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Greater Manchester Violence Reduction Unit

Hospital Navigator Pilot - Implementation Evaluation

February 2024

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1. Executive Summary

Introduction

In December 2020, the Greater Manchester Violence Reduction Unit (GM VRU) commissioned a hospital-based 'Navigator' violence reduction pilot programme in four hospitals. The Navigator programme became operational in May 2021 and was initially funded until April 2022, prior to being recommissioned until March 2025.

The Navigator programme seeks to support those young people (aged 10-25) who attend or have been admitted to an adult or paediatric Emergency Department (ED) with injuries or hospital ward resulting from violence. It aims, through offering support at a '*teachable moment*', to help young people to cope and recover from their experiences, to prevent retaliation, the escalation of violence and / or repeat victimisation, and to reduce exploitation. Where on-going needs are identified by Navigators, the programme endeavours to support young people in the community and refer them to other services for ongoing support.

Description of the implementation evaluation

The evaluation methodology was designed to address the following research questions:

- Was the pilot programme delivered as intended?
- What were the stakeholders' (Hospital staff, Navigator staff and VRU leads) perceptions of the Navigator programme?
- What worked well and what might be improved?

To address the research questions, it was determined to undertake the following steps:

- Develop a map of the client journey in the Navigator programme
- Develop a theory of change for the Navigator programme
- Undertake a quantitative analysis of Navigator client data
- Undertake a qualitative analysis of Navigator and key stakeholder views of the Navigator programme

Key Findings

The Navigator programme has evolved. A series of **client journeys** have been developed to illustrate these changes: a pre-intervention client journey; a client journey at 5 months, reflecting the distinct client advocacy and support stages of the programme; and a Navigator triage client journey, reflecting the commissioning of a 'community' Navigator service and its integration with the hospital-based programme.

Over its first two years of operation, the Navigator programme received 637 referrals (621 young people). Of these referrals, 276 (43.3%) young people were received into the service. 214 young people (77.5%) went on to receive one-to-one support and 269 young people (97.4%) had recorded professional sessions where the Navigator would have been involved with professionals and/or parents in relation to the case.

Over four fifths of referrals were made because of a young person attending the hospital with a violence-related injury. Almost three quarters of referrals were male, and most referrals were aged between 13 and 17 years old. Just under half of all referrals were of White ethnicity. However, there were many referrals for which the ethnicity of the young person was either not given or recorded.

Of the 276 young people received into the programme, around one-quarter (n=75 participants) completed a baseline questionnaire. This was used to assess young peoples' lifestyles, feelings of safety and support, experiences of violence and mental well-being. The same set of questions were also asked of young people on their exit from the programme, enabling the evaluation of the *distance travelled*[1] by young people during their engagement with the programme. A relatively small number of young people (n=51 participants) completed the exit questionnaire. However, the findings indicate **positive and statistically significant improvements in young peoples' lifestyles, feelings of safety and support, experiences of violence and mental well-being.** Unfortunately, the Navigator programme has not be able to undertake follow-up assessments of young people (at 6 months) as was originally intended.

Due to the limitations of the hospital admissions data made available to the evaluation, it is difficult to gauge the potential volume of demand (i.e., young people eligible to join the programme) presenting at hospital. Data quality was affected by both IT and resourcing issues across the hospitals. The data made available to the evaluation differs substantially from the TIIG (Trauma & Injury Intelligence Group) data provided by Liverpool John Moores University (LJMU) to the VRU. The admissions data is suggestive of significant variation in the referral practices across hospitals. Hospital staff perceived that the physical presence of a Navigator in a hospital was associated with a higher referral rate.

The **stakeholder interviews** provided valuable insight of the perceived need for, and development of, the Navigator programme:

[1] 'Distance travelled' refers to the progression of programme participants positioned against a set of soft outcomes, measured at the beginning and end of their engagement with the programme, that lead towards associated hard outcomes (Dewson *et al.*, 2000).

- Stakeholders regard the Navigator programme as meeting a pressing need for such a service. However, they are concerned that the demand for programme is not being fully met by the current level and deployment of Navigator staffing.
- Stakeholders believe that the presence of Navigators in hospitals is helpful in supporting an effective and smooth referral process. However, Navigators are not always present in hospitals. Stakeholders suggested that there should be a team of Navigators present for longer hours at each hospital, believing that this would ensure greater recognition of the programme by hospital staff and support an improved referral process.
- Stakeholders praised the Navigators for the way in which they have engaged and managed relationships with other agencies working with young people.
- Stakeholders perceived the programme to have reduced the motivation for retaliation by young people and helped others to cope with their vulnerabilities arising from experiencing violence.
- Stakeholders recognised that the variability in access to patient data across the hospital sites remain a barrier to the effective working of the programme, i.e., inhibiting the referral process.
- Stakeholders were concerned about the sustainability of the programme, once its VRU funding comes to an end.

The **Navigator focus group** illuminated an evolving and expanding programme. The development of a community-based Navigator programme and its interface with the hospital programme has been broadly welcomed as a valuable advance. The key findings of the focus group can be expressed as follows:

- The Navigators have devoted a substantive amount of time to fostering trusting relationships with hospital staff and promoting awareness of the programme. Both are seen as vital to the efficacy of the programme.
- The Navigator programme was designed to support the assessment and referral of young people presenting with violence related injuries in hospitals into ongoing support. In practice, however, Navigators have been drawn in to providing extensive informal advocacy and one-off support on behalf of those young people who do not formally consent to enrol on the programme. This large group of young people do not complete a baseline assessment. This proves a barrier to determining the overall need for and efficacy of the programme.

- Navigator access to existing hospital systems and patient data has remained problematic throughout the implementation phase of the programme, inhibiting the operational identification, and tracking of eligible young people presenting at hospitals. The limited access to, and poor quality of data, poses a barrier to the establishment of a robust impact evaluation.

Recommendations

The Presence of Navigators in hospitals: It is essential that a clear and consistent approach is developed to guide Navigator presence in hospitals and to balance this role alongside the other activities (i.e., work in the community) that Navigators perform. The Navigator programme needs to plan the presence of workers in emergency departments (EDs) and hospital wards, to maintain both programme promotion and relationship building, given the high turnover of hospital staff. It may be appropriate to embed Navigator programme information in hospital training and briefing documentation.

Longer lead-in and operational periods: To provide an effective intervention, sufficient time must be allowed to enable Navigators to build up a trusting relationship with a young person (prior to their formal engagement with the programme) and to commence the address of their challenges. This requires being comprehensively budgeted. Engagement with a young person requires to extend beyond contact in emergency departments and hospital wards to include contact in community settings. To ensure (and demonstrate) the sustainability of any improvement in a young person's well-being, more resource should be devoted to a longer-term follow-up. Information on a young person's outcomes should also be incorporated into a formal feedback process to ED staff. Data should be collected from such client follow-ups to inform an impact evaluation.

Navigator integration into hospital teams and access to patient data in hospitals: Navigators require being given honorary contracts to enhance their acceptance by other staff in the hospital. Navigators require being granted access to hospital IT systems (subject to confidentiality and permissions) in a timely manner, so that they can independently generate referrals to the programme.

Improving client data: It is necessary to improve the quality of data available for operational and evaluation purposes. New data capture procedures require being established. These include:

- The use of Hospital Admissions data (not available to this evaluation) to calculate

consistent referral rates to the programme across participating hospitals.

- The Navigator team improving their capture of both the baseline and follow-up assessment of young people, as well as identifying the number of young people who do not (formally) engage with the programme.
- Implementing a resourced (VRU) data management strategy to capture the onward referrals to helping agencies and six-month follow up assessments of young people (i.e., those have engaged with Navigators and exited the programme / or received support from other agencies).

Up scaling the programme: Assess the (potential) demand for the Navigator programme arising from different referral routes and settings. Consider the implications of the expansion of the programme (e.g., into the community) upon the endeavour to undertake an impact evaluation.

Low referral rates: Investigate the reasons underlying the low referral rates to the Navigator programme in hospitals.

Sustainability of the programme: The VRU must determine a strategy to plan for the continuance of the programme.

Duty of care to Navigator Staff: The VRU / Oasis must ensure that appropriate support structures for Navigators are established and maintained.

Feasibility of an impact evaluation: Establish a working group to consider the merits of undertaking a comprehensive and robust impact evaluation. This will require the active engagement of the VRU commissioners, hospitals, Oasis (as the service provider), the police and the agencies to which young people are referred. It will also be necessary to consult with service users (i.e., young people). This group should liaise with other VRUs that have developed or are developing similar interventions to assess the feasibility and potential benefits of collaborating in an impact evaluation.

2. Introduction

In December 2020, the Greater Manchester Violence Reduction Unit (GM VRU) commissioned a hospital-based 'Navigator' violence reduction pilot programme. The Navigator programme became operational in May 2021 and was funded until April 2022. It operated in four hospitals in Greater Manchester. It was subsequently recommissioned until March 2025. The Navigator programme seeks to support those young people (aged 10-25) who attend or have been admitted to an adult or paediatric Emergency department (ED) or hospital ward with injuries resulting from violence. It aims, through offering support at a '*teachable moment*', to help young people to cope and recover from their experiences, to prevent retaliation, the escalation of violence and / or repeat victimisation, and to reduce exploitation. Where on-going needs are identified, the Navigator programme endeavours to refer young people to appropriate community services in Greater Manchester, continuing to engage with young people after they leave hospital.

