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A&E Navigator & Community Links Evaluation

March 2023

West Yorkshire
Violence
Reduction Unit

Wavehill: Social and Economic Research

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List of abbreviations

ARI	Adversity Related Injuries
NEET	Not in Education or Training
SMS	Maryland Scientific Methods Scale
VRU	Violence Reduction Unit
YOT	Youth Offending Team

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1. Introduction

1.1 Background

The West Yorkshire Violence Reduction Unit (VRU) brings together specialists from health, police, local government, education, youth justice, prisons, probation and community organisations to tackle violent crime and the underlying causes of violent crime.

The VRU is committed to embedding a Public Health approach to reducing serious violent crime, which means looking at violence not as isolated incidents or solely a police enforcement problem. Instead, violence is seen as a preventable consequence of a range of factors, such as adverse early-life experiences, or harmful social or community experiences and influences. A Public Health approach to violence includes: improving outcomes for the population e.g. life expectancy and healthy life expectancy, identifying need, understanding the risk and protective factors and root causes of violent crime; and implementing an upstream approach and embedding evidence based preventative interventions at all levels (primary, secondary, tertiary) which include addressing the determinants of health.

The VRU supports a multi-agency, public health, long-term approach to preventing and tackling serious violence, in line with the Strategy, which is:

- Focused on defined population
- With and for communities
- Not constrained by organisational or professional boundaries
- Focussed on generating long term as well as short term solutions
- Based on data and intelligence to identify the burden on the population, including any inequalities
- Rooted in evidence of effectiveness to tackle the problem

The latest VRU Strategy Refresh[1] references the broad social and economic circumstances that together determine the quality of living, health, wellbeing and the safety of the population. It emphasises that deprivation and inequalities around these determinants show strong correlations to adversity and trauma and the root causes of serious violence. West Yorkshire has a significant number of areas experiencing disadvantage and this has been growing in recent years. One indicator of this is the number of people requiring crisis assistance in the region which has grown over recent years.

[1] West Yorkshire Violence Reduction Unit (2022)- 'West Yorkshire Response Strategy Refresh 2023. Serious Violence: West Yorkshire Strategy for Change'. December 2022.

The correlation between deprivation and can leave young people more vulnerable to childhood adversity and poor mental health which are both key risk factors for violence. Hospital admissions for violence increases exponentially with increasing deprivation. Hospital admissions for self-harm in West Yorkshire are noticeably higher for those aged 15 to 19 years compared to other years, which is consistent with national trends.[2]

What this highlights is that **many young people require support for a range of complex and inter-related issues, which cannot be addressed in isolation but rather requires a coordinated, multi-agency response**. As outlined in the Strategic Need Assessment,[3] deprivation is not casual for violence, but instead is a contributory factor because of its widespread consequences. This context provides an important lens through which to understand the role and contribution of interventions such as A&E Navigator schemes and the Focused Deterrence Car and the interface they provide between 'reachable' moments and more in-depth holistic support delivered through wider provision including Community Links.

The definition of serious violence as defined in the Strategy Refresh is:

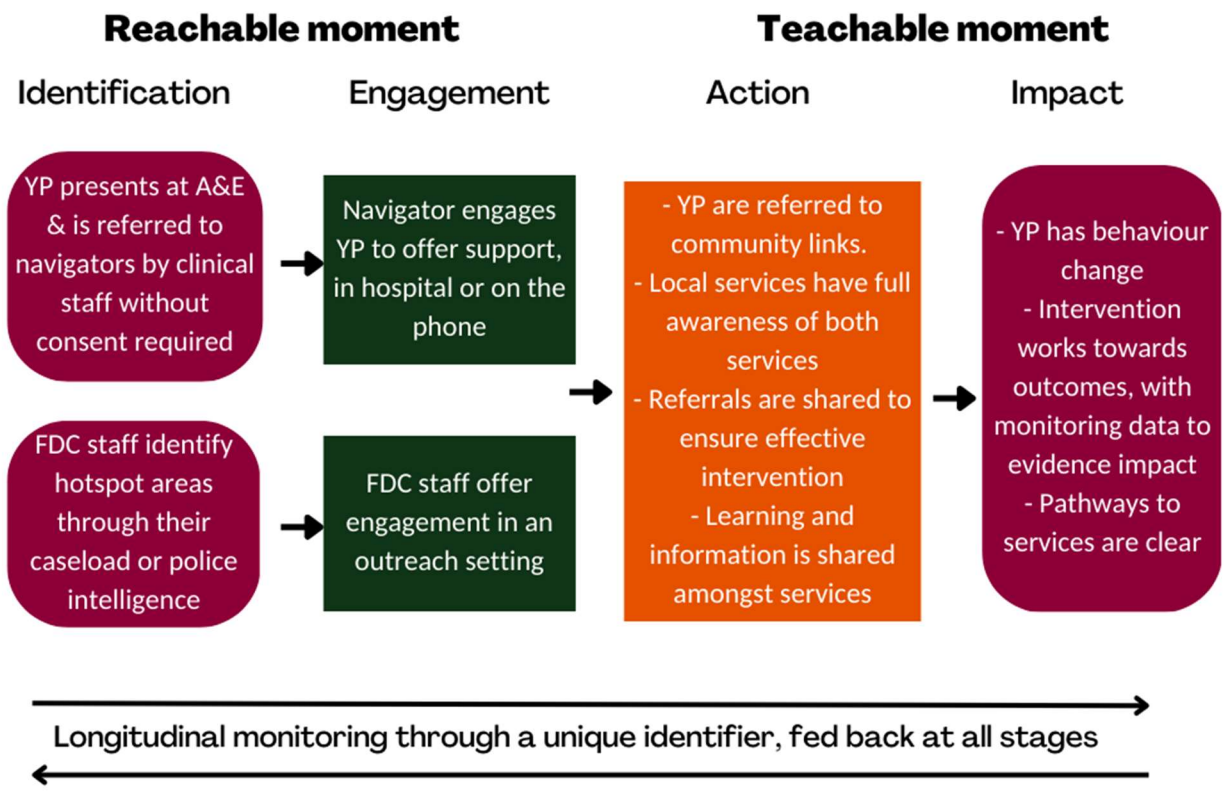
"Violence and serious violence includes specific crime types where there is the use of physical force or power, threatened or actual, against oneself, another person, or against a group or community".

This again is helpful in understanding that profile of young people reached, engaged and supported by the three interventions covered in this report.

Figure 1.1 over page shows our overview of the participant journey from A&E referrals moving through to Community Links, in order for the intervention to deliver effectively and ensure causal attribution as per the outlined aims. At present, there is no longitudinal journey mapping of the young person, which impedes the ability to evidence impact and achieve a higher Maryland Scale. It is important to ensure intelligence flow and partnership buy in throughout this whole journey to create clear pathways to services and ensure provision is effective for young people.

[2] West Yorkshire Violence Reduction Unit (2022)- 'Serious Violence in West Yorkshire: Strategic Needs Assessment 2022/2023'. December 2022.
[3] Ibid.

Figure 1.1: Model of particpant journey



1.2 Evaluation aims and objectives

The VRU commissioned Wavehill to undertake an impact evaluation of the A&E Navigator programmes established within Leeds Teaching Hospital NHS Trust and Bradford Teaching Hospital NHS Foundation Trust and the work of the Community Links provision. The evaluation has focused on providing the VRU with a better summative understanding of the impacts of the interventions in the West Yorkshire context to inform and improve future implementation and delivery. In addition, our evaluation aims to assist with understanding on how the VRU is tracking against the three Home Office mandated key success measures, namely:

1. A reduction in hospital admissions for assaults with a knife or sharp object and especially among those victims aged under 25,
2. A reduction in knife-enabled serious violence and especially among those victims aged under 25
3. A reduction in all non-domestic homicides and especially among those victims aged under 25 involving knives.

The main objectives for our evaluation as outlined by the VRU are:

- Determine causal attribution of the A&E Navigator programme, in Leeds and Bradford, including Community Links through establishing the impacts it is having in West Yorkshire.
- Evidence of engagement with a comprehensive range of program participants, officers, and other stakeholders as appropriate.
- Assess of the extent to which the named programmes contribute to the Home Office violence reduction success measures.
- Identify whether the programmes impacts are positive or negative, whether the programmes are having the intended impacts or whether there are also unintended impacts arising from their implementation, as well as casting light on direct or indirect impacts.
- Establish the value for money of the A&E Navigator and Community Links programmes.
- Support the programmes to advance data collection to allow enhanced level of evaluation (Level 4 SMS).

This report also provides a focus on 'what works' in the West Yorkshire content as well as outlining options and opportunities to scale-up or replicate the intervention in other areas of West Yorkshire and beyond. Finally, acknowledging the ambition of the VRU to improve the quality and usefulness of commissioned evaluations, our report provides guidance and support to assist the intervention to work towards Level 4 on the Maryland Scientific Methods Scale (SMS).

1.3 Research method

Our evaluation commenced in December 2022 with fieldwork delivery continuing into March 2023. The research has incorporated the following elements:

- Desk-based review of the existing evidence base on A&E Navigator schemes and quality youth provision.
- Review of monitoring returns and previous evaluation reports provided by the VRU, and the organisations commissioned to deliver the three interventions.
- Interviews with delivery staff teams including:
    - Navigators
    - NHS staff in Leeds
    - Commissioned Community Links organisations (Safetalk & Breaking the Cycle)
    - Referral organisations either involved with the delivery or that potentially could be involved

Our team has encountered difficulty in engaging the appropriate staff and delivery teams, which has hindered the ability to fully evaluate both programmes.

This is likely owing to the short timescales for evaluation delivery, as well as the time of year being towards the end of the financial year which may mean increased pressures on delivery as well as uncertainties around funding continuation. It has also been exacerbated by wider external influences including the winter pressures on NHS services, in particular affecting A&E units, and planned staff strikes by doctors, nurses and allied health professionals over our delivery period.

Our team has engaged in discussions other VRU's across the country that are delivering similar or comparable programmes, as well as contacting other evaluators that have been involved in reviewing their performance. This has provided valuable learning and context around the delivery of the interventions funded by West Yorkshire VRU as well as assisting us in understanding the extent to which the monitoring systems established for A&E are appropriate or could be improved and streamlined to unite delivery across the country.

Similar to the experience of other evaluators, we were unable to gain direct access to supported young people over the timeframe for our evaluation to ensure their voice could be heard. Whilst our team made every effort to make this happen, a lack of response from delivery organisations involved as well as practical barriers around entering A&E have meant we have only received feedback from one young person on the A&E service. Evaluations carried out by Liverpool John Moore's University with both Merseyside and Lancashire VRUs experienced similar challenges and contained limited direct feedback from young people. This is an area that requires further review and exploration by the VRU as the commissioning organisation.

Further, we have experienced difficulties in engaging a range of community organisations over and above the commissioned providers that are delivering the interventions. Whilst a list of referral organisations was provided through Leeds Navigators, the majority responded to inform us they were not involved and were not aware of the provision. We did therefore have discussions with those that were willing and put them in contact with respective navigators. To that end, this is a missed opportunity in that delivery leads could engage with all provision in the vicinity to ensure awareness of support provision, which would be able to support delivery of Community Links and subsequently a potential increase in the take up of services.

1.4 Caveats and limitations

Whilst our evaluation has adopted a mixed methods approach to provide as robust an assessment as possible of the impact of the A&E intervention, there are a range of limitations to our approach.

There are difficulties in ensuring that youth voice is adequately included in our evaluation. We have been unable to develop a rapport with young people mediated through a trusted gatekeeper. We have not been granted access to A&E, which would require ethical approval. This should be factored into any future research commissioning by the VRU.

In terms of monitoring, there is no unique identifier to track the longitudinal journey of the young person from their initial referral through A&E, through to Community Links and their achievement of positive outcomes. This means there is currently no follow up data or readmission rate data around A&E. This significantly limits the ability of our team to ascertain fidelity of delivery against the intended targets and outcomes included in the Theory of Change. We outline further detail later in this report.

Within the monitoring processes, there is no standardised method with different areas adopting different monitoring methods. This has created challenges for our team in aggregating data to produce an overarching picture of delivery numbers and profiles. This has been further exacerbated by the lack of unique identifier which means that it is possible that some young people may be accounted for multiple times if they have repeated engagements with the intervention. The monitoring system also does not show all engagements if they are not referred on but do have support, nor does it give insight into reasons for disengagement. To that end, it is possible that both projects are under reporting regarding engagements. Our team does not have confidence that the monitoring data is portraying accurate, unique engagements. This limits our ability to accurately understand the extent to which the interventions are engaging a comprehensive range of participants, as per the aims.

There are practical and ethical considerations which limit the ability to establish comparison or control groups to assess differences in agreed outcomes for young people engaged in these interventions and those that are not. As such, any requirement to adopt a more robust impact evaluation approach working towards Maryland Scientific Methods Scale (SMS) levels 2 and above requires discussion between a range of partners including the NHS, West Yorkshire Police, the VRU and wider referral organisations.

