and statutory partners. It legitimises relational, non-clinical, and preventive forms of care as practically necessary, rather than as soft supplements to clinical intervention. It names trust as infrastructure, with concrete implications for how services are designed, staffed, and governed. It supports quality improvement without collapsing quality into a single metric. In addition to the Quality Framework and this doctoral thesis, each of the three hub sites received a service evaluation report based on the case study data for their use.

For young people, the most direct contribution is the argument that their voice, their experiences, and their logics of care are central to understanding what hubs are and why they work. Future evaluation frameworks should include young people in determining what counts as evidence of value, not only as data sources within frameworks designed by others. This recommendation is directed at hub leaders, Youth Access, youth work organisations, and the researchers and funders who will design the next generation of evaluation work in this field.

Future directions for research and practice

The future of Early Support Hubs in England is uncertain. What is clear is that the field is changing. Government is piloting eight Young Futures Hubs in early adopter areas, testing what a nationally commissioned version of the model looks like in practice. What this model consists of, and how it related to Early Support Hubs, is at time of writing unclear. Hubs are using the Quality Framework to conduct quality improvement projects, giving the framework a practical life beyond its original evaluative purpose.

Economic evaluation is one important next step for Early Support Hubs, though this was beyond the scope of this doctoral study. Future commissioning will depend not only on whether hubs are valued by young people, but on whether they can demonstrate value for money and opportunity cost compared with other ways of organising early mental health support. This will require attention to the total costs of hub provision, including workforce, premises, supervision, safeguarding, youth participation, outreach, governance, data systems, and partnership work.

It will also require better evidence on whether hubs reduce costs or improve outcomes elsewhere in the system. Ideally, this would be supported by joined-up administrative data across government, allowing young people's trajectories to be tracked across health, education, employment, social care, youth justice, housing and crisis services. Such data linkage would make it possible to examine whether hub engagement is associated with reduced emergency department attendance, crisis presentations, specialist CAMHS referrals, school exclusion or disengagement, youth justice involvement, homelessness, and longer-term exclusion from education, employment or training. This is an ambitious goal, but it would generate evidence directly relevant to young people by supporting better research, more timely policy responses, and likely improve commissioning decisions towards impactful interventions. A longitudinal cohort study could also answer some of these questions, particularly around longer-term developmental, educational and social outcomes, but these studies are often costly, with high losses of participants to follow up, and would require a longer timeframe than policy cycles often allow for. In the near term, carefully governed cross-departmental data linkage may offer the most useful route to understanding the wider system value of Early Support Hubs.

The current evidence base is not yet sufficient to answer questions about impact, cost-effectiveness, affordability, and wider system value. The UCL Mental Health Policy Research Unit evaluation of Early Support Hubs is an important foundation because it is gathering evidence on the practices and outcomes of established hubs and is intended to support policymakers in evaluating their effectiveness, reach, and success in supporting a diverse group of young people. Its outcome dataset, including demographic information and measures such as RCADS, the Revised Children's Anxiety and Depression Scale, and SWEMWBS, the Short Warwick–Edinburgh Mental Wellbeing Scale, could inform future economic evaluation if linked to service utilisation, cost, and longer-term outcome data. To answer the larger policy questions, these data would need to be connected with wider administrative datasets across health, education, employment, social care, youth justice, housing, and crisis services. Without that linkage, evaluation will struggle to assess whether hubs shift costs or improve outcomes across the wider system. However, economic analysis in this field will need to avoid reproducing the narrowness of outcome measurement discussed above. If economic value is assessed

only through short-term symptom change, it risks missing the preventive, relational, and system-navigation work that hubs are designed to provide.

The development of a proportionate national outcomes framework for Early Support Hubs is a directly related priority. The field would benefit from a small number of common shared outcome measures that are meaningful to young people, useful to practitioners in everyday work, and capable of supporting comparison across services over time. Such measures should help hubs understand whether young people are accessing support, whether they feel heard and respected, whether distress, wellbeing, functioning, or practical circumstances are improving, and whether engagement with the hub is helping them navigate wider systems. The aim should not be to maximise the quantity of data collected, but to identify a focused set of measures that can support care, learning, quality improvement, and national understanding of impact.