The Navigator programme has been funded via the Violence Reduction Unit (VRU) Health and Well-Being Delivery Group and is overseen by the VRU Clinical (Dr. Rachel Jenner) and VRU Victim (Dave Gilbride) leads. Oasis UK[2] was commissioned to deliver the Navigator programme and recruited four ED 'Navigators' as well as broader management and co-ordination resources. In the Summer of 2022, Oasis UK received an extension of their commission by the VRU to provide a 'community' Navigator service operating alongside the hospital service. As part of the VRU research and evaluation commission, Manchester Metropolitan University (MMU) was commissioned to work with Oasis UK to establish and undertake an implementation evaluation of the Navigator programme. The scope of the evaluation was restricted to the hospital Navigator programme. MMU was also asked to assess the feasibility of undertaking a robust impact evaluation of the Navigator programme.

The purpose of this implementation evaluation report is to account for the first two years of the hospital Navigator programme. This report follows an initial implementation evaluation report (published in December 2021), which detailed a preliminary set of findings and recommendations to guide the further development of the programme. The VRU and Oasis UK adopted these recommendations. Over the course of its first two years of its operation, the Navigator programme has adapted its delivery to meet both the recommendations made in the initial implementation evaluation report and the changing opportunities for service delivery in Greater Manchester. In these

[2] https://www.oasisuk.org/oasis-youth-workers-for-manchester-hospitals/

terms, this report provides new insight and learning and is intended to support the ongoing development and evaluation of the Navigator programme.

The report includes an assessment of the number and characteristics of young people accessing the service. It also includes an account of the perceptions of key stakeholders (Navigators and Health Service staff) of the initial implementation and ongoing operationalisation of the Navigator programme. It is intended that this report will support the VRU's decision-making process regarding ongoing re-commissioning and / or upscaling of the Navigator programme.

The report is structured as follows. The next section provides a summary of the national and international literatures on Hospital Based violence intervention programmes (HVIPs) that were available prior to, and that have subsequently become available after, the launch of the programme. Thereafter, a programme theory of change is presented together with an 'evolving' client journey. Later sections of the report include assessments of the quantitative (client data) and qualitative (stakeholder perspective) data collected as part of the evaluation process, together with a series of client case studies. Finally, a set of key findings and recommendations are presented.

3. Background and Literature Review

This section of the report commences with an account of the policy context in Greater Manchester that served to inform the commissioning of the Navigator pilot programme. It progresses to provide an overview of the national and international literatures on hospital-based violence intervention programmes (HVIPs) that were available prior to, and that have subsequently become available after, the launch of the programme. Finally, it reports several recommendations based on these materials for evaluations of, and practice developments in, hospital-based violence intervention programmes.

The Violence Reduction Unit and the Navigator pilot programme

The Greater Manchester Violence Reduction Unit (GM VRU) has adopted a public health approach to violence reduction (HM Government, 2019[3]), comprising four linked stages: problem specification; understanding causes; developing and evaluating interventions; and scaling-up effective policies and programmes. Consistent with this approach the GM VRU commissioned the Navigator pilot programme, holding the aspiration that it be up scaled if it was found to be supporting the effective address of violence and its causes.

In 2019, the Home Office provided funding to establish Violence Reduction Units in the areas worst affected by violent crime (HM Government, 2019[4]). Knife crime was a significant dimension of the violent crime problem. In Greater Manchester, knife crime was found to have doubled between 2015 and 2018 (MMU, 2019), broadly mirroring the trend observed in other metropolitan centres in England and Wales [5]. Moreover, the average age of both victims and suspects of knife crime, as identified by police recorded crime data, was found to be falling (MMU, 2019). Those injured because of a knife or sharp object assault comprise a significant number of admissions to hospital EDs. In 2017/18, of the 4,986 such admissions to hospitals in England and Wales, 1,900 were 20- to 29-year-olds and 1,012 were 10- to 19-year-olds [6]. Whilst the number of admissions was observed to be increasing for both age groups, the most marked increase was amongst 10- to 19-year-olds [7]. In recent years the numbers of finished consultant episodes[8] for assault by a sharp object fell from 5,149 in 2018/19 to 4,091 in 2020/21, a likely consequence of the COVID-19 lockdown measures, prior to rising

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862794/multi-agency_approach_to_serious_violence_prevention.pdf
[4] ibid
[5] ibid
[6] https://www.england.nhs.uk/2019/02/teens-admitted-to-hospital/
[7] ibid
[8] A finished consultant episode (FCE) is a continuous period of admitted patient care under one consultant within one healthcare provider. FCEs are counted against the year in which they end. Figures do not represent the number of different patients, as a person may have more than one episode of care within the same stay in hospital or in different stays in the same year.

to 4,171 in 2021/22. The proportion of episodes involving those under 19-years-old was 17% in 2021/22[9], the largest percentage since these data were collected.

A public health approach to violence reduction regards violence as a preventable disease (Pertle *et al.*, 2015 [10]). Given that one of the strongest predictors of future violence-related injury is previous violence-related injury (Hankin *et al*., 2013[11]), identifying and helping survivors (and their families) whilst they are receiving treatment in a hospital setting offers prospect of interrupting the cycle of violence (Evans & Vega, 2018[12]; Pertle *et al*., 2015). Hospital-based violence intervention programmes are founded on the belief that people are most open to change when they are at their most vulnerable, due to trauma and receiving care for their injuries. Such a situation is regarded as a 'teachable moment', defined as *'a naturally occurring life transition or health event thought to motivate individuals to spontaneously adopt risk-reducing health behaviours'* (McBride, Emmons & Lipkus, 2003: 156[13]).

Inspirational evidence

A systematic review of hospital-based violence intervention programmes was conducted by Brice and Boyle (2020)[14]. Their review captured 13 studies that confirmed the potential of hospital-based (ED) violence intervention programmes to reduce both the re-presentation of violent injury and arrests due to violence. The types of intervention assessed were of two types: *brief intervention* (BI); and *case management* (CM). A BI intervention typically took place in an ED setting and lasted an average of 35 minutes. A CM intervention, commencing in an ED setting, typically unfolded over a much longer period-of-time. Such interventions were noted to last from anything between several months to multiple years after discharge from an ED. CM intervention aimed to identify and address the risk factors informing the behaviours likely to result in violent offending and victimization. Several studies found family-based, longer-term CM interventions to be valuable given the association between low levels of family cohesion (and parental involvement) and the prevalence of youth violence. Cheng *et al*. (2008)[15] found that parents were more likely to prefer this type of intervention and that it served to deliver behavioural changes amongst the young people involved, i.e., they were less likely to re-present to an ED.

[9] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2020-21
[10] Purtle, J., Corbin, T. J., Rich, L. J., & Rich, J. A. (2015). Hospitals as a locus for violence intervention. Oxford textbook of violence prevention: epidemiology, evidence, and policy, 231-238.
[11] Hankin, A., Meagley, B., Wei, S. C., & Houry, D. (2013). Prevalence of exposure to risk factors for violence among young adults seen in an inner-city emergency department. *Western journal of emergency medicine*, *14*(4), 303.
[12] Evans, D. N., & Vega, A. (2018). Critical care: The important role of hospital-based violence intervention programs.
[13] McBride, C. M., Emmons, K. M. & Lipkus, I. M. (2003) Understanding the potential of teachable moments: the case of smoking cessation, 18(2), 156-170.
[14] Brice, J. M., & Boyle, A. A. (2020). Are ED-based violence intervention programmes effective in reducing revictimisation and perpetration in victims of violence? A systematic review. Emergency medicine journal, 37(8), 489-495.
[15] Cheng, T. L., *et* al. (2008). Effectiveness of a mentor-implemented, violence prevention intervention for assault-injured youths presenting to the emergency department: results of a randomized trial. Pediatrics, 122(5), 938-946.

Brice and Boyle (2020) found the efficacy of hospital-based violence intervention programmes to vary. Of the ten studies that assessed the efficacy of a particular intervention via a Randomised Control Trial (RCT), eight reported a statistically significant beneficial effect in one or more outcome measure related to the risk of engaging in violent behaviours. Such outcome measures spanned '*attitude change'*, '*service utilisation'*, *'violent revictimisation'* and '*violent arrest'*. The two studies that failed to identify a statistically significant beneficial effect in an outcome measure were critiqued as being '*poorly focused on reducing violence'* and '*insufficiently powered'* in their ability to reduce violent behaviours.