2. A&E Navigator programme

Summary

- Navigators aim to provide consistent care, advice and support to people who have experienced violence and may be at risk of future violence. The service aims to reduce reinjury and involvement in violent criminality, subsequently resulting in fewer hospital admissions.
- The evidence base highlights that a large proportion of patients who engage with comparable services present with more than one social issue, the most common of which included alcohol misuse, drug misuse and violence.
- Hospital-based interventions can only make a significant contribution where they are firmly linked to a strong network of community provision and longer-term support.
- Helping young people access or re-engage with, existing longer-term support such as education and mental health care, is an important part of the journey towards achieving longer-term impacts.
- A 'teachable' moment has the potential to increase an individual's motivation to change. A&E navigators can also help with reaching and engaging vulnerable young people who are not on the radar of statutory services.
- Neither Leeds or Bradford services have a formalised a pathway by which follow-up data can be collected from young people coming to the end of their engagement, or services associated with Community Links.
- In Leeds, Community Links related monitoring data indicates that around 5% of all referrals were already known to services. This points to positive additionality being delivered.
- Interviewees believe that the services are having a positive impact on reducing the frequency of repeat offending and attendances to A&E, however this cannot be evidenced in the absence of longitudinal monitoring data

2.1 Intervention background

The A&E Navigator programme is one of the flagship initiatives of the VRU requiring significant investment of resources since inception in 2019/20. A&E Navigators are a support service for people who find themselves in A&E due to violence. Navigators aim to provide consistent care, advice and support to people who have experienced violence and may be at risk of future violence.

Navigators aim to link people with appropriate community support services with a view to assisting people to address the factors that may make them vulnerable to violence. Closely attached to the Navigator programme, is the work of the Community Links, ensuring clear, consistent pathways are in place from the navigator into community provision. The service aims to reduce reinjury and involvement in violent criminality, subsequently resulting in fewer hospital admissions.

2.2 Delivery model

The A&E Navigator programme has been running in both Leeds and Bradford since 2019, as a support service for people who find themselves in A&E due to violence primarily, as well as other presenting issues. Navigators aim to provide consistent care, advice and support to people who have experienced violence and may be at risk of future violence. The aim is to link the young people that engage with navigators with the appropriate community support services, providing a clear pathway and thus increase engagement with such services to encourage behaviour change in line with the programme's outcomes.

Leeds's Navigator service is administered and led by the Safeguarding Department at Leeds Teaching Hospitals NHS Trust. As opposed to being provided by the local authority, the service's Navigators are employed directly by the Trust. Thus whereas Navigators working for Bradford's service do not have access to patient medical and safeguarding records as Navigators are provided by the local authority, those working for the Leeds Trust can access these records. Both Leeds and Bradford's Navigator services, however, can record details of engagements with young patients.

Navigators in Leeds are based on-site and are available to give support from Monday to Friday from 9 am to 5pm every week. As opposed to Bradford's Navigators, who are often present on the ward and may engage with patients in the department's reception, Leeds's Navigators rely upon clinical staff to refer patients to the service. As a result, engagement generally takes place by the bedside of young patients or over the phone once a patient has been discharged. In Bradford, Navigators are employed on a rotation basis, with two workers based on-site within the emergency department every night of the week from 4PM until midnight, enabling them to engage with patients in real time.

Both navigator services employ formalised referral pathways between clinical staff and the Navigators. In Leeds, these pathways are integrated into the hospital's electronic medical records system (Primary Pathway Manager), meaning that referrals to the Navigator service are managed in line with general practice across the hospital. Referrals are filled in by clinical staff via an electronic form and sent to Navigators, who can access the patient's medical records and engagement details via the centralised medical records system. This also means that Navigators can identify instances of repeat attendances amongst young patients are directly refer these patients to the service.

"It's been consistent, it was all set up with access to Primary Pathway Manager. (PPM) We use the PPM to refer into the Navigators via a form. Other forms like housing are a nightmare, as the patient is often discharged before the form is complete. The Navigator form is easy, and their poster helps tell you what you need". (**NHS staff member, Leeds**)

Bradford Navigators engage with staff members working within the A&E department, Paediatric and Minors' wards at the beginning of every shift to identify young people who may be in need of support. Navigators have access to all areas of the hospital, and thus they circulate children's wards and also engage young people in the waiting area of the emergency department. Hospital staff members can contact the Navigators either verbally or via pager to notify them in real time of a young person in need of support.

"We have developed an in-hospital call out, which sees the youth workers carrying a pager and able to be "called" by clinical staff who feel a young person would benefit from some support, or to undertake other pastoral support if they are anxious or feeling isolated." **(Project team member, Bradford)**

2.3 Evidence base

To enable our team to compare the delivery model and performance of the A&E Navigator service in Leeds and Bradford with schemes operating elsewhere in the UK, we reviewed a range of evaluative reports.

One of the earliest service examples is from Scotland where the Navigator service, funded by the Scottish Government and managed by the Violence Reduction Unit in partnership with Medics against Violence, NHS GGC and NHS Lothian, has been operating in the Emergency Department of Glasgow Royal Infirmary (GRI) since December 2015 and from November 2016 in the Emergency Department at the Royal Infirmary of Edinburgh (RIE).[4] The service aims to support people to **move away from violent or chaotic lifestyles**. Patients who have engaged with the service are often frequent attenders at Emergency Departments, either because of repeated violence (interpersonal or self-directed) or substance misuse or with a range of non-specific medical symptoms that may reflect their chaotic lifestyles. The Navigator intervention starts in the hospital and continues in the community and may involve one or more of community partner organisations.

The evaluation report highlights that 78% of patients have accepted the offer of support, with some continuing to work directly with the Navigators in the community. The service offered support to 439 patients during their first 12 months at GRI and their first 6 months at RIE.

[4] Goodall, C., Jameson, J. & D.J. Lowe (2017)- 'Navigator: A Tale of Two Cities'.

A large proportion of patients who engaged with the service presented with more than one social issue, the most common of which included alcohol misuse, drug misuse and violence.[5] The impact evidence presented in the report is mainly qualitative and case study based. Whilst the report refers to the transformational impact that the Navigator support can have on people's lives, there is limited impact data presented.

Redthread's Youth Violence Intervention Programme (YVIP) provides support to Emergency Department teams to ensure a holistic approach is taken to tackling youth violence and exploitation, and its implications.[6] It aims to present pathways out of violence and exploitation for young people wanting to make positive changes in their lives as well as promoting and nurturing partnership working across the system to join up the way in which local areas respond to youth violence and exploitation. Their report found that although the need for a dedicated YVIP service is well understood and appreciated within the Emergency Departments hosting the service, it is not yet universally accepted across the NHS.

Crucially, the report emphasises that youth violence has complex roots within communities and that hospital-based interventions can only make a significant contribution where they are firmly linked to a strong network of community provision and longer-term support. The report also cites a need to measure impacts beyond the hospital episode to support cross-system funding as well as a lack of comparative studies which demonstrate the effect of the service compared to standard Emergency Department care. Drawing on academic evidence from the US, the report[7] concludes that YVIP's exert at least some of their effect by helping young people access or re-engage with, existing longer-term support such as education and mental health care. However, the ability to better demonstrate this requires services to use follow-up data from young people and linking data across collaborating organisations to measure improvements in outcomes of interest to the many agencies involved. One of the recommendations in the report is to develop cross-system, place-based funding agreements with an explicit commitment to share data to support the evaluation of outcomes within and beyond the NHS.

The Youth Endowment Fund's report on emergency department violence interventions[8] outlines that the presence of violence intervention programmes in Emergency Departments is a 'teachable' moment which may increase an individual's motivation to change, with Navigators able to connect patients to issues related to alcohol, violence or drugs to services on discharge. Some programmes can provide post-discharge support for up to six months. The post discharge follow-up is identified as an important success factor.

[5] Violence includes interpersonal violence, self-directed violence, sexual assault, childhood abuse and domestic abuse.
[6] The Health Foundation & Nottingham University Hospitals NHS Trust (2020)- 'Redthread YVIP Adoption and Spread'.
[7] Ibid
[8] Gaffney, H., Jolliffe, D. & H. White (2021)- 'Emergency department violence interventions'. Toolkit technical report. Youth Endowment Fund. November 2021.

A more recent evaluation of Redthread's YVIP delivered across the Midlands was published by John Moores University in 2022.[9] The research found that of all eligible referrals, only approximately one in five were known to other statutory services, while around a third of those who were known to statutory services engaged with those services.

This suggests that the intervention was **helping to reach and engage many vulnerable young people who were not on the radar of statutory services** and who, in the absence of the support, experience adverse outcomes relating to violence. The West Midlands service operates on a hub and spoke model, with the team based in Birmingham providing outreach to other sites. Nottinghamshire operates a hybrid model, which consists of the majority of the team at the major trauma centre and one youth worker based at a smaller hospital.

One of the key factors which was perceived to work well about the programme, was the supportive, trusted relationship that was developed between young people and their youth worker. Qualitative data captured by the service suggested young people had improved mental wellbeing because of engaging with the programme, in addition to increased confidence and self-esteem. Findings from the monitoring data suggested a significant reduction in risk of self-harm from initial assessment to end assessment. Further, qualitative findings and quantitative analysis of assessment scores from the monitoring data showed that **young people had improved outcomes in crucial protective factors against involvement in violence**, including improved family relationships and friendships, and engagement in education, training and employment. Data also demonstrated young people had improved feelings of safety as a result of engagement in the programme.

Findings from analysis of the monitoring data showed significant reductions in young people's experience of violence, crime, and exploitation, and their participation in violence and criminal behaviour, suggesting Redthread was achieving its overarching long-term aim.[10] However, the report outlines **limitations in the data due to difficulties in recruiting young people to take part in the evaluation**. In addition, the current outcomes are not based on validated measures or scales and inclusion of such tools would increase reliability and validity of identified positive impacts of the programme.

A feasibility study plan produced by the Behavioural Insights Team on behalf of Thames Valley Violence Reduction Unit concluded that while there is enthusiastic adoption of hospital-based navigation interventions and a theoretical foundation for why they may be effective, there is **limited evidence on their efficacy**.[11] UK analyses to date are primarily descriptions of service uptake with an adult population with no empirical data gathered for violence-related outcomes generated by such interventions.

[9] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.
[10] Ibid
[11] The Behavioural Insights Team (2021)- 'Feasibility study plan: Multi-site evaluation of practices: Hospital Navigators'.

2.4 Theory of change

West Yorkshire VRU provided a draft Theory of Change in order to set out the inputs, outcomes and impact of the intervention. The aim of this was to reduce Adversity, Trauma and Harm caused by violence and support the system ambition for West Yorkshire to be a Trauma Informed and Responsive system by 2030, as well as develop a whole system approach to responding to multiple disadvantage.

The focus of the project is on those presenting with injuries from violent crime, assuming this is evident at the point of identification, aiming to reduce victims of crime and A&E attendances relating to violence, particularly those under 25 which is the target age range for the project. As the ToC identifies, effective delivery requires accurate and accessible information sharing between navigators and clinical staff as well as active engagement from young people.

Given that the interaction between young people and navigators will be the initial engagement point, it is assumed that this is the Reachable moment, which highlights the importance of a clear pathway to Community Links provision in order to provide teachable moments and thus encourage behaviour change, in order to achieve the outlined outcomes and impacts.

Our assessment of the ToC has identified the following assumptions, which will impact the ability to determine the causal attribution of the programme to achieve the VRU's overall aims:

- Assumes high proportion of young people consent to be engaged
- Assumes high proportion of young people take up the referral
- Assumes high proportion of young people maintain their engagement with the Community Links provider
- Assumes continuity of hospital/clinical staff

Details of the theory of change can be seen in Figure 2.1 over the page.