This work must be undertaken carefully. Applying too many outcome measures or choosing measures primarily to satisfy research and economic evaluation demands, risks producing data that are costly to collect, burdensome for young people and staff, and of limited interpretive value. Worse, poorly implemented measurement can interfere with the relational care work that makes hubs effective, by shifting encounters away from listening, trust-building, and practical support towards form completion and score production. Poorly designed data collection is not a neutral inconvenience. It is expensive in time and resources, obscures rather than reveal service value, and does a disservice to young people, practitioners, commissioners, and funders.

A national outcomes framework could nevertheless bring substantial benefits if developed in the right way. It could support comparison across hubs, strengthen the evidence base for prevention and early intervention, and enable more robust analysis of who hubs reach, what forms of support they provide, and what kinds of change follow. However, this process should build on the participatory and sector-engaged approach used in the Youth Access Quality Framework rather than being imposed from the top down by academic or policy institutions. Young people, hub practitioners, service leaders, commissioners, funders, and researchers should be involved in deciding what is worth measuring, how measures are introduced, how

data are interpreted, and how the burden of data collection is kept proportionate. The central test should be whether measurement improves understanding and care, rather than merely increasing the volume of information available for external reporting.

Future economic evaluation should therefore be mixed-method, theory-informed, and co-designed with young people and hub service staff, building on a proportionate outcomes framework rather than assuming that more measurement automatically produces better evidence. Cost-consequence analysis may be useful at this stage because it can present service costs alongside multiple forms of value without forcing them prematurely into a single outcome metric[230]. For Early Support Hubs, relevant consequences may include changes in distress and wellbeing, access and engagement, school attendance, education or employment participation, crisis presentations, emergency department attendance, CAMHS referrals, housing stability, safeguarding activity, and young people's experience of trust, belonging, and practical support. This approach would allow commissioners to examine affordability, opportunity cost, and wider system value while retaining a broader account of what hubs are intended to do.

Longer term, cost-effectiveness or cost-benefit analysis may become possible if there is sufficient data on total service costs, service utilisation, downstream health and social care use, education and employment outcomes, and longer-term trajectories for young people. These analyses would need to be developed carefully so that economic value is not reduced to short-term symptom change alone. The appropriate commissioning question is what level of public and voluntary-sector investment is justified by the benefits hubs generate for young people and for the wider system. These approaches should be developed alongside young people and hub services, so that what is valued economically remains aligned with what is valued in care.

This economic question sits within a wider English policy environment concerned with prevention, earlier intervention, and pressure on specialist health, education, employment, and social care systems. The government's independent review into mental health conditions, ADHD and autism identifies sustained demand across these systems and argues for support that is available earlier, better aligned across

services, and matched to functional need rather than diagnosis alone[231]. It also highlights the relationship between mental health difficulties, neurodevelopmental conditions, and young people not being in education, employment, or training. These are the kinds of cross-sector outcomes that future economic evaluation of Early Support Hubs should examine.

The contribution of this thesis is to clarify what must be included in future evaluations. Early Support Hubs should not be assessed only as short-term symptom-reduction services. Future economic evaluations should examine whether hubs provide cost-effective infrastructure for access, trust, early help, system navigation, and sustained engagement with young people who are poorly served elsewhere.

The absence of full economic evaluation does not mean the framework has no current policy or service value. Its immediate contribution is to define quality in a way that can already guide hub development, improvement, and funding decisions, while longer-term research builds evidence on impact and cost-effectiveness. The Prudence Trust is already funding grants to hubs based on the Quality Framework standards. A section of the report by the Centre for Mental Health *Future Minds: A roadmap to transform children and young people's mental health by 2035*[94] draws on the discussion section in this thesis to set out principles for evidence creation in youth mental health, placing these arguments in a policy-facing document that will reach audiences beyond academia. The Shared Outcomes Fund research, led by Appleton and colleagues, will publish its full findings in summer 2026, adding a broader national evidence base to the qualitative picture this thesis has developed. Whether Early Support Hubs become a model of care that is spread and sustained across England will depend on all of this, alongside continued advocacy, available government resources, and a political context that is, as always, uncertain.