Case management (CM) hospital-based violence intervention programmes in the UK

Prior to the launch of the Greater Manchester hospital Navigator programme, there were several other hospital-based violence intervention programmes operating in the UK[16], including: the Oasis Youth Report System at St. Thomas' Hospital in London; the St Giles Trust (SGT) Intervention Service at Wolverhampton and Coventry hospitals and the Major Trauma Centre (MTC); the Glasgow Navigator Programme; and the Redthread Charity intervention at Queen's medical centre, Nottingham. Whilst none of these interventions had undergone robust evaluation, reports on their services users and intervention modes provide a range of valuable insights.

The **Oasis Youth Report System (OYS)** at St. Thomas' Hospital (Ilan-Clarke, Kagan, DeMarco & Bifulco, 2016[17]) commenced in August 2010 and continues to the present day at the Oasis Waterloo hub. The aim of the OYS is to guide the young people, presenting at St. Thomas' hospital with violent injury (inflicted by themselves or others), to an appropriate intervention service. An evaluation of OYS, between August 2010 and July 2016, found that 1,060 young people aged between 12 and 20 years old were referred to the intervention due to their violence-related injuries. Of this number, 79% were identified as being eligible for the service, based on the referral criteria outlined by Oasis, over half (55%) of whom had been the victim of a violent assault, whilst 20% had a self-inflicted injury. One third of those eligible engaged with the service. Most young people viewed themselves as victims, though a significant number viewed themselves to be both victims and perpetrators. Most of the young people were male (74%) with an average age of 15. Those presenting with a violent injury were given the opportunity to engage with the intervention once they were discharged from the ED. The young people choosing to participate were assessed via lifestyle and symptoms questionnaires, which

[16] At time of literature review (where reports were available)
[17] Ilan-Clarke, Y., Kagan, L., DeMarco, J., & Bifulco, A., (2016). Evaluation of Oasis Youth Support violence intervention as St. Thomas' hospital in London, UK., *Centre for Abuse and Trauma Studies (CATS)*, 2-4.

found that the young people exhibited high levels of psychological disorder. 56% exhibited one disorder, whilst 42% exhibited two or more disorders at the time of interview. Following the intervention process, and via further assessment, it was found that the young people exhibited a reduction in both lifestyle risk and psychological disorders. The young people who engaged with the OYS were given the opportunity to attend face-to-face sessions with a youth worker. The number of such sessions was determined according to the severity of risk that the young person posed to themselves and/or others. Several cases were followed up a year or more after the intervention, providing some evidence of its longer-term benefit.

The **St Giles Trust (SGT) Intervention Service** was designed to support young people presenting at hospital with injuries resulting from violence, exploitation, gang and/or county line related activities. The intervention, launched in 2019, provides casework support aimed at facilitating young people to develop positive lifestyle choices, to take productive steps towards a *'constructive future'*, enabling them to desist from violence and crime-related activities. A report published in 2019 identified that there had been 105 referrals to the intervention. Of this number, 78 were identified as being male and 27 identified as being female. Most (72) were under the age of 18, with the remainder (32) being 18 or older (1 unknown). The programme adopted a four-stage intervention process, including: initial contact in the hospital setting; support after discharge, for up to six-weeks; in-depth longer-term support; and referral to additional specialist services if required. Of the 105 young people referred to the service, 19 (17.6%) were not contactable, having either provided false contact information or having left the hospital before someone could meet with them. A further two young people declined engagement. A key outcome measure adopted by this intervention was a reduction in the number of young people re-presenting at ED. A review conducted in December 2019, eight months after the start of the intervention (May 2019), identified that there was only one re-presentation for violence-related injury and eight for mental health-related issues across the two sites. The wider impact of this intervention is difficult to assess as limited data was collected regarding reductions in gang-related activity etc. The report recognises this limitation and notes that the engagement of external agencies is required to gather such information. The report also evidences wider limitations in the data management procedures of the programme.

The **Glasgow Navigator Programme** was established, in 2015 by the Scottish Violence Reduction Unit[18], in recognition that young people presenting in EDs held limited engagement with statutory support services. The programme seeks to help young people to change their lives through enabling

[18] Goodall, C., & Lowe, D. (2016) Navigator Scotland: Six months on. Violence Reduction Unit

their engagement with a multitude of health, education, employment and housing services. The Navigators frequently accompany young people to meet such '*trusted community partners'* and will *'advocate on their behalf'* where necessary. The overarching ambition of the programme is to reduce the strain being placed on the NHS by violence-injuries. Assessment of the programme has been via qualitative research of the perceptions of service users, most of whom held the programme in high regard. There has been no systematic effort to measure the impact of the programme on re-presentation for violence-related injuries.

The **Redthread Charity** operated a three-year pilot in Queen's medical centre, Nottingham. The intervention targeted individuals aged 11 to 24 who presented with violence-related injuries because of serious assault (e.g., stabbings and gun crime), sexual assault or domestic violence. A youth work team, working alongside Accident and Emergency staff, would try to engage with the young person at the earliest possible opportunity (i.e., in the waiting room or on the ward like BI interventions). Young people participating in the programme were allocated a case worker, who would seek to establish an intervention plan aimed at disrupting problem behaviours and removing the young person from environments in which they may meet criminal organisations. The case workers adopted an advocacy and mentoring approach, meaning that they would accompany and support the young person to access services and benefits.

Emergent evidence

Since the onset of Government funding, several Violence Reduction Units have commissioned providers to establish hospital-based violence intervention programmes. Several have recently published evaluation reports, including the Merseyside Navigator Programme and the Lancashire Navigator programme. The Youth Endowment Fund (YEF) has also delivered a 'Feasibility Study of Hospital Navigators', examining multi-site evaluation practices in the Thames Valley area. In London, the NHS and Violence Reduction Programme have developed a guide to effective implementation for in-hospital violence reduction services[19]. Finally, the College of Policing has reported on the South Yorkshire Police A&E Navigators programme[20]. Each report is now summarised in turn.

Quigg *et al* (2022)[21] report on the initial development and implementation of the **Merseyside Navigator programme** (June 2021-June 2022), which targets children and young people aged 10-24

[19] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2022/03/In-Hospital-Violence-Reduction-Services-A-Guide-to-Effective-Implementation-FINAL.pdf
[20] https://www.college.police.uk/homicide-prevention/ae-navigators-south-yorkshire-police
[21] Quigg, Z., Butler, N., McCoy, E., & Germain, J. (2022). Service evaluation of the initial development and implementation of the Merseyside Navigator Programme.

years old identified as having attended a hospital ED because of an assault. The intervention focused on crisis and safety support, stabilisation and outcome support and maintenance support. During the study period, there were 108 referrals across three hospital sites. The majority (81.5%) of referred individuals were aged 13-17 years old. It was estimated that 17% of eligible young people were referred to the Navigator Programme. The programme used a Strengths and Difficulties (SDQ) survey and Outcomes Star to monitor 'distance travelled' outcomes[22]. However, and due to the infancy of the programme, there were limited data available to the evaluation. The **Lancashire Navigator programme[23]** operated at two hospital sites in Blackpool and Preston in 2021/22, with an extension to other EDs across Lancashire. At Blackpool, the ED Navigator is a nurse and is based in the ED the safeguarding team. Engagement was made with 547 patients during 2021/2022. The report based on this programme focuses on its qualitative elements rather than its quantitative impact.

The **Thames Valley Violence Reduction Unit and the Youth Endowment Fund (YEF)** sponsored a study of the five hospital Navigator programmes operating in the Thames Valley area. The study developed a theory of change to guide the implementation and evaluation of the programmes. It also undertook an assessment of the feasibility of evaluating the impact of variations in programme delivery across the intervention sites and of the programme as a whole. The study concludes that, "*Assessing the feasibility of an impact evaluation for the hospital Navigator programme is not clear-cut"* (Sutherland *et al*., 2023:44)[24] but that a relevant outcome measure would be the hospital readmission rates of referred patients. It recommends that data linkage with other services would provide a wider set of outcomes with which to evaluate the programme. It also suggests that constructing comparison groups, of patients when Navigators are and are not present in an ED, might prove beneficial in evaluating the impact pf the programme.

A recent systematic review by Webster *et al* (2022)[25] examined 13 studies, including seven Randomised Control Trials (RCTs) and six observational studies of hospital-based (gun) violence intervention programmes in North America. RCTs are considered one of the most robust evaluation designs. To date, no RCT of such an intervention has taken place in the UK. The findings of the review suggest some evidence of the interventions delivering protective effects but that evidence of reduced risks for violence was mixed. In part, the findings of the different studies were difficult to compare as they deployed differing outcome measures, control conditions and follow-up periods. The authors

[22] The 'distance travelled' refers to the individual progression participants make in terms of achieving soft outcomes that lead towards associated hard outcomes, as a result of participating in a project and against an initial baseline set on joining it (Dewson *et al*, 2000)
[23] Goldthorpe, J., Ward, F., Wheeler, P., & Dodd, S. (2022) Lancashire Violence Reduction Network: Trauma Informed Programmes Evaluation Report 2021/22
[24] Sutherland, A., Makinson, L., Bisserbe, C., & Farrington, J. (2023). Hospital Navigators: multi-site evaluation of practices. Youth Endowment Fund.
[25] Webster, D. W., Richardson jr, J., Meyerson, N., Vil, C., & Topazian, R. (2022). Research on the Effects of Hospital-Based Violence Intervention Programs: Observations and Recommendations. *The ANNALS of the American Academy of Political and Social Science*, *704*(1), 137-157.

make several recommendations (presented below) intended to support the rigorous evaluation of hospital-based violence intervention programmes.