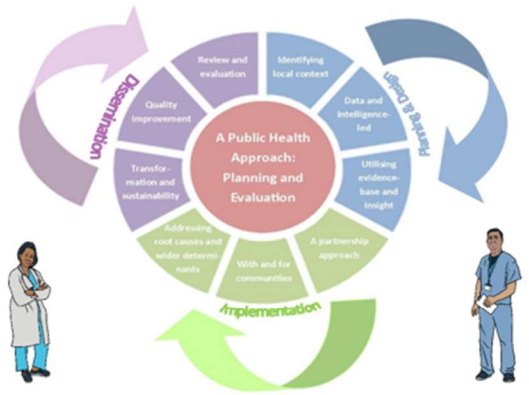
Figure 2.1: A&E Navigator Theory of Change

Across West Yorkshire (WY), we will work together to reduce, Adversity, Trauma and Harm caused by violence through the A&E Navigator Service & Community Links Providers to support our system ambition for:

West Yorkshire to be a Trauma Informed and Responsive system by 2030 and develop a whole system approach to responding to multiple disadvantage

Outcomes

- Children and young people affected by serious violence will be supported
- Children and young people struggling with mental health or drug/alcohol issues will be supported
- Increased number of young people in employment
- Reduction in serious Violence and Knife Crime, particularly amongst those victims aged under 25
- Reduced numbers of A&E attendances for knife related violence, particularly amongst those victims aged under 25
- Young people engaging in mainstream education / training / employment
- Contribute to reduction in school exclusions and improvement in attendance
- Genuine reduction in contact with police
- Young people see overall improvement in health and wellbeing
- Reduce inequalities and improve life expectancy
- Children and young people's needs are better met
- Increased trust with NHS services



Impact

- Improved identification of those needing support from services
- Earlier identification of need
- Improved trust in services
- Increased knowledge of pathways joining local services
- Positive impact on young person from interaction with navigator
- Improved information sharing between services
- Volume of positive engagements
- Reduced revictimization of those supported
- Reduced harm caused to and by those supported
- Increased resilience/awareness & use of coping mechanisms)
- Reduced arrest rates for those offenders supported
- Reduced criminality amongst those offenders supported
- Reduced risky behaviour by those supported
- *Reduced progression against ASB sanctions*
- Shift to an intervention based on level of vulnerability to capture wider audience in need

Inputs

Funding -	VRU funding, CCG funding (£100k) Broader CL funding
Capacity -	7 day 1pm-12am service*, 9am-5pm weekday service, hospital staff (reception teams, wider A&E management, nursing staff)
Products -	Existing Data sharing agreements Risk assessment tool Resilience framework – CL element (distance travelled) Evaluation report ISTV data VRU Needs Assessment & Response Strategy
Partnerships -	Bridge partnership, Breaking the cycle, youth in mind Youth Justice Service, Market place VRU, Local authority, internal services
Delivery -	A&E Navigator service & CL provision
Support -	VRU & healthcare partnership

Activities

- Hospital staff submit formal referrals through to navigators
- Navigators screen weekend records for retrospective interaction (screen based on age, reason for admission, time of admission and medical needs)
- Hospital staff alert Navigators re patients to speak to
- Navigators identify additional patients whom they feel relevant to speak to (through engagement with young people)
- Identify victims of knife/bladed instrument related violence in A&E
- Navigators prioritise serious cases for 'in person' intervention
- Navigators identify less serious cases for intervention via phone
- Navigators secure consent from individuals
- Person centred risk assessments completed using formal tools
- Person centred risk assessments completed not using formal tools
- Referrals made to various services where appropriate
- Record made on patient management system
- Record made on Navigator held record system *moving towards Electronic Patient Record update
- Complete VRU monitoring return
- Update Caseload management process (CL) – capturing distance travelled

Outputs/Measures

- Number of interactions between navigators and individuals
- Number of refused engagements
- Number of Navigator produced referrals for ongoing support to community links
- Number of Navigator produced referrals for ongoing support elsewhere
- Number of knife crime/serious violence victims identified
- Number of knife crime/serious violence perpetrators identified
- Number of referrals related to mental health
- Number of referrals related to trauma and adversity
- Number of times alternative choices information provided (and context – interests, onwards support.
- distance travelled during the engagement with community links – uptake, engagement with service, hearing and understanding needs of the individual, providing support

Tracy Brabin Mayor of West Yorkshire | West Yorkshire Violence Reduction Unit | NHS West Yorkshire Integrated Care Board | West Yorkshire Health and Care Partnership

2.5 Monitoring processes

Within both services, Navigators fill out an assessment form following their engagement with a young patient. This assessment form is part of monthly monitoring data, recording demographic information (e.g., age, gender, ethnicity) and contextual data regarding, for example, the young patient's reason for presenting, the extent to which they are engaged in criminal activity, whether or not they are known to community services and whether or not they are NEET (Not in Education or Employment). As Navigators at Leeds also have access to patient medical records, they may also ascertain which patients have made repeat attendances to the emergency department.

Neither service has a formalised a pathway by which follow-up data can be collected from young people coming to the end of their engagement, or services associated with Community Links. Navigators pursue an informal method of collecting follow-up data by contacting young patients who have shown a specific interest in the service. In Bradford, follow up engagement may be regarded through WhatsApp, and case and interventions notes are written up at the end of each intervention. Such information is, as of the time of reporting however, maintained internally.

"We don't track longevity. We do follow-up calls but not for everyone, mainly just for people that have shown real interest in the programme and Community Links. Follow-up support is at our own discretion and its usually young people who really want to engage. We put initial support in place, then we work on long term support for them" - (**Navigator)**

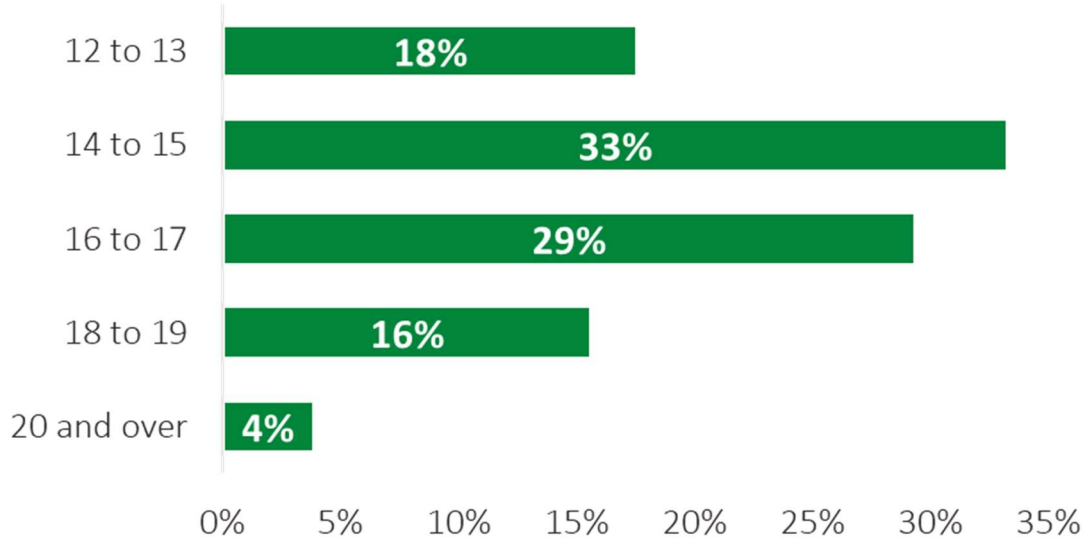
"Talking to partners is important also to ascertain impact. It's difficult to do follow up as interventions in exploitation mean children move around a lot. We do keep in touch and have children out of district who we work with, but it's hard to gauge long-term impact."- **(Navigator)**

2.6 Profile of young people engaged

2.6.1 Leeds

In Leeds, the majority of young people who presented in A&E identified as male (72%). Data showing the ages of young people presenting at A&E had been available for only a small proportion of those who engaged with the Navigator service (Figure 2.2). Resultantly, findings representing age distribution cannot be taken as fully representative of that of the young people who have engaged with the service. Of the data available, around one third were aged between 14 and 15, followed by 29% that were aged 12 to 13.

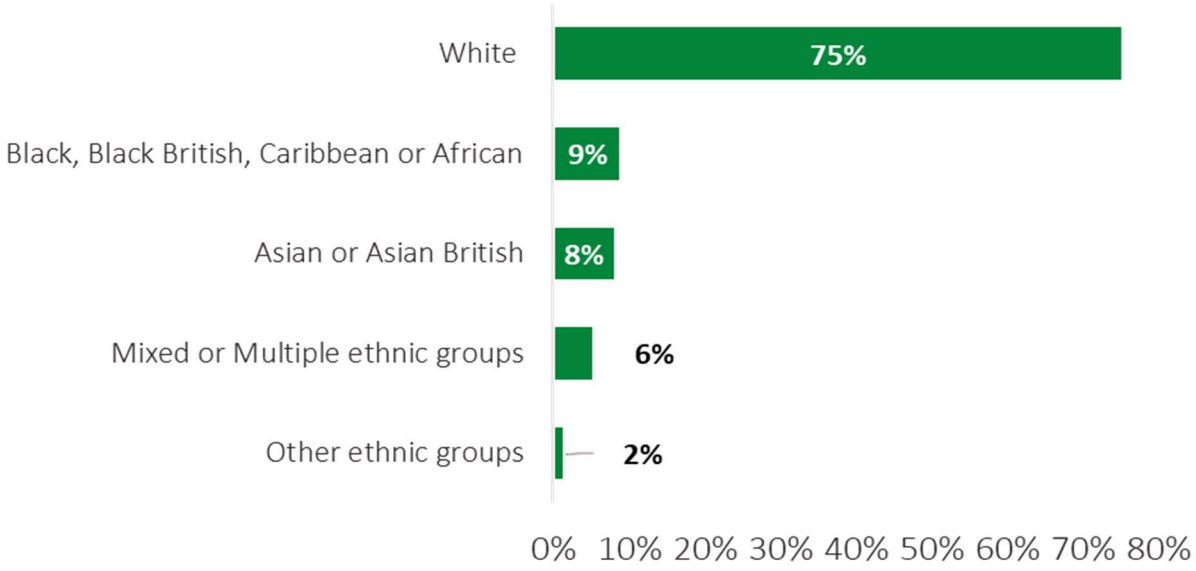
Figure 2.2: Age range of young people



Source: A&E monitoring data, N= 51

Three quarters of young people (75%) presenting at A&E identified their ethnic category as White, whilst those identifying as Black made up the second most populous group in the sample at 9% (Figure 2.3). This aligns with the most recent census findings on ethnic groups within Leeds, whereby 79% of young people identify as White. In contrast, those belonging to Mixed or Multiple ethnic groups were overrepresented, with the figure for A&E standing at 6%, against Leeds's figure of 3.4%.[12]

Figure 2.3: Ethnicity of young people



Source: A&E monitoring data, N= 669

[12] Census 2021, Office for National Statistics

Further research is needed to determine the implications of specific ethnic groups being either overrepresented or underrepresented within population samples for those accessing Navigator services. It is also important to note that ethnicity is not available for all the data recorded by navigators, with around 15% of the sample either reporting their ethnicity as unknown or not reporting at all, thus the picture cannot be completely accurate. Whilst one group's over-representation may indicate a 'negative' finding, it may also indicate a more 'positive' finding, such as that young people from this demographic feel more comfortable and able to access aid through healthcare staff and the Navigator service.

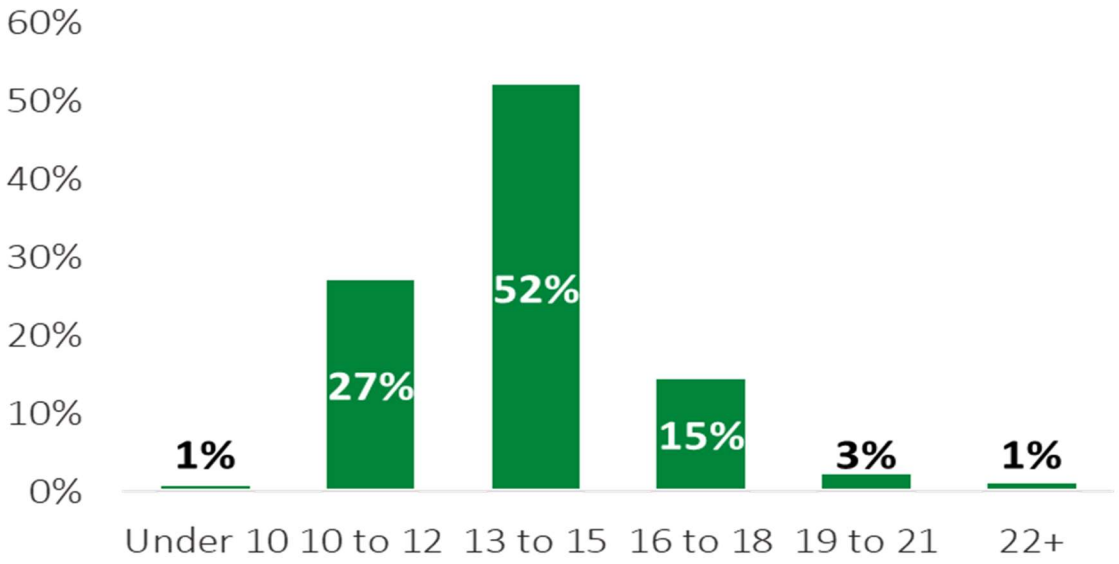
Three quarters of young people (75%) presenting at A&E reported that they were engaged in either some form education, employment or training. Given that the findings from the monitoring data suggest that the majority of young people were aged under 18, it is likely that a large proportion of this sample were enrolled at school or college / sixth form at the time of recording. The remainder of young people (25%) were recorded as NEET (Not in Education, Employment or Training). Linked to this, anecdotally, one of the young people that provided feedback noted that as a result of their engagement with navigators and subsequent engagement with community links, they have been supported to go back into education on a reduced timetable.

Given that an outcome within the theory of change is to ensure engagement in education or training, longitudinal monitoring around if those identified as NEET moved out of that position would be required moving forward. With that said, the navigators are engaging, for the majority, those that are already in education or training.

2.6.2 Bradford

Similar to the profile in Leeds, approximately two thirds of young people (67%) presenting at A&E identified as male, with the majority of the remainder identifying as female (32%). The most populous age group belonged to young people aged between 13 and 15 (52%). In addition, 27% were aged between 10 and 12 and 1% were under 10. With the target age of the intervention being aged 11 and over, this indicates that a small number of young people are being supported outside of the target (Figure 2.4 over page. It would be helpful moving forward to understand why this is the case and subsequently shift the target if appropriate.