What I am more confident about is the longevity and ongoing contributions of the three hubs at the centre of this thesis. They have continued to serve the young people of their communities for decades through a combination of funding creativity, dedicated staff, and a shared commitment to a particular way of understanding and responding to young people's distress. It is embedded in the organisational cultures, the relationships, and the logics of care that this thesis has

tried to describe with sufficient precision that others might recognise, protect, and build on what they have made.

Conclusion

This thesis asked what model of care Early Support Hubs enact, what logics underpin that model, and how hubs relate to existing statutory youth mental health services. It found that there was no single hub model at the outset. The hub category was coherent enough to organise advocacy, service development, and policy discussion, but not yet sufficiently specified to constitute a replicable model of care. The comparative case studies identified the shared logics of care that gave the field coherence beneath its terminological variation, and the Quality Framework translated those logics into a more explicit and usable structure. Early Support Hubs have moved from a boundary concept closer to a model of care, and this thesis was part of making that happen, not only documenting it.

Trust is the mechanism through which those logics become practice. It is produced organisationally, through continuity, accessibility, boundaries, follow-up, and the accumulated memory of how a service behaves over time. What the case studies revealed, consistently and across all three sites, is that the most valuable features of hub care are also the hardest to specify, codify, or transfer to new settings. Low turnover, stable leadership, accumulated community relationships, and institutional memory are not incidental features of good hubs. They are the conditions under which hub care becomes possible at all. That has direct implications for how the model is adopted elsewhere: the logics and standards can be named and spread; the trust on which they depend cannot simply be centrally manufactured.

The tensions surrounding hubs are ethical and political as much as they are technical. Funders, commissioners, and government need evidence that justifies allocation decisions. Services need recognition for work that is relational, developmental, and slow. Both demands are legitimate, and the pressure to resolve them by reaching for narrow outcome metrics before the model is well understood has distorted the field. Measurement matters, and it needs to fit the model. The Quality Framework offers a basis for evaluation that focuses on the enabling

conditions of care alongside its outcomes. That is the beginning of the work, not its completion.

These three arguments connect. The logics of care create the conditions under which trust becomes possible. Trust is what the legitimacy struggles are ultimately protecting. And the politics of evidence are sharpest precisely at the point where what hubs do best, building the organisational conditions for young people to engage with care, is least visible to the systems that fund them. Getting the model right before measuring it is a precondition of knowing what is worth expanding, and what will be lost if it is scaled carelessly.

Early Support Hubs matter not because they offer a neat new intervention, but because they preserve and institutionalise forms of youth mental health care organised around relationship, access, continuity, and a refusal to abandon young people whose lives do not fit the categories that statutory systems have built to contain them. As Young Futures Hubs begin to scale nationally, the question is whether the system can hold what makes these services valuable to young people in the first place.

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List of Abbreviations and Definitions

Abbreviation	Definition
A&E	Accident and Emergency
AMHS	Adult Mental Health Services
BACP	British Association for Counselling and Psychotherapy
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CORC	Child Outcomes Research Consortium
CORE-10	Clinical Outcomes in Routine Evaluation, 10-item measure
CUREC	Central University Research Ethics Committee
DBS	Disclosure and Barring Service
GBOs	Goal-Based Outcomes
GDPR	General Data Protection Regulation
GP	General Practitioner
ICB	Integrated Care Board

LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, and other minority sexualities or gender identities
MDT	Multidisciplinary Team
NHS	National Health Service
PDSA	Plan-Do-Study-Act
PHQ-9	Patient Health Questionnaire-9
RCADS	Revised Children's Anxiety and Depression Scale
ROMs	Routine Outcome Measures
SCORE-15	Systemic Clinical Outcome and Routine Evaluation, 15-item measure
SDQ	Strengths and Difficulties Questionnaire
SPA	Single Point of Access
YIACS	Youth Information, Advice and Counselling Services
YP-CORE	Young Person's Clinical Outcomes in Routine Evaluation

Appendix A: The Youth Access Quality Framework

Uploaded as separate PDF as per University of Oxford guidelines.

Appendix B: Feedback Zine from Youth Engagement Co-designers

Uploaded as separate PDF as per University of Oxford guidelines.

Appendix C: Interview Participant Information Sheets, Information Poster, and Consent Form

Uploaded as separate PDF as per University of Oxford guidelines.