Conclusion

Whilst the motivation for establishing hospital-based violence intervention programmes rests in the emergence of promising evidence, robust evaluations of their efficacy remain limited. Even in North America, where more rigorous evaluation models have been advanced, variations in programme delivery have hampered the clarity of insights that can be drawn from these interventions. In the UK, a significant number of hospital-based violence intervention programmes have now been launched. This provides an opportunity to explore the merits associated with differing types (and durations) of interventions, from engagement in 'teachable moments' to practical support through advocacy, youth work, mentoring and specialist referral based the longer-term (i.e., beyond six months) needs of the young people. At present, few of these programmes have been evaluated. Where evaluations have taken place, these have tended to report the numbers and characteristics of referrals, and the findings of qualitative research with programme stakeholders.

The two systematic reviews (Brice & Boyle, 2020); Webster *et al*., 2022)), reported above, highlight the value of undertaking comparative studies and of using Randomised Control Trials. If such an impact evaluation programme was to be established it would be important to establish large trial sample sizes to ensure statistical robustness, develop clear guidance as to how evaluations should report intention-to-treat (ITT), and to deploy a broad spectrum of baseline and outcome data. Future impact evaluations should also couple quantitative and qualitative dimensions (interviews and focus groups). These reviews also make several practice-oriented recommendations, including: encouraging and developing broader partnerships between hospital-based violence intervention programmes and organisations undertaking community outreach and violence interruption interventions; and training intervention staff in the importance of collecting and analysing data.

4. Methodology

This section of the report describes the methodology guiding the implementation evaluation. In presenting the methodology, it is important to note that the evaluation team has worked closely with Oasis UK, since their commission, to develop both the intervention and the design of its evaluation. This co-produced and iterative approach has served to fruitfully inform the delivery of the intervention and its evaluation. It has been motivated by the desire to learn lessons from the pilot programme to shape its effective up-scaling.

The evaluation methodology was designed to address the following research questions:

- Was the pilot programme delivered as intended?
- What were the stakeholders' (Hospital staff, Navigator staff and VRU leads) perceptions of the Navigator programme?
- What worked well and what might be improved?

The evaluation design reflects the commissioning calendar underpinning the Navigator programme. An early findings report was published in December 2021, only 5 months after the establishment of the pilot programme. This was used to inform the decision-making on the recommissioning of the service. The subsequent recommissioning of the programme to March 2025, enabled the implementation evaluation to extend to a period of 2 years.

To address the research questions, it was determined to undertake the following steps:

- Develop a map of the client journey in the Navigator programme
- Develop a theory of change for the Navigator programme
- Undertake a quantitative analysis of Navigator client data
- Undertake a qualitative analysis of Navigator and key stakeholder views of the Navigator programme

These aspects of the evaluation are now described in more detail.

Mapping the client journey

This task commenced prior to the start of intervention delivery. The *client journey* through the Navigator programme, articulated in a series of flow diagrams (see below), was developed over several meetings with the strategic leads from Oasis UK, the VRU clinical lead and the VRU victims lead. The client journey serves to describe the operational delivery of the Navigator programme. Relatedly, it serves to guide the data management and collection plan for the evaluation. Over the

duration of the Navigators programme, the client journey has evolved. This was due to both operational issues and the subsequent commissioning of a 'community' Navigators service to complement the hospital-based programme. The latter led to an increase in the capacity (staff) of the Navigator team to meet the complexity of needs presented by the young people referred to the service.

A theory of change for the Navigator programme

The theory of change (ToC) underpinning the Navigator programme was developed through extensive dialogue with the strategic leads from Oasis UK, the VRU clinical lead and the VRU victims lead. It also draws on the documentation produced by GMCA / VRU in the commissioning of the programme, and a review of the evidence base underpinning hospital-based violence intervention programmes (HVIPs). The Navigator ToC has been designed to be consistent with the overarching GM VRU logic model. The ToC is best understood as a 'live' model in that the intention is to revise and augment the model as the Navigator programme matures.

Quantitative (data and) analysis

Data are routinely collected as part of the operational delivery of the Navigator programme via the Oasis UK EVIDE / Impact Tracker system. Participants (or the parents / guardians) sign a consent form, allowing their data to be shared for evaluation purposes. Oasis UK provide MMU with pseudo-anonymised data that contain no identifying characteristics (i.e., name and address) apart from a unique reference number. The unique reference number enables data extracted from the impact tracker to be merged, allowing an assessment of the participant's characteristics (i.e., age, gender and ethnicity), engagement, activities, and assessments (both risk and needs) at different points in the intervention (from entry to exit). Data are provided csv / excel files, which are then built into a relational database for evaluation purposes.

The process of data capture and recording allows new data on clients to be added to the relational database, periodically, as they progress through the intervention. It was intended that Oasis record the risk assessment and needs assessment (including the WEMWBS[26] questions) of the client at the start of the Navigators intervention (baseline) and upon a young person exiting the intervention (typically 2 - 6 weeks) (exit), as a measure of outcome. Changes to operational activity, resulted in changes to the original ambition. Thus, the intention to undertake an assessment at a follow-up point

[26] Warwick-Edinburgh Mental Wellbeing Survey (https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/)

(e.g., six-months) was not completed by Oasis. This was primarily due to a lack of resource as the Navigators focussed efforts on meeting the needs of the young people engaged with the service.

An initial data transfer to MMU was made two months after the start of the intervention (July 2021) and periodically (October 2021, May 2022, and September 2022), to ensure data completeness and that data quality issues could be assessed and addressed. MMU assessed these data, identifying where improvements in recording and data transfer were required. A final dataset for evaluation exercise was provided in June 2023. In addition to Navigator programme data, each hospital in which the Navigator programme is based agreed to provide summary data on the numbers of people attending hospital each month, with a breakdown of those who are in the target intervention age group and presenting due to a violent injury. However, there were issues with receiving data from some hospitals due to changes to SPOC, staffing and systems. These data have also been used to probe the feasibility of undertaking an impact assessment of the Navigator programme.

Qualitative (data and) analysis

Data were collected through two phases of fieldwork; the first took place between July and September 2021 (with findings and subsequent recommendations reported in the interim report), the second phase took place between February and April 2023. The findings or both phases are presented in this report. The research deployed semi-structured individual and group interviews.

Phase 1: Semi-structured interviews (14) were conducted with a range of stakeholders spanning the commissioners (VRU), the strategic and operational leads of the Navigator programme, and hospital staff from each of the participating hospitals. These data were subsequently supplemented through a group interview with Navigator staff (4) and Oasis UK management staff (2). The stakeholders were questioned on the following themes (See Appendix C):

- The design of the Navigator intervention
- The operation of the Navigator programme, inclusive of how the Navigator team deliver the intervention, noting any barriers or systemic issues to delivery
- The relationship between Navigators and ED staff
- The relationship between Navigators and local providers / youth services (referral organisations)

Phase 2: Semi-structured Interviews (7) were conducted with a range of stakeholders (as in phase 1). A group interview with 12 Navigator staff, including one supervisor, was also undertaken. The stakeholders were questioned on the following themes:

- Stakeholders Involvement with Navigators
- Aims and objectives of Navigators
- If the demand is met by Navigators
- Current referral system
- Benefit to stakeholders' working practices
- Positives for Navigators
- Scope for improvement

The focus group with Navigators addressed the following themes:

- The evolution of Navigators
- The client journey in Navigators
- Meeting demand
- Referral Criteria
- Information Sharing
- Advocacy work
- Onwards referrals
- Data Management
- Sustainability

In all cases, interviewees were provided with an information sheet and consent form, making explicit their right to withdraw from the interview (or focus group), as well as noting the risks that may (or may not) be associated with engaging with the interview process. The interviews were summarised in note format. Data was stored on MMU systems. The findings of the interviews are presented thematically in the report, below, with the views of ED staff and stakeholders presented separately from those of the Navigator staff.

Case studies

Finally, combining information captured through the above steps, seven client cases studies (i.e., vignettes) were developed by Oasis and the research team. The case studies are intended to support the development of an in-depth and multi-faceted understanding of both the diversity of, and complex needs exhibited by, the clients supported by the Navigator programme. They illustrate the varied

journeys that clients take following their initial engagement with the programme and the challenges faced by Navigators in trying to support them [27].

[27] Crowe, S., Cresswell, K., Robertson, A. *et al.* (2011) The case study approach. *BMC Medical Research Methodology*. **11**, 100 https://doi.org/10.1186/1471-2288-11-100

5. Intervention Client Journey

Over the duration of the Navigator programme, the client journey has evolved. This has been due to the operational learning captured in the implementation of the programme, and because of the decision to commission a 'community' Navigator service to complement the hospital-based programme. Reflecting this evolution, this section of the report presents three client journeys.