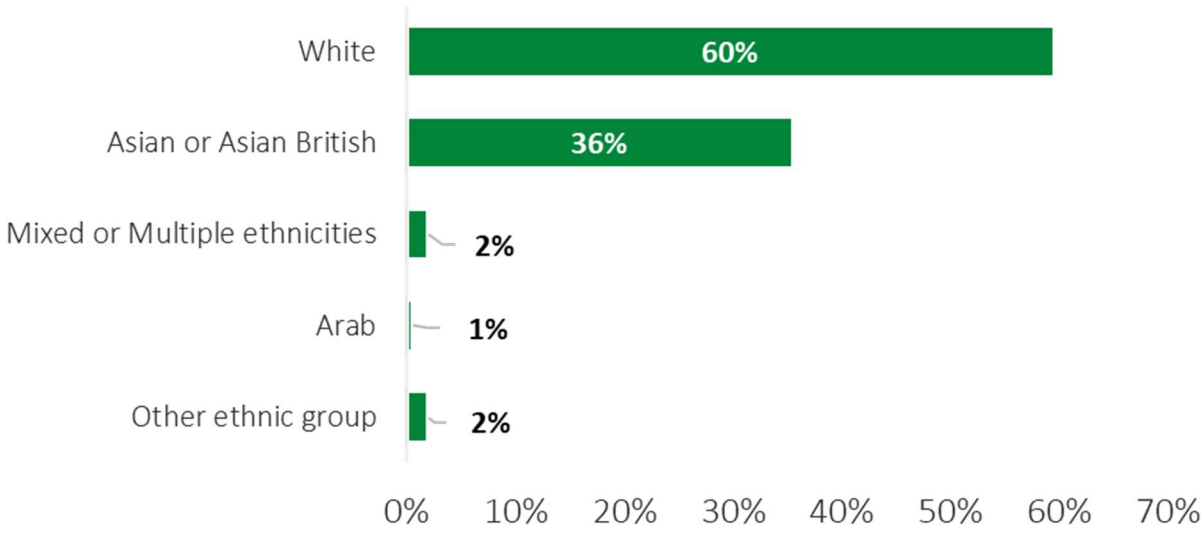
Figure 2.4: Ages of young people



Source: A&E monitoring data, N= 1431

Over half of young people (60%) presenting at A&E identified their ethnic category as White, whilst those identifying as Asian or Asian British made up just over a third of the sample at 36% (Figure 2.5). Such figures are consistent with the data available for Bradford as per the census., for example with 32% of the population identifying as Asian.[13]

Figure 2.5: Ethnicities of young people

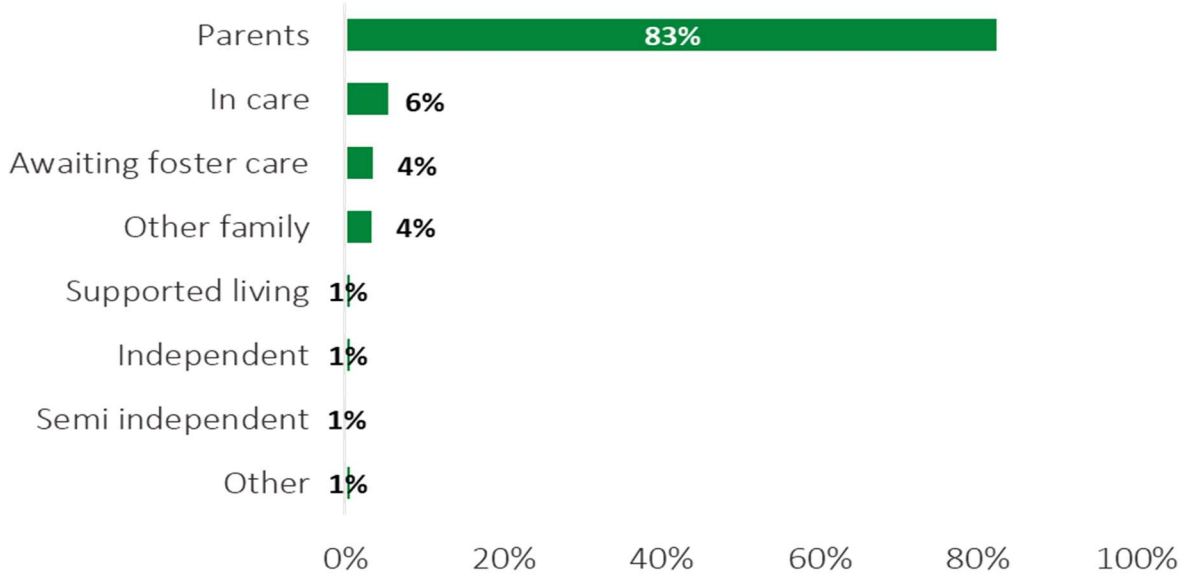


Source: A&E monitoring data, N= 146

The majority of young people (83%) presenting at A&E were reported to have been living with their parents at the time of recording, along with 4% living with other family members, which is to be expected given the most common age group is between 14 and 15.

[13] Census 2021, Office for National Statistics

Figure 2.6: Residential status of young people



Source: A&E monitoring data, N= 1328

2.7 Presentation at A&E

2.7.1 Leeds

Patients under the age of 25 who present at A&E are screened and triaged by clinical staff in accordance with the severity of their situation. Medical staff screen patients with a generalised risk assessment tool for all young patients who present in the A&E department. Once referred onto the Navigator team, patients undergo a separate risk assessment tool employed specifically by youth workers. For presentations involving patients under the age of 18, details of the attendance are cross-referenced with children's and social services to confirm whether the young patient is known to them, on top of the navigator provision. Although the majority of referrals come from the emergency department, medical staff from around the hospital can also refer young people into the Navigator service.

All patients between the ages of 11 and 25 who either present with, or appear at risk of, involvement in serious violence and/or criminal exploitation are automatically referred onto the Navigator team and are offered direct engagement on-site. Young patients who are identified by medical staff to have had repeat attendances at the emergency department may also be directly referred to the service. Because Navigators are directly employed by the Trust, consent does not have to be given from the young patient in order for the referral to be passed on.

For both young patients who have not been categorised as priority cases and are deemed not to be involved in violence / organised crime, (e.g. instances of injury or alcohol / substance abuse) as well as those who have attended the emergency department outside of the Navigator's working hours (e.g. on the weekend outside of their 9 to 5 hours), Navigators attempt to engage with them over the phone following discharge. Therefore, **engagement with young patients either takes place at the bedside or over the phone depending on the extent to which the young person is suspected to be at risk of violent or criminal exploitation**.

At the beginning of the project, young patients presenting at the emergency department with poor mental health were deemed eligible for direct referral into the Navigator service. However, since rollout the eligibility criteria for priority cases has shifted, with patients presenting with such issues being redirected to the corresponding hospital branch dedicated to treating patients experiencing issues with their mental wellbeing:

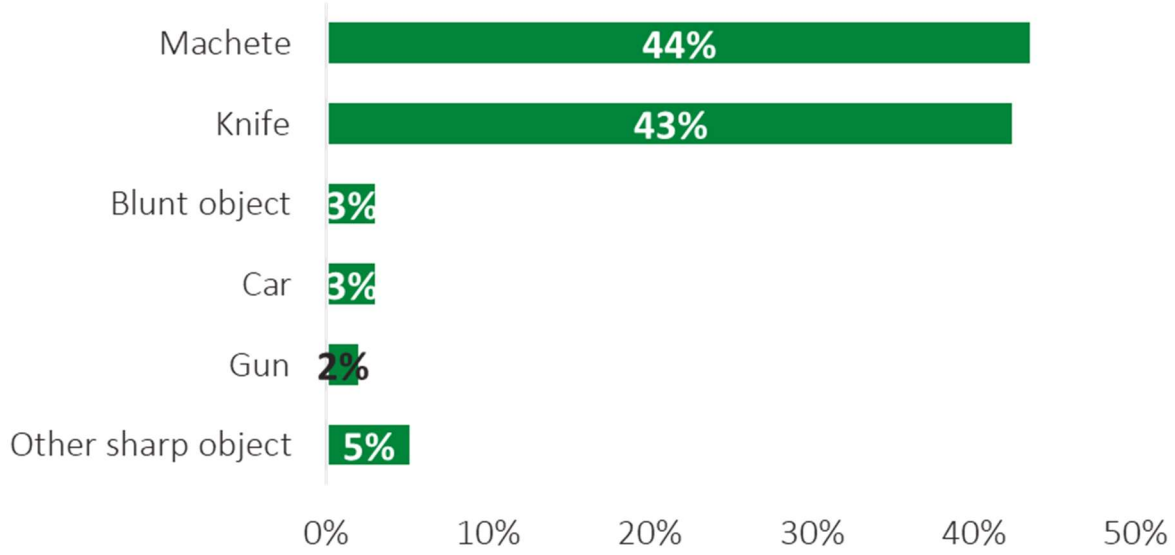
> "Most of our referrals are for mental health. However, we've had to make changes to the delivery and stopped taking them in because there's already a specific location in the hospital for mental health services" – **(Navigator)**

Monitoring data available in Leeds indicates that the majority of young people in Leeds were referred through Leeds General Infirmary (90%). This supports the notion that it would be beneficial for navigators to be based only in the Leeds General Infirmary, as at present they are based on both sites, meaning travel time must be accommodated when engaging with young people. Being placed in one location in which the majority of referrals are will support efficiency of support.

Upon presentation, the majority of young people (85%) had not had previous alcohol involvement whilst 15% had. Additionally, the majority of young people (84%) had not had previous drug involvement whilst 16% had.

Of those that were referred owing to violence, around one fifth (19%) were recorded as presenting with knife injuries, and the data available around weapon use indicates that the majority of young people either used a machete (44%) or a knife (43%) to cause harm. However, it is important to note that this data was only available for a small proportion of the data sample, and the parameters in which this is recorded are not clear. For example, it is not clear specifically how many young patients were in A&E as a result of any form of weapon, prior to recording information around weapon type. The majority of young people (89%) claimed to have no previous participation in street gang activity.

Figure 2.7: Weapons used by young people to cause harm



Source: A&E monitoring data, N= 94

2.7.2 Bradford

The Bradford Navigator service targets young people presenting with a wide range of conditions / circumstances. As well as offering support to patients who present as perpetrators / victims of violence, it also extends its support to those presenting due to poor mental health, substance misuse, injuries, identifies those not in education or employment (NEET), and those involved or at risk of criminal/ sexual exploitation.

The rationale for a wide-ranging eligibility criterion is that these conditions have been identified as part of a broader web of circumstances that tend to present within criminally exploited young people.

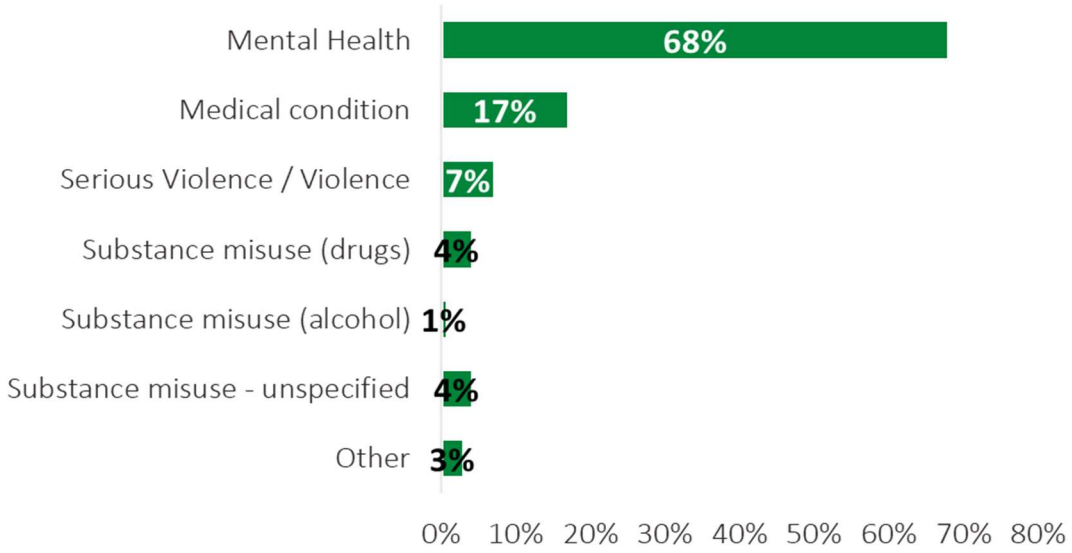
> "A&E often is people who have presented as a result of violence for whatever reason, weapons etc. We also encourage them to work with those who present with mental health crises or substance misuse. Often, they're all linked; symptoms like these can be the first presenting factor for their organised crime involvement. It's giving support around push and pull factors for triggers to stop it happening again and have that moment of pause" – **(Youth service staff member)**

For A&E attendants who are listed as 'already known to services' on the hospital system; and are flagged as vulnerable to exploitation, risk assessments are undertaken every 30 days via DRAMMs (Daily Risk Assessment Management Meetings). First-time attendees, on the other hand, are put through the general hospital safeguarding processes.