Pre-Intervention: A high-level client journey through the Navigator intervention, based on the original intention of the programme, is illustrated in Figure 1a. The client journey starts in most cases with a young person entering an emergency department for medical attention (there are some cases when a young person is on a hospital ward). The young person is triaged by hospital staff and a decision is made (by the hospital staff) regarding the young person's suitability for inclusion in the intervention. This is based on the following criteria: they are not under statutory safeguarding processes (which require to be completed to a satisfactory point, prior to a decision to refer), and if they meet the criteria (a young person is aged between 10 and 25; and has presented with injuries from a violent encounter), and permission is granted by the young person (and / or parent) to make a referral. Following clinical intervention, the young person is referred to a Navigator. The Navigator may be on-site, enabling immediate engagement or a follow-up contact will be arranged in the Hospital or upon discharge. The Navigator will meet with the young person and provide both support and advocacy[28] . At this point, the Navigator will seek the consent of young person (or their parents / guardians) to participate in the broader Navigator programme. If consent is granted, a risk and needs baseline assessment is undertaken by the Navigator and the young person. The key intention of the assessment is to identify community-based interventions that serve to meet the young person's needs. If these can be successfully identified (need and availability of service), the young person will be referred to a helping agency. The Navigator will continue to work with the young person, providing advocacy and mentoring for a period of two to six weeks dependent upon the specific needs of the young person. At different points in this client journey a young person may make the decision to disengage with the Navigator programme.

Client journey at 5-months: Whist most of the above client journey remains the same, due to an enhanced understanding of processes over the first few months of operation, it was necessary to revise and add elements to the client journey. This included the capture of the extensive work (informal support / advocacy) being undertaken in the 'pre-consent' phase of the programme, as well

[28] Advocacy means **getting support from another person to help you express your views and wishes.**

as aspects of community engagement and onward referrals. Frequently, it was found that a young person would seek Navigator support / advocacy, but that they would not consent to formally enroll into the programme. In some instances, young people would consent to formally engage with the programme following their referral to, and engagement with another agency. These changes are reflected in Figure 1b.

Navigator Triage: The commissioning and integration of a new 'community' Navigator service commenced alongside the original hospital-based programme. Referrals to the expanded programme, therefore, came through the two routes. It was identified early in the pilot that the existing hospital-based programme demanded ongoing community work with young people, once they were discharged from hospital. Navigators found that they were spending considerable resource in managing the needs of these young people. In response, the VRU commissioned a new 'community' Navigator service. Through time, young people were also referred directly to the 'community' service. In essence, the nature of the Navigator engagement with young people was the same even though the referral route differed. A 'Navigator Triage' stage was implemented in which a Navigator triage worker makes contact with, and assesses the suitability of, young people prior to allocating them to a Navigator Youth worker. To cope with the volume of referrals an allocation system adopting a traffic light system was established. Young people assessed as "red" or "amber" (an indication of the severity and complexity of their needs) receive priority attention. Due to the complexity of needs embodied in the young people referred to young people via both referral routes, the Navigator programme has been required to establish a waiting list for potential clients. These changes are reflected in Figure 1c.

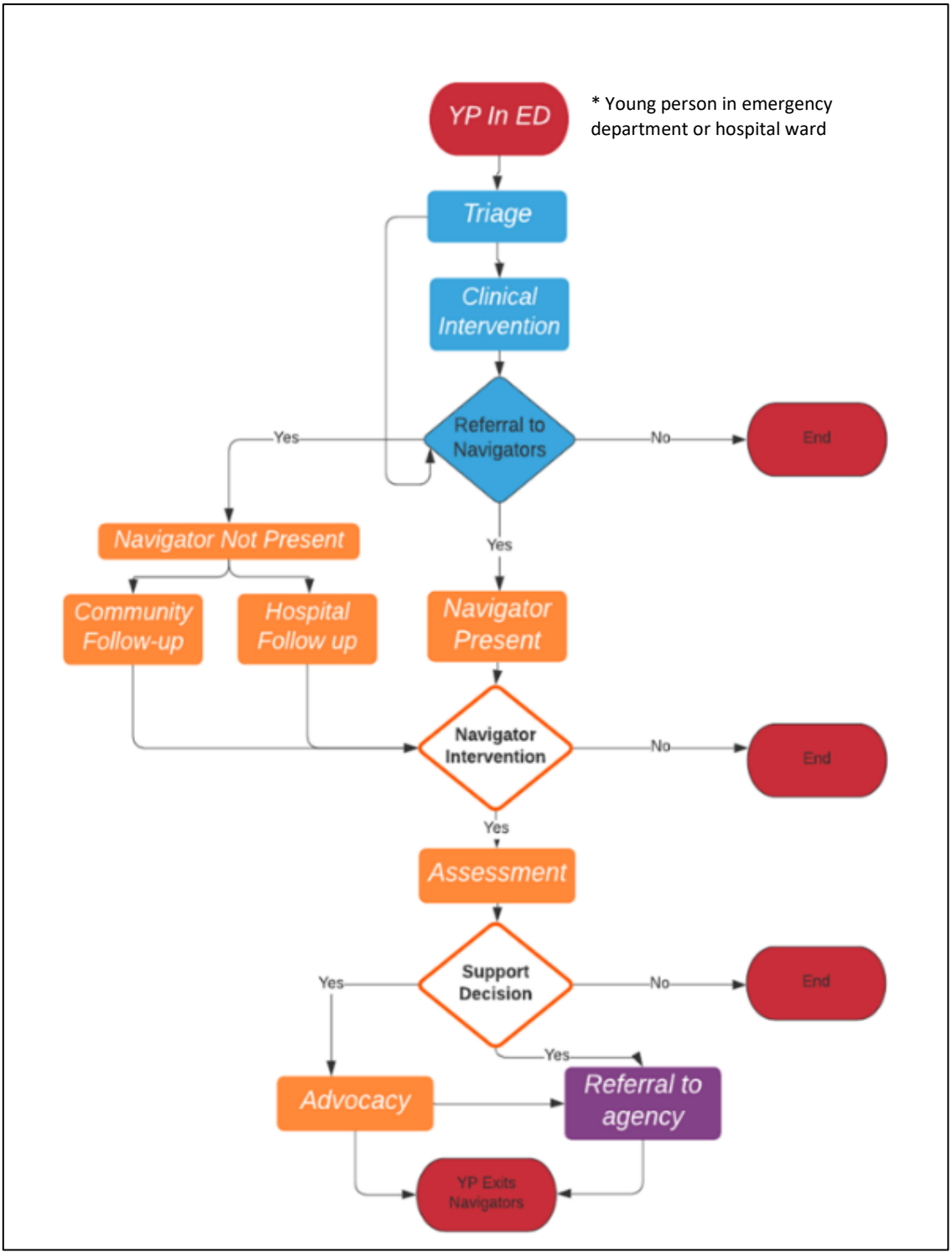

Figure 1A: Navigator Client Journey A: Pre-intervention client journey

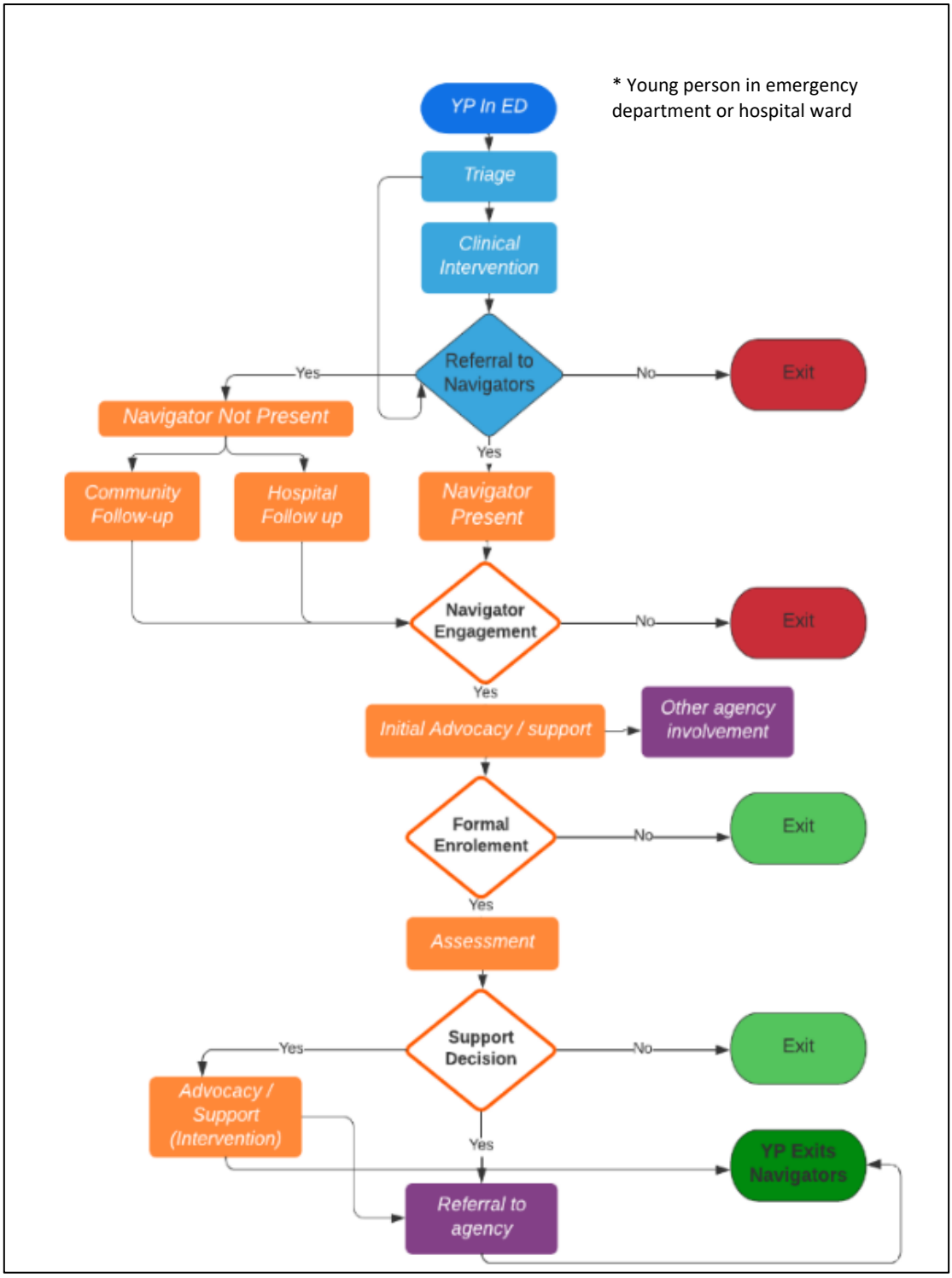

Figure 1B: Navigator Client Journey B: Client Journey at 5 months

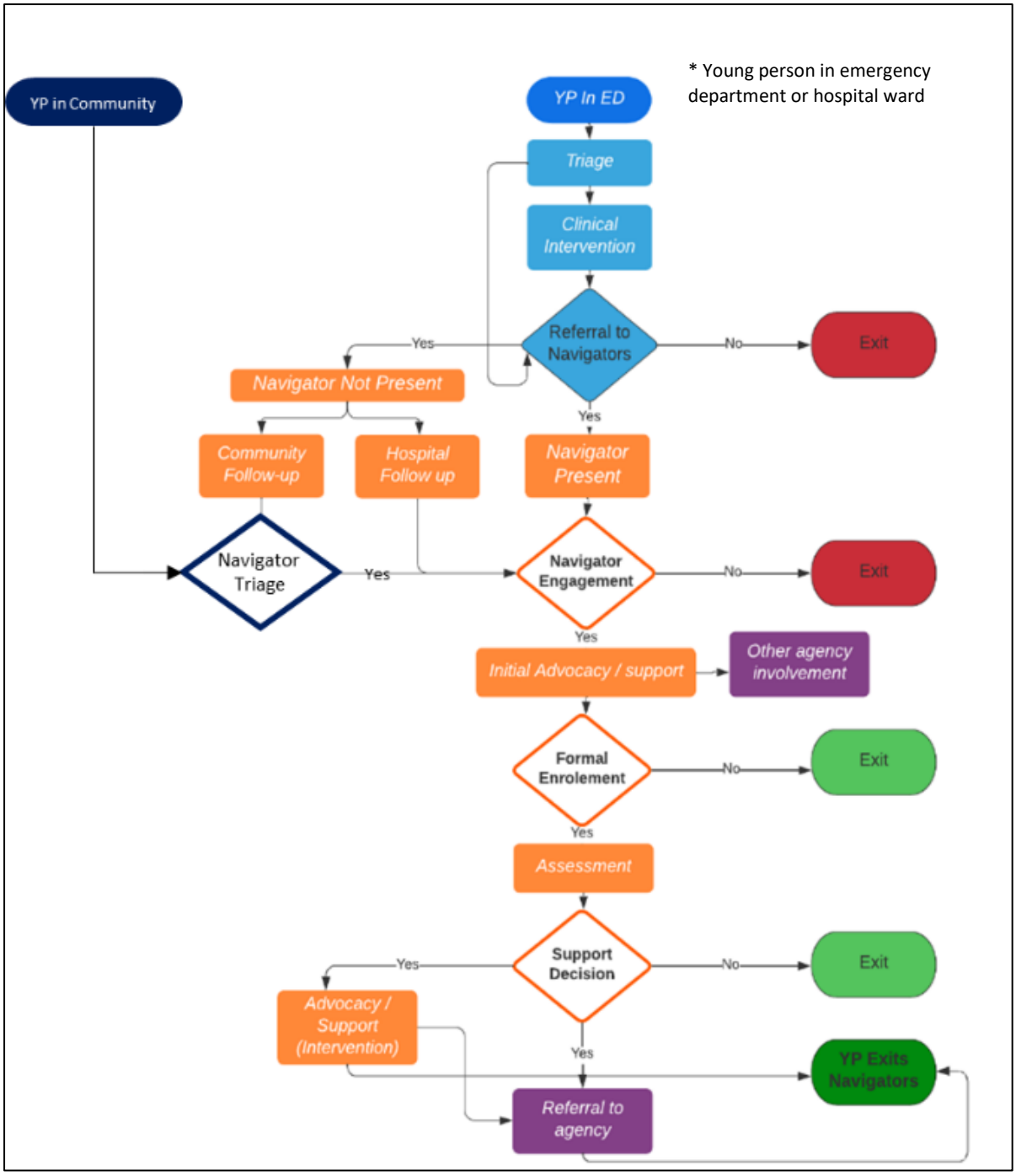

Figure 1C: Navigator Client Journey C: Navigator Triage

6. Intervention Theory of Change

A theory-based evaluation is one that starts by unpacking the theoretical or logical sequence by which an intervention is expected to bring about its desired effects (Treasury, 2011). A theory of change explains both the 'mini-steps' that are required to achieve a long-term outcome and the connections between the mini-steps. The theory of change (ToC) for the Greater Manchester Navigator programme, presented in Figure 2 (below), was co-produced by Oasis and MMU.

The key components of a ToC are: the rationale, including the need and context of the intervention including the long-term change that the intervention seeks to support; the target group receiving the intervention; the underlying assumptions on how changes may happen; inputs into the programme, including funding, staffing, volunteers, equipment; activities delivered by the intervention; the enablers (conditions or factors) that need to take place for the intervention to work. These include *internal enablers* that are within the control of the intervention, and describe how the intervention will be delivered, and *external enablers* which are beyond the intervention's immediate control; the outputs of the intervention, including the numbers receiving and exiting the intervention; and the outcomes that the programme seeks to achieve in the medium and long term. These components, tailored to the Navigator programme, are detailed in Figure 2. A more detailed ToC is available in parallel documentation to this report. The ToC is used (in conjunction with the client journey) to guide the data capture and analysis entailed in the implementation evaluation.