Whilst no data was known for 40% of young people, the majority (96%) of young people remaining reported that they had no previous involvement in violence. This indicates that the intervention is capturing those that may have committed their first offence or are not yet involved in criminality, suggesting that the support offered will be early intervention and thus at the most effective point to prevent further harm.

In terms of reasons for A&E attendance, **the majority of young people (68%) presented with mental health needs, whilst 17% had a medical condition and 7% were involved in serious violence.** This suggests that whilst the project is targeted towards serious violence, those in Bradford are capturing a wide range of issues, as per their initial delivery plan.

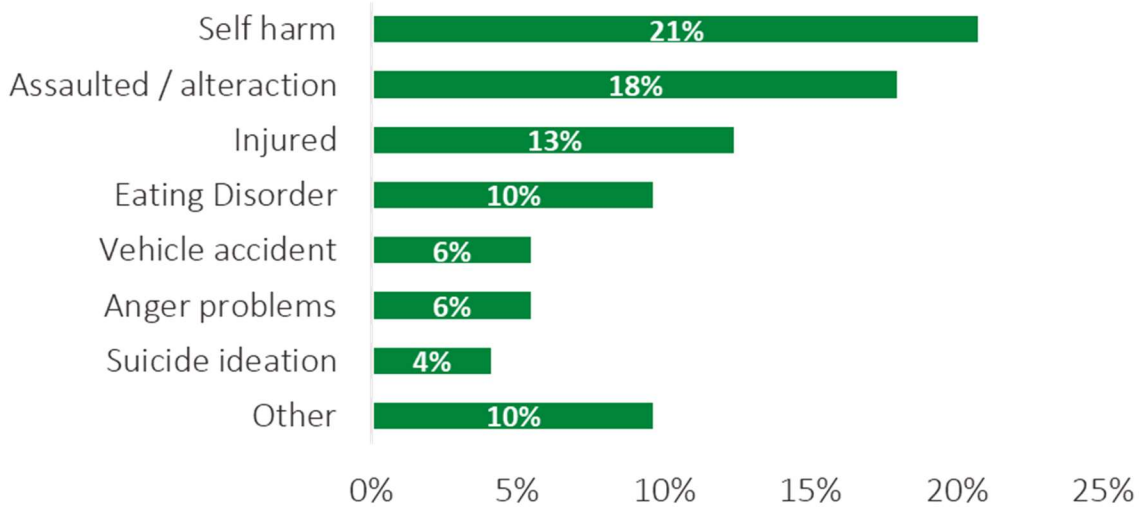
Figure 2.8: Main presenting issue of young people



Source: A&E monitoring data, N= 1504

In addition to their main presenting issue, a large proportion of young people (21%) reported self-harm as another presenting issue, and 18% had altercation or assault issues. Whilst data is only available for around 10% of the sample, the majority (88%) of those being referred to navigators were victims rather than perpetrators, suggesting that their presenting issue could be as a result of a previous altercation or involvement with violence.

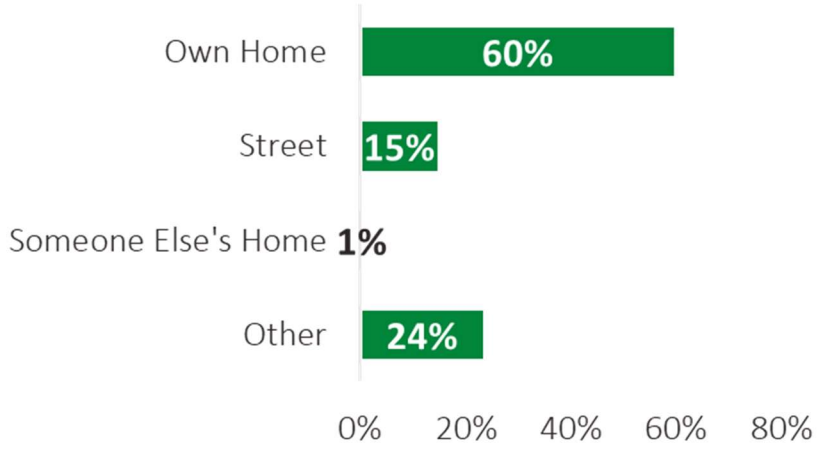
Figure 2.9: Other presenting issues of young people.



Source: A&E monitoring data, N= 72

In terms of where the incident took place, the majority of young people (60%) reported it to be in their own home and 15% reported it to be on the street. It is important to note however that location type was only recorded for 20% of those recording a presenting issue, thus it does not show an accurate assumption. In addition, the logic in which this is completed is not clear from the data.

Figure 2.10: Incident location type

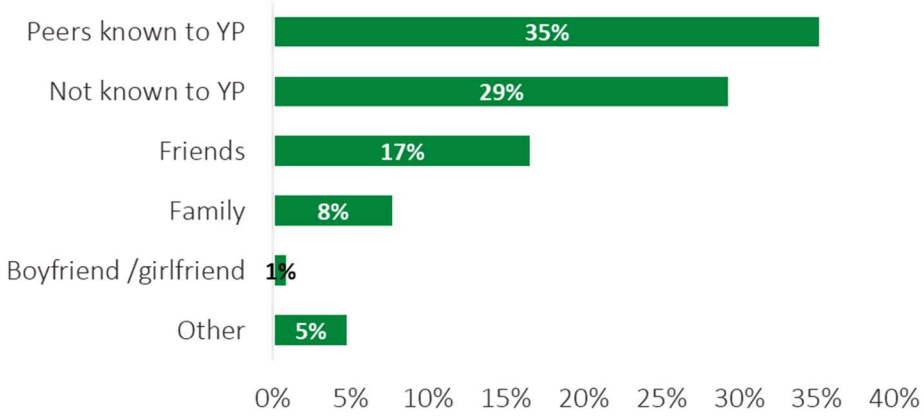


Source: A&E monitoring data, N= 310

The majority of young people (97%) did not have previous alcohol involvement or previous drug involvement (90%), similar to the profile in Leeds. With that said however, this data was not recorded for almost half of all reported young people, therefore indicating that there could be greater involvement. Whilst there is minimal data available (around 10% of all referrals) regarding whether or not other parties were involved, for those that did provide data, another party was known for around half (54%) of all referrals.

It was then possible to code the information reported of the other parties, of which 35% were school or other peers known to the young person, whilst 29% were not known to the young person (Figure 2.11). It should be noted here again that the logic in which this information is completed is not clear, for example the monitoring does not initially include whether or not other parties were involved, prior to understanding if such parties were known. Linked to this, 62% or young people were not concerned for their own safety.

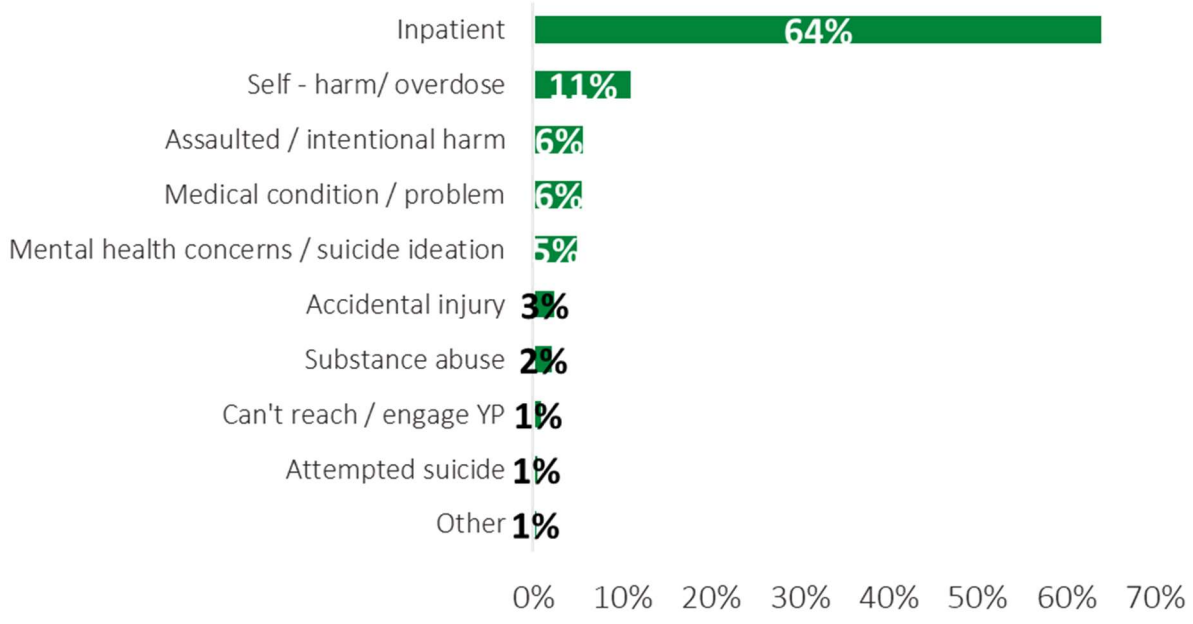
Figure 2.11: Other parties' relationship to young person



Source: A&E monitoring data, N= 54

Looking at injuries, the majority of young people (64%) were inpatients, indicating that navigators are engaging with those that have a requirement to be admitted to hospital rather than those that have been discharged, in line with their initial delivery plan. This further suggests opportunity to engage with young patients whilst in hospital, rather than retrospectively, depending on the severity of their injuries.

Figure 2.12: Injuries of young people



Source: A&E monitoring data, N= 1,001

2.8 Community Links Referrals

2.8.1 Leeds

As mentioned, **the Leeds Teaching Hospitals NHS Trust does not have a formal system of recording the proportion of engagements that lead to a referral after their interaction**. Additionally, they do not share data regarding the degree to which young patients engage with the Navigators. For example, numbers of interactions, reasons for disengagement or take up of referral. The Navigators do, however, hold anecdotal evidence and experience that informs upon this. In interviews they expressed that the majority of young patients do engage; and of those who do, the majority want to be referred into Community Links.

> "We record our rate, and 95% engage which is pretty good for our cohort. Some of the bravado slips away when you're in a hospital with a wound, and then there's an opportunity to build the trust" – **(Navigator)**

> "I'd say there's a really high engagement rate, probably around 90% want to be referred. However, monitoring on this needs to be improved" – **(Navigator)**

Both members of the hospital's Safeguarding team and the Navigators attend weekly meetings whereby patient cases are discussed and appropriate referral services for each individual are established, therefore giving opportunity for anecdotal feedback.

The lack of formal longitudinal tracking however limits the ability to evidence causality in line with the outlined aims, as there is minimal understanding of impact past the initial discussion between the young person and navigator. In addition, this hinders the level the intervention is able to achieve on the Maryland Scale.

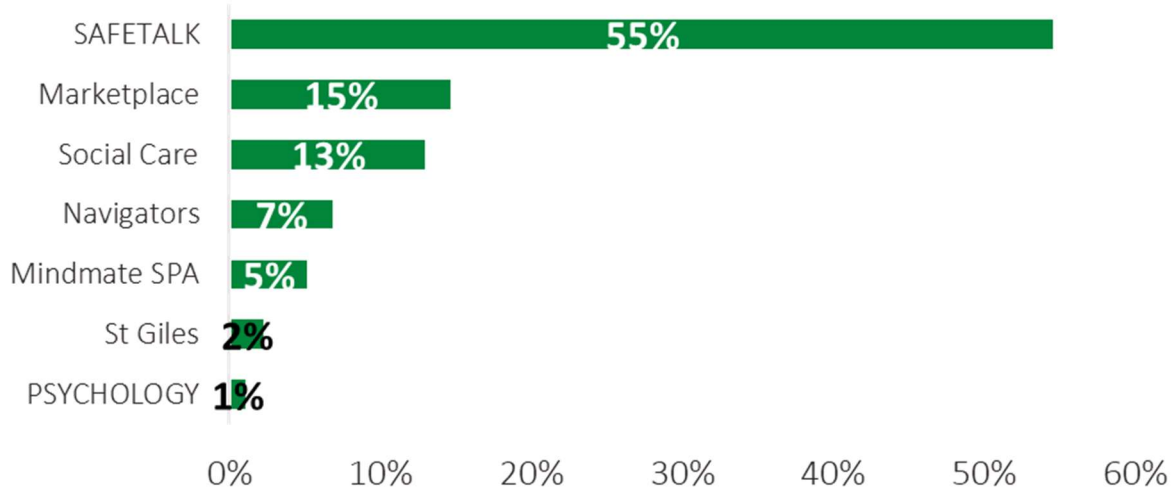
> "There's a multi-agency approach in terms of assessing the vulnerability of young people. We speak to safeguarding, and safeguarding speak to the young people themselves. Also any young person that has been involved in violent crime has a strategy meeting. These meetings look at the risk around the young person, what is and isn't working for them, we look at the circumstances around them, and a plan is put in place for the young person." – **(Youth service team member)**

Community Links related monitoring data indicates that around 5% of all referrals were already known to services, however this information is only available for less than 20% of all young people reported, indicating that it is not possible to fully understand the extent to which young patients referring were known to services or if the intervention was having any impact on the increased take up of services.

It should also be noted that over half (57%) of all referrals were reported as no action needed, however the reason for this is not clear regarding whether it is owing to disengagement, discharge from hospital, already being known to services or as the young person did not feel the need for support. More accurate reporting around reasons for no action would benefit the accuracy of impact reporting and increase understanding of progress towards outcomes.

Of those that were referred, SAFETALK stands as one of the primary services by which young patients are referred, accounting for 51% of all referrals, owing to be it being the commissioned Community Links organisation for the navigator intervention (Figure 2.13 over page). Young patients were also referred to mental health services such The Market Place and Mindmate SPA, with such services accounting for 20% of all referrals. We attempted contact with these referral organisations to ascertain some understanding around the take up of support, however such attempts were unsuccessful for the most part.

Figure 2.13: Referral organisations



Source: A&E monitoring data, N= 243

Anecdotally, both Navigators and hospital staff members agree that the **referral pathways between the Trust and Community Links are clear** and direct young patients towards receiving personalised support, which suggests the intervention is delivering towards the intended impact of increasing knowledge of pathways to services as noted in the ToC. The infrastructure connecting the Trust to Community Links is ensuring that patients are made aware of and have access to services which are designed to remedy their specific situation. In addition to this, it ensures that community-based services are supported with regards to identifying and supporting members from their target group, thus supporting the impact of improved identification of those needing support, as indicated in the ToC.

"I'd say there's a very clear pathway to Community Links. We have a clear criteria in place for what happens after A&E and I feel we also provide more targeted support. For example, we could give bereavement support rather than just general health / wellbeing support. So I think it has increased the use of young people's services, but again this is hard for us to track and monitor." – **(Navigator)**

"We've seen it's working well with our partner agencies. Even with children's social care they've already started to share that information with them. It really helps their services and level of engagement, and that they can get the right support to them. It's supporting the network there." – **(Safeguarding staff member)**

As part of our consultations, we were able to engage with two organisations that had received a small number of referrals as well as Safetalk, who further agreed that the pathway was clear, noting that there was a clear referral point that was being utilised, albeit in small numbers, to increase the caseload of the services and therefore increase their abilities to reach their target group.

Linked to this, they noted that the referrals that were coming through were appropriate, specifically with many related to knife crime. This also meant however that some were not at the appropriate point to receive support, as navigators were engaging them when they were still experiencing trauma. Whilst this may limit the take up of support, it is still providing a clear pathway of support and increasing awareness of the services available to young people that need it, as often it is their first time engaging with any services. Given this increased awareness and the fact some are engaging, referral organisations were confident that the provision of an A&E navigator can contribute to behaviour change, in line with the intended outcomes.

As navigators have no formal way of understanding the take up of referrals into other organisations, Community Links services have no formal pathway to report to the Navigators any changes with regards to their caseload, or developments with those referred into them. Resultantly, **Navigators and clinical staff cannot be sure of the degree to which the service is having an impact upon the amount of young people being referred into Community Links**. Linked to this, the small number of other referral organisations engaged indicated that they cannot specify figures for those being referred and taking up support, as there is no formal monitoring present.

Moving forward, a method in which to provide monitoring regarding the whole young person journey would be of benefit. This could be through regular engagement with Community Links provision in order to discuss the outcome of referrals, as well as discussing the appropriateness of the young people being referred.

"The missing piece for us is knowing if they're being used at the community level - what happens to kids when they refer them. Seems to be no checking and feedback to let us know. Navigators don't have the capacity to contact people that have gone through to see who has done what." **(Navigator)**

If we had more leadership involved, we would have more capacity to do the admin wraparound to find out the impact. For example in mandated safeguarding meetings, navigators can pick people up that have been missed, but this tends to only be for really vulnerable people' – (**NHS staff member)**

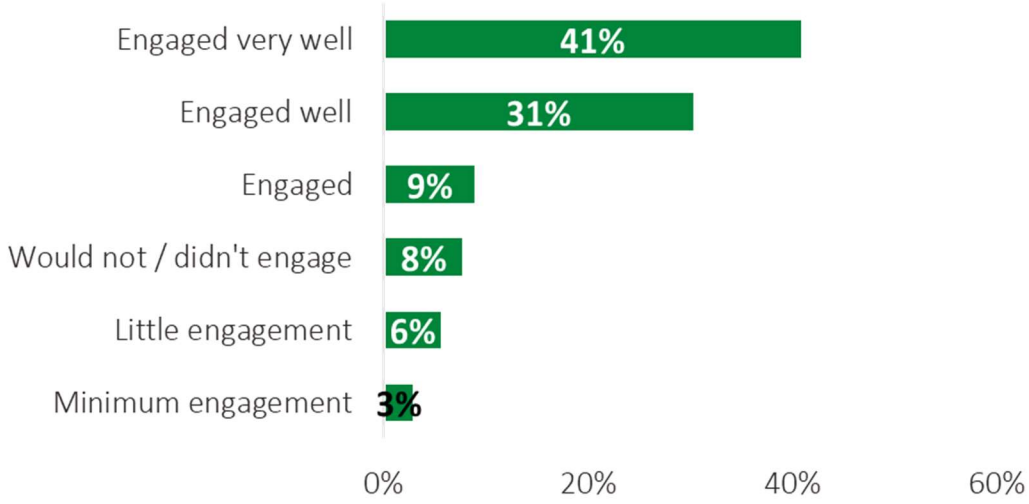
Additionally, there is no formalised system in place whereby Navigators can contact young patients referred onto Community Links and measure outcomes. Young patients can be contacted and invited to sit on quarterly meetings alongside the project team in order to give their verbal feedback on the service but aside from this, young patients are contacted on an impromptu basis, and there is no requirement to record details of these engagements. The lack of formal pathways make longitudinal data harder to track for all parties involved, further evidencing reasoning to provide monitoring for the whole young person journey.

2.8.2 Bradford

Through data monitoring, Bradford records both the degree to which a young patient has engaged with Navigators, as well as whether or not a young patient has been referred into Community Links services. Findings from this data suggest that whilst the majority of young patients engage well with the Navigators, only a minority go on to be referred into the Breaking the Cycle Community. Reasons for this however are not clear.

The majority of young patients were recorded to have had positive engagements with the Navigators, with 72% being recorded to have engaged 'well' or 'very well' (Figure 2.14). Those that would not or did not engage were often unavailable to be engaged at that time (e.g. patient was asleep or already discharged). According to data representing levels of engagement between Q1 and Q3 of 2022-23, 21% of young people who were initially engaged within the hospital setting continue to engage with Navigators following their discharge. This figure also therefore indicates that in the same period, 79% of young people disengaged from Navigator support following their discharge. Once again, the reasons for this are unclear.

Figure 2.14: Young patients's engagement level in A&E



Source: A&E monitoring data, N= 141

Community Links monitoring data indicates that 4% of young patients presenting at A&E had been referred onto the Breaking the Cycle Community or elsewhere, with 5% already known to the service, whereas 91% of patients required no further action to be taken following engagement. This however does not suggest that young people engaging with navigators are not receiving important support and information around pathways that can be utilised. As of the time of recording, project team members reported that the proportion of young patients engaging with Community Links had been on the increase, but data reflecting this claim had not been provided.

Like Leeds, Bradford has no formalised system in place by which young patients' progression can be tracked past their engagement with the Navigator service. Following their referral into Community Links, patients are contacted on an impromptu basis, and details of their engagement may be recorded via WhatsApp. There is no requirement, however, by the funder, for these engagements to be recorded or shared. Similarly to Leeds, Bradford also has no formalised system by which Community Links services can report back to the Navigators service regarding caseload and/or feedback from young patients. Therefore, the extent to which the project has resulted in an increased caseload for community-based services cannot be accurately ascertained.

2.9 Outcomes and impacts

With no (or a limited) system of tracking the developments of young patients in place, the longer-term impacts of the support cannot be reliably ascertained or evaluated against the outcomes in the ToC. Project team members, alongside clinical staff have expressed the need for a tracking infrastructure to be established if the services' outputs are to be assessed against the Home Office's aims around the reduction of youth violence. Longitudinal tracking and systems that monitor journey movement from start to finish are also required to uplift the level achievable on the Maryland Scale.

> "We don't know the effects of the referrals just yet because we don't have the data. It would be good to know if the other services have further data on that. There have been talks about getting in touches with certain services which we refer to most... seeing if we can use their existing database to get what we need, or start a project on it" – **(Youth service staff member)**

> "It's difficult to set up a robust tracking system when funding is only reconfirmed on an annual basis. It's also labour intensive to track young people longer-term but this is something that should be explored"– **(Youth service staff member)**

Both Navigator and clinical staff in both areas have reiterated that the service's impact on localised violence amongst youths and social / health inequalities is difficult to ascertain due the lack of a follow-up system and the nature of the funding model. With no established feedback loop with community-based services, the project team cannot easily access and record outcome data for patients undergoing and exiting Community Links. In the case of Bradford, impact data is informally recorded in case and intervention notes for individual young patients. Such qualitative formatting, however, is not in itself sufficient to evidence impact on a holistic scale.

> "I don't get a chance to speak to youth workers to find out what's happened. Anecdotally, they have positive conversations and some case examples of people who have had positive intervention. Some of those on the fringe of gang issues have been impacted positively" – **(Youth service staff member)**

In passing on learning, a representative from Merseyside VRU gave details of their follow-up pathway and how it operates. As part of their Navigator service, young people are contacted at set intervals following initial engagement to allow for the collection of follow-up data and feedback from young patients and other beneficiaries of the service (such as their parents or guardians). An activity such as this could support the uplift in Maryland levels.

> "Anything where they do consent to follow up… we'll then ring them a few weeks later. If we make a referral, they'll (A&E staff) follow up that and see if the (Navigator) service can get in touch of them. We have set points, there'll be a six week follow up. 3 months and 6 months…. Or (we'll do) a parent follow up. The parents feedback was really good"- **(Representative from Merseyside VRU)**

However, according to a project team member, due to the short duration of West Yorkshire VRU's funding contract, the team have been unable to establish an infrastructure to allow for such collection and the recording of follow-up data, as well as a formalised feedback loop with Community Links service. This aligns with the aforementioned broader evidence base, in which short term funding hinders the ability to embed systematic changes with delivery.

> "It's hard to measure the impact… every year they've (the project team) had to wait to see if the service is being refunded. Funding by the Home Office via the VRU, then this year waiting to find out how much they'll be receiving going forwards. It's not been straightforward. Each time colleagues have bene thinking if it's continuing rather than thinking how they can improve or expand.' – **(Youth service staff member)**

2.9.1 Engagement with young people

Staff generally feel that A&E acts as a reachable point by which Navigators can engage with young people, who may have otherwise have not been acknowledged by community services. The service reaches out to them at a time when they're vulnerable, meaning young patients may be more likely to engage with Navigators and accept support from Community Links.

> "On the ward it's easier; the young people are more vulnerable so they want to engage more to get help" – **(Navigator)**
>
> "Some of the bravado slips away when you're in a hospital with a wound, and then there's an opportunity to build the trust" – **(Navigator)**

Furthermore, according to one Navigator, delivery has been slightly altered since the project's inception to ensure confidentiality when talking with young patients and thus optimising levels of engagement.

"We've also started using private rooms on the ward after people get admitted to chat with them rather than on the general ward. I think this has meant young people are more willing to have an open conversation."– (Navigator)

Due to the nature of A&E, opportunities to engage and build up a rapport with young patients may be missed or obstructed as a result of their physical and/or mental state. Patients presenting with alcohol / substances abuse, injuries, illnesses and mental health problems may be less able or willing to engage with the service, however monitoring indicates that this cohort may be small. In addition, it is important at all times that the medical intervention required takes priority, thus it may not always be appropriate to engage the young patient at the point in which they are initially referred. To that end, it is useful that navigators are able to engage retrospectively, albeit anecdotally it was noted that this may have a lower engagement rate. Moving forward, there would be benefit in including such information in the monitoring in order to better understand the most effective engagement method or teachable moment point.

"A lot of things are obvious to us; might be alcohol for example. All the time patients are waiting in the department could be a good time to intervene. A lot of people are still drunk in the waiting period, but others may be appropriate" – (NHS staff member)

"It's rare that they're (engaged) in A&E; it's after they've been discharged. I think it's hard to get in touch with them, and I get completed assessment forms of no contact for weeks. Young people don't answer the phone or reply to texts. If they see them on the wards they can play games and it's a bit easier" – (NHS staff member)

2.9.2 Navigating consent

The Navigator service, as carried out in Leeds, does not require the consent of a young patient to accept referrals made by clinical staff on their behalf, as navigators are employed directly by that NHS trust. Staff working at the emergency department have expressed the utility of bypassing consent in certain circumstances.

> "It's case by case if I tell them or not. If I have a rapport built, I'll let them know about the service and that I'm going to do it (refer them), or sometimes it's just a referral. Good to be able to bypass the consent as the group of people often don't like to engage with services. Often there'll be police present, so they think you're trying catch them out in front of police" – (NHS staff member)

This approach however, whilst potentially increasing engagement, may have implications for general levels of trust between young people and healthcare / community services. Furthermore, young people referred to the Navigators without having given consent may refuse to engage with the service. With that said, it was noted that overtly obtaining consent and ensuring the young patient is aware can support the engagement moving forward.