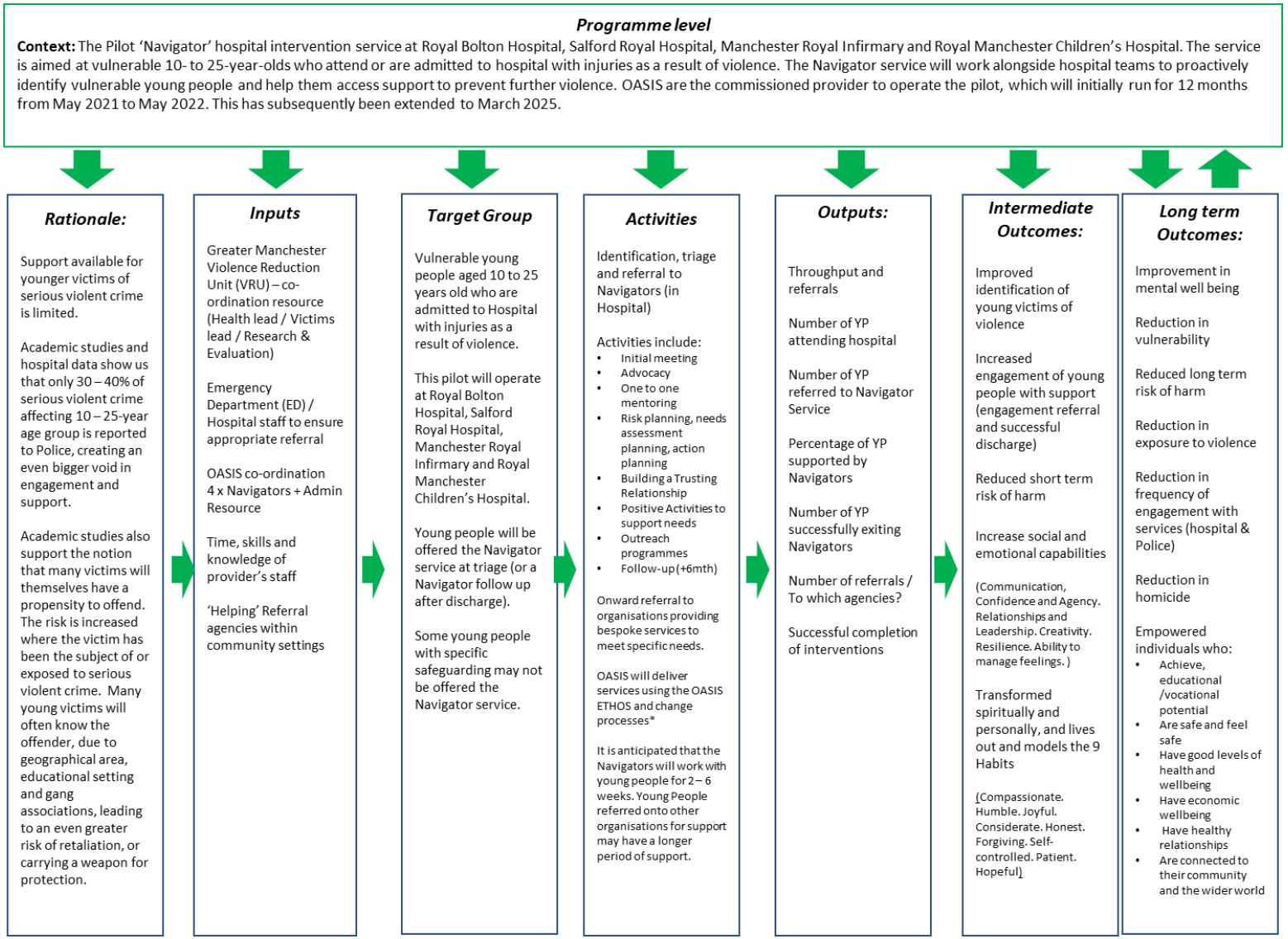

Figure 2: The theory of change for the Navigator programme

The implementation evaluation, detailed in this report, seeks to assess the adherence of the Navigator programme, and its achievements with respect, to its ToC. To this end, the evaluation spans consideration of the inputs, target group, activities, outputs and intermediate outcomes of the programme. Specifically, it focusses on the following actions intended by the Navigator programme:

Within the emergency department or hospital ward (at point of identification)

- Identification, triage and referral to Navigators (hospital staff and Young Person -> Navigator)
- Initial Navigator meeting – (Bedside conversations in hospital (ED or on the ward))

Navigator - With young person (within 6-week period) and linked to outcomes

- Initial Navigator meeting – (Bedside conversations in ED, on the ward or in the community)
- 1:1 mentoring with the young person (weekly)
- Risk planning, needs assessment planning, action planning (Navigator and Young Person)
- Building a trusting relationship (Navigator and Young Person)
- Advocacy role – supporting the young person to engage with community activities and community support

Referral Organisation (2 weeks +), linked to the additional needs of the young person and outcomes

- Activities to support the additional needs of the young person

Infrastructure / systems, linked to system outcomes

- Communication re the Navigator project
- Information / training / education of hospital staff
- Developing community networks in the three Navigator pilot boroughs
- Signposting of and referral to community agencies

Systematic Data Collection

- Embed monitoring (Oasis tracker system to capture referrals, risk and needs assessment, and activities)
- Capture knowledge and learning from activities

Follow-up with the young person to monitor changes in behaviour and needs (6+ months) (Note: Due to resource constraints this action was not completed)

7. Client data

This section of the report presents a quantitative assessment of the Navigator client journey. It is based on the data captured within the first two years of the programme's operation. It spans consideration of those young people presenting in hospitals and those engaging with the Navigator programme. It commences with a description of the data and its qualities prior to reporting a set of findings.

Quantitative data

The quantitative analysis assessed both the numbers of young people presenting in hospitals and those engaging with the Navigator programme. Of those young people presenting in hospital s, we distinguish total attendances, the attendances of those aged between 10 and 25 years old and the attendances of those aged between 10 and 25 arising because of a violent incident. For those young people who engaged with the Navigator programme, we present data from the Oasis impact tracker. This enables an account of the characteristics of this cohort of young people, their engagement with Navigators, the activities undertaken with the young people, and the findings of the baseline risk and needs assessment.

Data quality / access issues

The quantitative data available to the implementation evaluation are limited. This is a consequence of several factors: First, the OASIS EVADE case management system captures referrals, baseline and exit assessments. However, there are limited number of cases where the client moves through the entire journey as planned with corresponding data captured. Second, there is also limited data addressing the nature of onwards referrals to other agencies. Third, Oasis was unable to complete the follow up assessments of clients. Finally, whilst the data management plan established a single point of contact (SPOC) in each of the four hospitals participating in the programme, with the purpose of collating monthly admissions data, SPOCs changed roles during the study period leading to both shortfalls and delays in data transfer. Data were subsequently provided by the Trauma & Injury Intelligence Group (TIIG) Surveillance System operated by Liverpool John Moores on behalf of the Violence Reduction Unit (VRU). These data were markedly different (in both volume and trends) to the data provided by hospital SPOCs. Due to changes in the IT system at Manchester Royal Infirmary, data has not provided to TIIG since September 2022.

Emergency Department Attendance data

From the start of the Navigator programme, the ambition was to collect attendance data from each of the four sites, covering the four metrics:

- Total number of attendances
- Number of attendances of CYP aged 10-25
- Number of attendances of CYP aged 10-25 with injuries
- Number of attendances of CYP aged 10-25 with assault injuries

This presented a significant challenge due to hospital resourcing constraints, system and staff (SPOC) changes, resulting in limited data being provided. During the evaluation period, no data was provided by Salford Royal and only a few months data were provided by Manchester Children's Hospital. The evaluation has access to more complete data, for the first twelve months of the programme's operation, from Manchester Royal Infirmary and Royal Bolton Hospital. [These data are presented in appendix D together with corresponding TIIG Data]. Given the available data several observations can be made using the SPOC dataset:

- For the period April 2021 to May 2022 (data provided by Hospital SPOC), there were 436 attendances of CYP aged 10-25 with assault injuries at Manchester Royal Infirmary. Of this number, 62 referrals were made to the Navigator programme, a referral rate of 14.2%.
- For the period April 2021 to May 2022 (data provided by Hospital SPOC), though there are four months of missing data, there were 182 attendances of CYP aged 10-25 with assault injuries at Royal Bolton Hospital. Of this number, 107 referrals were made to the Navigator programme, a referral rate of 58.8% referral rate.

Later sections of this report explore the reasons behind the shortfalls in data capture in more detail (see appendix D). Three data sources have been identified (the initial SPOC data, Trauma and Injury Intelligence Group (TIIG) data from Liverpool John Moores University, and Hospital Admissions Data). However, and in relation to the data presented here, it is worth noting that Manchester Royal Infirmary is larger (i.e., has a larger hospital workforce) than Royal Bolton Hospital, due to the higher number of hospital attendances. Further, Royal Bolton Hospital had a dedicated co-ordinator for the Navigator programme based on site, which may account for this higher referral rate in this setting.

Intervention data

Intervention data was collected by the Navigator programme via its OASIS EVADE case management system. This section presents an analysis of these data. The analysis includes an assessment of the referral data and both the baseline and 'distanced travelled' data of those young people who engaged

with the programme. 'Distance travelled' refers to the progression a programme participant makes, measured against a set of soft outcomes captured by the baseline and exit questionnaires, that lead towards associated hard outcomes (as specified in the Theory of Change).

Referrals to the ED Navigator programme

Between May 2021 and May 2023 (25 months) there were 637 referrals to the hospital Navigator programme. This figure includes those who subsequently engaged with the service (brief intervention (BI) and case management (CM)) and those who did not (self-exited and uncontactable). Figure 3, below, illustrates the distribution of these referrals on a month-by-month basis. There was an average of 23.5 referrals per month, with the lowest number of referrals occurring in August 2021 (n=12), a possible consequence of both the summer holiday period and a change of staffing in hospitals (see qualitative section, below). The largest number of referrals occurred in March 2022 (n=45).