As Navigators in the Bradford service are employed by the Council, rather than the Trust, clinical staff cannot bypass young patient consent and refer them into the service. This means that there is additional pressure on Navigators in Bradford to successfully engage young patients with the service in order for referrals to be sent. It may also mean that the number of referrals to Bradford's Navigator service is less than what it would be had the Navigators had the ability to bypass patient consent, as referrals then become dependent on the young person's willingness to engage with the service.

> "It is a voluntary engagement that enables young people to have a safe space in which to talk and for them to feel less alone in what has happened to them" (Project team member)

A representative for Greater Manchester's VRU has highlighted issues that their respective Navigator service experienced around the consent-based model of youth engagement. They stated that it was easier to obtain consent once the service was further integrated into emergency departments, and A&E staff received briefings on how to engage with young patients.

> "We had some difficulties with regards to communicating what Navigators are to the A&E staff… (We had to) figure out how to best approach the young people; we operate by a consent based model, so it was figuring out how to do everything and send referrals with (their) consent. We've overcome this now, had more face to face briefing with staff to aid delivery" – (VRU representative, Greater Manchester)

In this sense, issues around consent may be minimised by ensuring that opportunities for learning between Navigators, members of safeguarding / children's team are created, facilitated and embedded into delivery.

2.9.3 Emotional impact

According to Navigators, **one of the primary impacts of the service is the emotional support that young patients can access during a vulnerable and reflective moment within their life**. For patients that do not have a social support system in the form of family / friends / teachers, Navigators can step in to offer them personalised and meaningful support;

> "I think it's really about supporting someone that's just undergone a really traumatic event. Usually we're their only port of call as they won't tend to have family/friends come and visit them. A lot of the young people don't have that initial advice on what to do, so I think that initial support we provide is crucial." **(Project team member)**
>
> "In terms of long-term impacts, it's a really good opportunity to build a relationship with the young people... I feel we do everything we can to provide the community support" – **(Navigator)**

Navigators have also identified in particular the services' impact upon young patients from disadvantaged communities and / or those living in deprived neighbourhoods. Patients from these groups appear to be the primary beneficiaries of the service. In this sense, the service may contribute towards the reduction of health inequalities, whilst this is not a specific outcome of the intervention, as young patients are brought into the reach of community support services;

> "The most basic and main impact is; young people who didn't have that information now have it. When you look at the cohort on it, we look at the socioeconomic factors impacting these young people… those who are the most disadvantaged are suffering from the worst violence. To those young people, it's reproducing health inequalities, they're now getting access to extra support that they wouldn't otherwise get access to. Someone to reach out to them, someone who is a trusted adult." **(Navigator)**
>
> Particularly for the serious violence it's trying to catch things before something really serious happens. Prison and hospital are the two things you don't want to happen" – (**Navigator)**

Whilst not representative of the support as a whole, feedback we received from the one young person commenting on the Navigator service highlighted the effectiveness of the support in learning to control their emotions and having support to mediate any family issues, noting that this support comes without judgement. If feedback such as this could be duplicated on a larger scale, it would provide strong evidence for the positive impact the intervention is having.

2.9.4 Supporting the reduction of A&E incidences

Interviewees expressed belief that the project was having a positive impact on reducing the frequency of repeat attendances and attendances to A&E, however this cannot be evidenced in the absence of longitudinal monitoring data and nor is it accounted for in monitoring data. Whilst in Leeds, staff in the emergency department have been undertaking audits of readmittance rates to A&E, neither Bradford nor Leeds have established systems in place to monitor changes in rates. This is owing to it not being a priority within the Trust given that is it not primary NHS delivery, exacerbated by short term funding, NHS staffing issues and uncertainty around the future of the Navigator system.

Whilst Navigators in Bradford's service cannot access patient medical records, information regarding reattendance rates may be recorded within case and intervention notes for young patients referred onto Community Links. Project team members have reported anecdotally that the service is contributing towards a reduction in these rates; however this has not yet been evidenced through monitoring data.

Navigators in Leeds can, in theory, check if a young patient has been repeatedly admitted to A&E. This does not appear to be a requirement within the monitoring data, however, and interviewees have reported that they do not have sufficient evidence to suggest that the service is reducing repeat incidences or attendances.

> "This is hard to measure. We've had people that have been referred to us repeatedly, but this is quite a low number. It does have a positive impact, but it's hard to put in numbers" – **(Navigator)**
>
> "It's targeting the right people; the service is well known in terms of violent injuries. At the start, I noticed a lot coming back repeatedly and I've not noticed that as much recently"- **(NHS staff member)**

Audits on reattendance incidents are also complicated by the frequency of patients who attend A&E seeking non-emergency care. Due to difficulties in accessing healthcare, patients may attend A&E seeking general treatment and therefore cannot be counted within measures designed to represent levels of violence amongst local youths.

> "We've got junior doctors doing audits on readmittance rates. It's hard to know because emergency care has changed to make it more difficult to judge. Access to healthcare is so limited, so they (young people) come to ED as it's the only place to come."- **(NHS staff member)**
>
> So many patients wait hours and still don't leave when they know they have to keep waiting for other health problems… so (we) have to look at why they're attending"– **(Youth service staff member)**

A lack of clarity and formal monitoring around reattendance rates appears to be an issue affecting Navigator services outside of West Yorkshire also. Representatives of both Leicester and Merseyside's VRU were unable to inform as to whether or not their services had contributed toward a reduction in reattendance in their respective services, whilst representatives from Greater Manchester's VRU could partially inform.

> "(We're) not sure about attendance rates with regards to data. It's difficult getting information from hospitals… Compared to 2018/19, 2021/22 had 20% less admissions with sharp bladed attendances, and that was a trend across Greater Manchester. But we can't really provide evidence for our part in that."- **(Representative from Greater Manchester VRU)**

This comment from a representative of Greater Manchester's VRU suggest that consent-based delivery models, such as Bradford's, may face more barriers to measuring readmittance rates, and resultantly may face more barriers to measuring the impact of the service. This is due to the fact that the youth workers working alongside such models do not always have access to patient records and must rely on the hospitals to provide this data. Resultantly, if services such as Bradford's were to be recommissioned, it may be a consideration whether or not to adopt a more embedded delivery structure whereby youth workers are provided for by the hospital and have access to patient records. This may make it easier to measures impacts such as readmittance rates in the long term.

2.9.5 Improving relationships between young people and staff

Some interviewees agreed that their project had been **improving relationships between young patients and staff**, in line with the impact of improved trust in services as per the ToC. Since the eligibility criteria for referral into the Navigator services are generally broad, young patients presenting with a range of problems can access support through the Navigators. This may improve young patients' perception of healthcare staff since they can be seen to be offering personalised support based on patient need as opposed to making their service exclusion to those presenting as victims of violence.

> "It's improved awareness a lot. It's a credit they're doing inappropriate referrals because it shows they're seen as a service that's willing to help. And a team that's willing to help. It is that relationship building. Being more visible in the department is great and means people understand their role" – **(Safeguarding team member)**

Navigators appear to be unsure of the degree to which the project has had an impact on the relationship between young patients and staff. Whilst, at the time of this report's publishing, research is being conducted to gauge the services impact on relationships within Bradford's service, most claims of positive impact across the two services remain anecdotal. The lack of clarity around this subject may also be due to the fact that clinical staff may be perceived as solely performing administrative or medical role, as opposed to an emotional or supportive one. Young patients may not therefore identify the staff as actively trying to help them over and above their medical need.

> "Not sure it's having a negative impact on relationships with clinical staff, but (I) can't see it having a positive one. It's more just a question of, 'are you happy for a referral?'" – **(NHS staff member)**

> "I'm not sure. Usually staff in A&E just refer on. We're trying to make it easier; before they would have to fill in forms which might create a block. All the (staff) have to do is make a phone call. Then the navigators would pick it up" – **(NHS staff member)**

Some interviewees have indicated that **having Navigator staff physically on the ward may improve the relationship between staff and young patients**. If the clinical staff could be seen working alongside the Navigators, patients may begin to identify the former more so with the forms of emotional and social support provided by the latter. This may also support the intended impact of improved information sharing between services as per the ToC as navigator services will be more visible to share information and learning with.

> "(I) tried to engage a Navigator once to check age range, but often it goes to the answer phone. Staff don't really engage them (Navigators) other than the referral, it's never really a person you can see or speak to. I think it would be good for them to be on the ward" – **(NHS staff member)**

3. Maryland Scientific Methods Scale

Based on our assessment of the A&E Navigator programme, there are several options for supporting the intervention to work towards a higher Maryland SMS level. However, this will require a fundamental review of data sharing agreements and processes as well as practical, resource and ethical considerations.

One of the key barriers to enabling these interventions to achieve the higher Maryland SMS level is the current short-term funding arrangement. Several stakeholders suggested a degree of reluctance to put in place more robust data collection systems, most notably to enable longitudinal tracking on young people reached through the A&E intervention, in the absence of any security around their longer-term funding.

More broadly, as outlined in our report, there are several comparable navigator schemes operating across the UK. In England, many of these are commissioned and funded by VRUs. This raises a question as to whether the Home Office should consider standardising an approach to monitoring and impact measurement to facilitate data aggregation and comparability. At present, and as evidenced in our report, each scheme operates a different approach which serves to limit collective learning across the VRU network and the potential to reduce duplication between different schemes.

Our assessment is that the current interventions are generally aligned with Level 1 on the Maryland SMS, albeit there are gaps and limitations even at this level. As outlined in the feasibility study plan produced by The Behavioural Insights Team,[14] there are trade-offs regarding what is observable and/or measurable and whether this is measurable within the delivery timeframe of an intervention. For example, observing or measuring aspired to impacts such as reductions in criminality, arrest rates or rates of young people being Not in Education, Employment or Training (NEET) or increases in employment rates, improvements in health and wellbeing and life expectancy is in itself challenging. Assigning a level of attribution or assessing the causal links between the reachable moment achieved by A&E navigator services on to the teachable moment delivered by Community Links, presents further complexity and challenge.

The Behavioural Insights Team, along with other evaluators,[15] recommend that research teams draw on multiple data sources, both quantitative and qualitative, to improve the validity and reliability of findings.

[14] The Behavioural Insights Team (2021)- 'Feasibility study plan: Multi-site evaluation of practices: Hospital Navigators'.
[15] See Limitations of the study section of The Health Foundation & Nottingham University Hospitals NHS Trust (2020)- 'Redthread YVIP Adoption and Spread'.

This should include the use of administrative data, measurement of behavioural outcomes using validated tools, and the ability to evidence and analyse control, research and mechanisms of change at different stages of the delivery pathway. This is currently lacking in the A&E and Focused Deterrence intervention models and, as a result within the work of the Community Links interventions. What is also evident in our evaluation, and of comparable evaluations of navigator services, is the absence of any youth voice in the process. This, in part, is due to the difficulties in securing input from young people at different stages of the pathway, including the absence of the necessary data sharing systems and data consents to access young people. But it is also because of an absence of sufficient resource to enable the voice of young people to be meaningfully embedded in the delivery process.

To this end, **we recommend that the VRU and commissioned services adopt Lundy's rights-based model of youth participation** (Figure 4.1).[16] This will help to embed a core set of principles in the delivery of each intervention to ensure that there are clear, creative and realistic opportunities for young people to express their views and influence future delivery models. This should be regarded as a core and consistent thread across the three interventions and as part of any future data capture and impact assessment process.

Figure 4.1 Lundy's rights-based model of youth participation

[16] Source: www.participationpeople.com

With specific reference to the different levels on the SMS, we provide below our recommendations for changes to the monitoring processes across the three interventions to enable a higher level to be achieved. Crucially, these cannot be actioned in isolation but rather require a whole system approach and sufficient resourcing to enable longer-term tracking from 'reachable' moment to 'teachable' moment and beyond.

3.1 Unique IDs

At present, there is no system to enable linkage between the different providers involved in support a young people from the initial point of engagement, through to onward referral and then support via community-based provision. This limits the ability to track a young person's subsequent engagement with NHS services (A&E attendance), or targeted youth provision. **Being able to establish a unique ID that can be matched with NHS patient records and the police database will enable a more accurate picture of impact to be assessed and determine whether a young person is known to statutory services.**

The A&E Navigator services provide referrals into Community Links and other targeted, early help provision. However, there is currently no tracking to determine what proportion of young people referred subsequently attend the community-based provision or the outcomes achieved. Conversely, there is no tracking in place to ascertain what happens to young people that declined a referral. This limits the ability for the interventions to achieve Level 2 or higher on the Maryland SMS. Other navigator services have put in place systems to undertake a 6-month follow-up with young people supported to ascertain their current situation and undertake an assessment using a validated assessment tool. Data is also required to determine whether the young people referred into Community Links were already known to the contracted provider as this would provide a measure of additionality delivered by the A&E navigator service.

3.2 Comparison group

Achieving Maryland SMS Level 2 and above largely requires the ability to establish a comparison group to provide a counterfactual (i.e. what would have happened in the absence of the intervention). The ability to establish a true comparison group differs between the A&E and Focused Deterrence interventions. For both, there are also ethical considerations related to a cohort of young people being regarded as outside of a 'treatment' or scope of intervention.

Within the intervention, a comparison group would be a cohort of young people who are eligible for support through the intervention but who decline to engage. It is highly unlikely that this group would consent to be contacted as part of any follow-up evaluation activity.

As such, the exercise in comparing outcomes for the intervention group against the comparison group is likely to be based on administrative data derived from patient or police records as opposed to primary consultations.

Whilst this has limitations, it would enable the use of techniques such as regression or the use of propensity score matching[17] to be used to adjust for differences in the intervention and comparison group. This would in theory enable the intervention to achieve Maryland SMS Level 3, although the complex and multi-faceted nature of factors that may result in a young people presenting at A&E may lead to difficulties in calculating the attribution rate and the absence of any qualitative data may lead to difficulties in testing causality.

The feasibility of establishing a comparison group for young people that take up and engage with the offer of support provided by Community Links requires further discussion amongst partners. What is perhaps more feasible is undertaking a before and after comparison of the intervention group and using control variables to account for before and after changes in macro level factors. This would achieve Maryland SMS Level 2. To do this, Community Links providers would need to undertake an initial vulnerability assessment. This would achieve Maryland SMS Level 2. To do this, Community Links providers would need to undertake an initial vulnerability and/or risk assessment to establish a baseline and then to follow this up at appropriate points to determine distance travelled and progress against desired outcomes.

The exact process of undertaking this assessment will need to be consistent with Lundy's rights-based model of youth participation and secure sufficient buy-in from the frontline staff providing support from Community Links providers. This will likely require work to agree both the assessment tool used and the process by which it is administered. Further work will also be required to agree suitable control variables such as dosage (number of sessions), quality (of the support provided) and participant profile (for example age, education or employment status). This approach may also need to consider the potential to draw on wider data such as the presence of Adverse Childhood Experiences,[18] in particular to avoid re-traumatisation.

[17] Propensity score matching (PSM) is a quasi-experimental method in which the researcher uses statistical techniques to construct an artificial control group by matching each treated unit with a non-treated unit of similar characteristics.

[18] For example: Physical abuse, Sexual Abuse, Emotional Abuse, Living with someone who abused drugs, Living with someone who abused alcohol, Exposure to domestic violence, Living with someone who has gone to prison, Living with someone with serious mental illness; and Losing a parent through divorce, death or abandonment.

3.4 Cost benefit analysis or cost consequence modelling

Lifting the three interventions to Maryland SMS Level 2 or Level 3 would help to underpin any credible cost benefit analysis (CBA) or cost consequence modelling. The CBA produced for Redthread's YVIP provides a useful resource to identify what core data is required to support any modelling or calculations.[19] This includes:

- Number of young people reattending hospital for assault-related injury in the 12 months following the intervention.
- The proportion of young people involved in violence with in the 12 months following the intervention.
- The number of young people involved in crime in the 12 months following the intervention.
- The proportion of young people either staying with/or moving into education, employment or training in the 12 months following the intervention.

The above neatly demonstrates **the need to access patient records, police and court data and data from local authority education welfare services or the Department for Work and Pensions to track these indicators over a 12-month period** (and potentially beyond). Also required is a true calculation of the intervention cost, which is likely to extend beyond the cost of the interventions themselves to include other statutory and non-statutory provision.

As with the CBA produced by Outcomes UK,[20] this data will enable recognised, published cost sources[21] to be used to model the costs avoided or saved because of the positive outcomes achieved for the young people reached through the interventions. Without access to this data and given the absence of any robust systems for tracking the journey of young people from the respective 'reachable' moments delivered within the A&E units into the 'teachable' interventions delivered by Community Links, we are unable to provide any credible estimate or assessment of overall value for money.

What this means is that the existing ToC makes reference to a series of outcomes that would contribute to financial savings and social cost benefits, but where this cannot be evidenced.

[19] Outcomes UK (2020)- 'Redthread's Youth Violence Intervention Programme: A Cost Benefit Analysis and case for scaling across hospital Emergency Department locations.'
[20] Ibid
[21] Includes: Heeks et al. (2018). 'The economic and social costs of crime.' Home Office: London, Malik et al. (2020) ''Violence-related knife injuries in a UK city; epidemiology and impact on secondary care resources.' EClinicalMedicine 20 (2020) 100296 and New Economy Manchester (now GMCA Research Unit) Unit Cost database v2.0.

In addition, our team are **unaware of any quantifiable targets that have been assigned to the interventions** which limits our ability to model what potential cost benefit ratios or cost consequences could be should these be met. For example, what is the target for reducing A&E attendances as a result of the intervention or how many young people are envisaged to reengage with education, employment or training following support through Community Links?

Several of the envisaged outcomes outlined in the ToC relate to broader changes such as improvements in mental health and wellbeing, reduced inequalities, improved life expectancy or improved trust in services. Although tools such as the HACT Social Value Bank[22] can assist with assigning financial metrics to a range of outcomes, including those relevant for the VRU, what is needed is a clear understanding and agreement between the VRU and the commissioned providers on the primary outcomes to be measured and over what timeframe impact is to be assessed.[23] What we do know from the evidence base is the projected cost benefits based on comparable (but importantly not matched) interventions.

3.4.1 Projected cost benefit for A&E interventions

The cost benefit analysis produced by Outcomes UK based on Redthread's YVIP across hospital Emergency Department locations[24] captured data from young people at 6 and 12 months following their engagement. **The report highlights a £4.90 benefit per £1 spend on YVIP, with the cost benefit spread across several public organisations and agencies**. The report also highlights that the intervention is relevant and impactful in addressing violence prevention for a range of Adversity Related Injuries (ARIs) beyond those that are knife-related. One of the conclusions from the research is that benefits are realised over varying timeframes, as expected as part of a public health approach to violence prevention.

One of the issues raised in the report by Outcomes UK[25] is also discussed in report by Liverpool John Moores University,[26] namely the challenge of securing investment from an individual hospital to fund a service that is delivering a broad range of outcomes for non-health care settings. This is a relevant consideration for the VRU in making a case for investment to mainstream or sustain funding for the intervention within A&E.

[22] View details of the HACT Social Value Bank
[23] This is important given that some outcomes may accrue over time and any cost-benefit analysis may need to factor in Net Present Value (NPV) calculation.
[24] Outcomes UK (2020)- 'Redthread's Youth Violence Intervention Programme: A Cost Benefit Analysis and case for scaling across hospital Emergency Department locations.'
[25] Ibid
[26] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.

The evidence base includes different cost-benefit ratios and estimations, which highlights the **absence of a standardised and adopted CBA methodology for assessing navigator services operating with Emergency Departments**. For example, Florence et al[27] economic evaluation of a long-standing ISTV programme demonstrated a large societal benefit cost ratio of £82 for every £1 spent. The technical toolkit report produced by the Youth Endowment Fund reported that programmes have a large desirable impact on offending outcomes, estimated to be equivalent to a 38% reduction in crime and violence, albeit the authors acknowledge that this result is based on a small number of studies.[28]

A further report looking at the cost of violence to the healthcare system in Wales[29] indicated that 84% of the short-term costs are associated with addressing the consequences of interpersonal violence, rather than self-inflicted violence. **The average cost calculated within this study of medical requirements of A&E interventions resulting from physical harm and violence was estimated at £1,254 per patient who required medical treatment**. These costs were offset against those calculated for ambulance call outs, A&E attendance and emergency admissions. The below table shows the calculated unit costs of injuries. Interventions such as navigators that can contribute towards the prevention of A&E incidences can be said to produce a cost avoidance to A&E departments, as such making it a worthwhile intervention.

Table 4.1 Prevalence of harms and medical requirements following injury

Type of injury	Prevalence of harm among victims	Medical requirement following injury	Unit cost
Minor bruising	59%	0%	£0
Severe bruising	28%	29%	£1,262
Scratches	21%	0%	£0
Cuts	27%	36%	£930
Stabbed	4%	68%	£1,265
Broken bones	6%	85%	£3,097*
Nose bleed	7%	0%	£0
Broken nose	2%	100%	£1,199
Lost teeth	2%	84%	£300
Chipped teeth	2%	100%	£156
Dislocation	2%	39%	£930
Concussion	2%	86%	£732
Internal injury	1%	0%	£0
Facial injury	1%	36%	£930
Eye injury	0	0%	£0

Source: : Heeks et al. (2018). 'The economic and social costs of crime.'

[27] Florence, C., Shepherd, J., Brennan, I. and T.R. Simon (2014)- 'An economic evaluation of anonymised information sharing in a partnership between health services, police and local government for preventing violence-related injury'. Injury Prevention, 20(2), pp.108-114.
[28] Gaffney, H., Jolliffe, D. & H. White (2021)- 'Emergency department violence interventions'. Toolkit technical report. Youth Endowment Fund. November 2021.
[29] Costs of violence to the healthcare system in Wales, Public Health Institute & Liverpool John Moores University (2020)

Although it is possible to apply existing cost benefit methodologies used for similar A&E interventions for the services commissioned by the VRU, it is better for the exact approach and necessary construction of more robust monitoring and data capture processes to be agreed and owned by the commissioner and delivery partners. Any continuation and/or expansion of the A&E intervention should be preceded by a workshop session to consider these issues prior to commencing delivery.

4. Conclusions and recommendations

4.1 Conclusions

West Yorkshire VRU commissioned Wavehill to undertake an impact evaluation of the A&E Navigator programmes established within Leeds Teaching Hospital NHS Trust and Bradford Teaching Hospital NHS Foundation Trust, and the work of the Community Links provision.

Our evaluation has focused on providing the VRU with a better summative understanding of the impacts of the interventions in the West Yorkshire context to inform and improve future implementation and delivery. There are positive impacts of the delivery of the A&E Navigator and intervention with Community Links. This has engaged with vulnerable young people in line with the intended audience and contributed to increased use in services and therefore potential decreases in violence, criminality and A&E admissions.

Whilst there are gaps in the data that hinder the representativeness of the sample, it is possible to draw some conclusions regarding demographics. The interventions is most commonly engaging white males aged 12 to 16, and available data (albeit minimal) indicates that those engaging are from more deprived neighbourhoods. Ethnicity varies across location of the intervention, with the majority in line with that of ethnicity in the West Yorkshire area in accordance to the most recent census data.

For A&E, the evidence base highlights that a large proportion of patients who engage with comparable services present with more than one social issue, the most common of which included alcohol misuse, drug misuse and violence. When presenting at A&E, and in line with the evidence base, the majority of patients have more than one presenting issue. Data available, whilst not fully representative, indicates that patients are involved in violence along with mental health support requirements. In Leeds, only 5% of those referred were already known to services, thus suggesting the intervention is working towards increasing awareness and subsequent caseloads of Community Links support.

The lack of longitudinal data collection across the intervention referring into Community Links hinders the ability to fully assess the extent to which the intervention is meeting the intended outcomes and a causal attribution to the overall aims around A&E admittances. This has been exacerbated throughout our evaluation by the inability to engage with young people that have received support and understand the direct impact this has had on them. In addition, limitations to the monitoring data points to an under reporting of those supported.

With this considered, anecdotally, staff and stakeholders interviewed believe that the services are having a positive impact on reducing the frequency of repeat attendances to A&E.

In order to strengthen the interventions, navigators in A&E would benefit from being more visible within the ward, and more embedded within day to day practices to ensure effective information sharing.

Regarding the Maryland Scientific Methods Scale, our assessment suggests that the current interventions are generally aligned with Level 1. This is partly owing to the lack of longitudinal data provision and unique identifier, which would support data collection throughout the participant journey. One method identified to improve this level would be to adopt Lundy's rights-based model of youth participation, as this would embed core principles that could be employed to support focused data collection.

In the absence of follow up data and quantifiable targets, it is not possible to construct a robust cost benefit or cost consequence model to the interventions. However, broader research undertaken with similar interventions points to potential cost benefits. Notably, research indicated that it is hard to gain investment within a hospital for A&E interventions, thus making a case for investment from elsewhere.

4.2 Recommendations

1. In Leeds, there is logic for A&E navigators to be based only in the Leeds General Infirmary, to mitigate travel time between locations and support delivery efficiency. In Bradford consideration should be given to adopting a more embedded delivery structure whereby youth workers are provided for by the hospital and have access to patient records. This may mitigate issues around consent by ensuring that opportunities for learning between Navigators, members of safeguarding / children's team are created, facilitated and embedded into delivery through more formal team connections.
2. Developing a formal network to share information more broadly throughout both services with both police and medical staff rather than only staff working within the intervention would be of use, and will support overall service provision for young people.
3. A method to provide monitoring regarding the whole young person journey would be of benefit. This could be through regular engagement with Community Links provision to discuss the outcome of referrals, as well as discussing the appropriateness of the young people being referred. To complete this, we would recommend a unique identifier per young person used in line with recommendations to increase the Maryland Scale. Improvements to longitudinal monitoring would support robust cost analysis.
4. The ability to engage with young people retrospectively once they have been passed to Community Links support would be beneficial in order to collect more impactful data that may not have been appropriate to collect alongside the medical intervention taking place. This could support impact evidence whilst also providing understanding on the most effective engagement method or point.
5. More accurate reporting around reasons for no action for those engaging A&E Navigators but not Community Links would benefit the accuracy of impact reporting and increase understanding of progress towards outcomes.

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