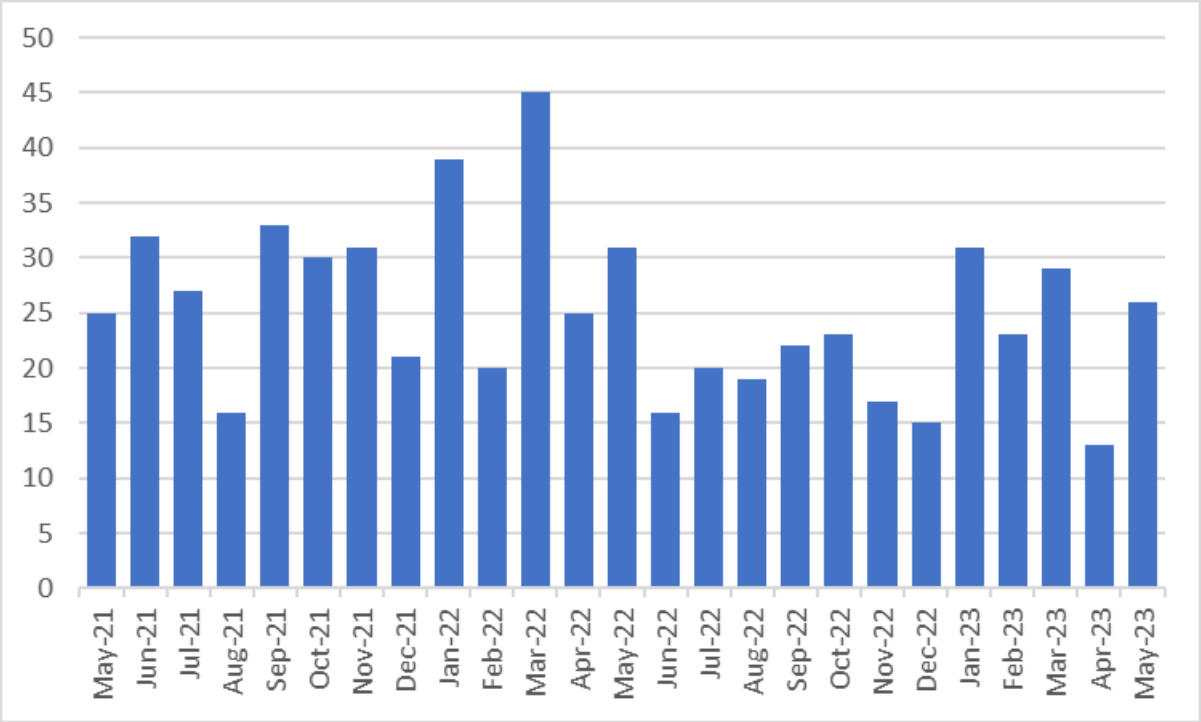

Figure 3: Number of referrals (May 2021 to May 2023) by Month

The data indicate that there were 621 unique ID references, implying that several young people were referred to the programme on more than one occasion (14 young people had two referrals and one young person was referred three times) during the 25-month intervention period. Figure 4, below, illustrates the distribution of referrals across the four programme sites. The Navigator programme received over two-fifths of the total number of referrals (n=271, 42.5%) from Royal Bolton Hospital,

almost a quarter (n=150, 23.5%) from the Royal Manchester Children's Hospital, 119 (18.7%) referrals from Salford Royal Infirmary, and 97 (15.2%) referrals from Manchester Royal Infirmary.

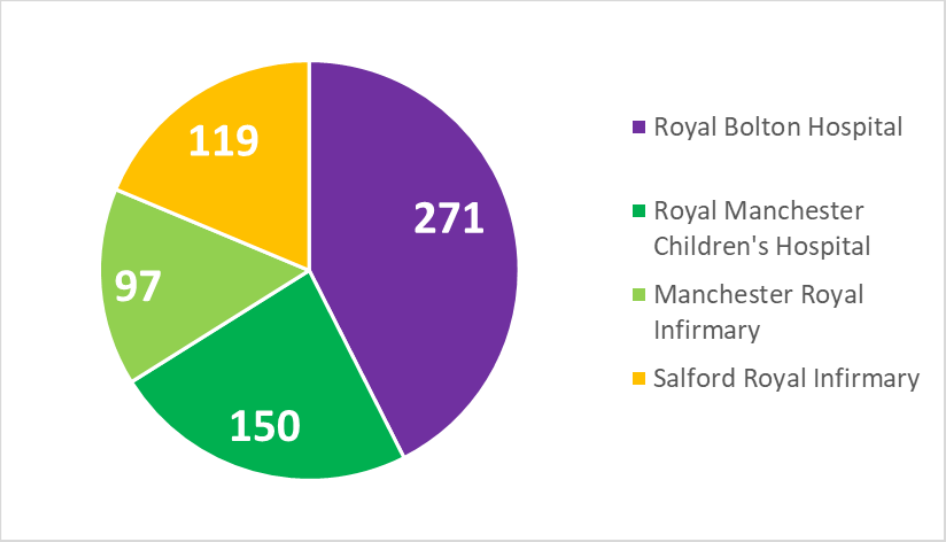

Figure 4: Number of referrals (May 2021 to May 2023) by Hospital

Reason for Referral to the Navigator programme

Figure 5, below, identifies the main reasons why young people were referred to the Navigator programme. Over four fifths (n=518, 81.3%) of referrals were made because of a young person attending the hospital with a violence-related injury, including violence with a weapon (e.g., gunshot and knife wounds), and violence without a weapon (e.g., punch or kick injury). A smaller proportion (n=86, 13.5%) were referred because of other factors such as self-harm or suicidality, anger issues and / or risk-taking behaviours. In a few instances (n=19, 3.0%) young people were referred because of situations arising from sexual offences / exploitation, domestic incidents, and particular crimes (e.g., Robbery), but with no injuries being recorded. At the commencement of the project, the referral process was still being refined, which accounts for some referrals being made based on the identification of self-harm. Whilst these young people did not present because of violence, they exhibited characteristics which led staff (hospital and Navigator) to believe the young person was at risk of violence. The reasons for 14 (2.2%) referrals were unclear / unknown at the time of referral.

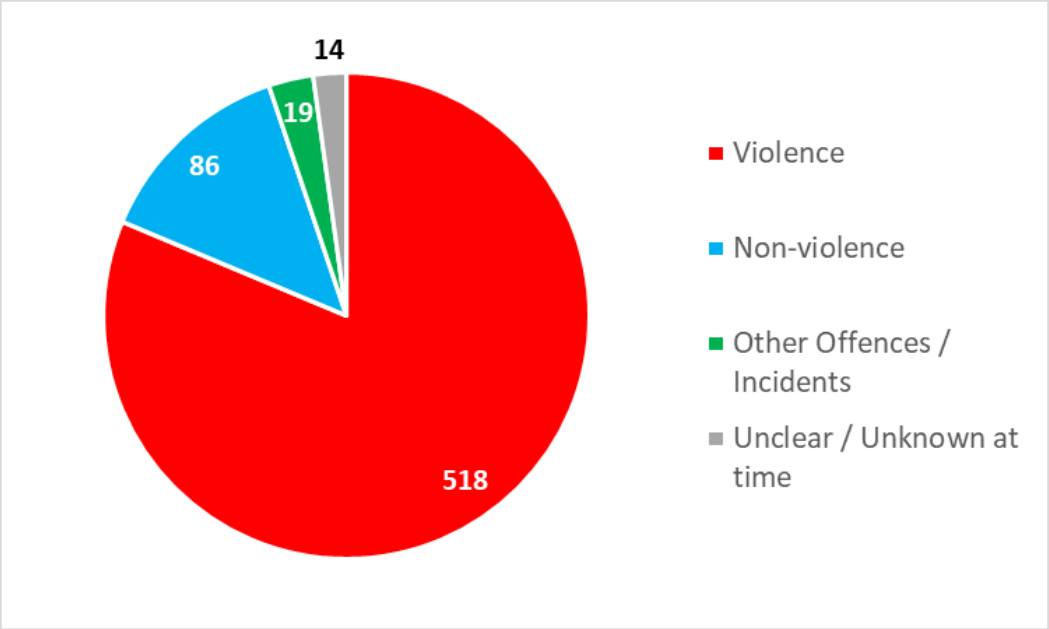

Figure 5: Reasons for Navigator referrals.

The characteristics of Young People referred to the Navigator Programme

Gender

Of the 637 young people referred to the Navigator programme, 72.8% (n = 464) were male and 25.7% (n=82) were female. In six instances, the gender of the young person was not disclosed, and three young people presented as gender variant / non-conforming. Table 1, below, presents the gender breakdown by the ED that the young person attended. The proportion of referrals that were male varied by ED. Manchester Royal Infirmary (MRI) had the largest proportion of males (86.6%) and Salford Royal the lowest (66.4%).

Table 1. Gender breakdown of young people by emergency department

Gender	Royal Bolton	RMCH	MRI	Salford Royal	Total
Did Not Disclose	2		1	3	**6**
Male	183	118	84	79	**464**
Female	85	32	12	35	**164**
Gender variant/non-conforming	1	0	0	2	**3**
Grand Total	**271**	**150**	**97**	**119**	**637**
Percentage Male	**67.5%**	**78.7%**	**86.6%**	**66.4%**	**72.8%**

Age

Figure 6, below, presents the age profile of the young people referred to the Navigator programme by gender. On average, those young people referred were 16 years old (m = 16.7, sd. = 4.3), with the

males being slightly older (m = 16.9, sd. = 4.0) than the females (m= 16.5, sd. = 3.4). Most referrals were drawn from those aged between 13 and 17 years old. In twenty (3%) cases, the age of the young person fell outside the age range (i.e., 10-25 years old) intended for the client group of the Navigator programme, thirteen were older and one younger.

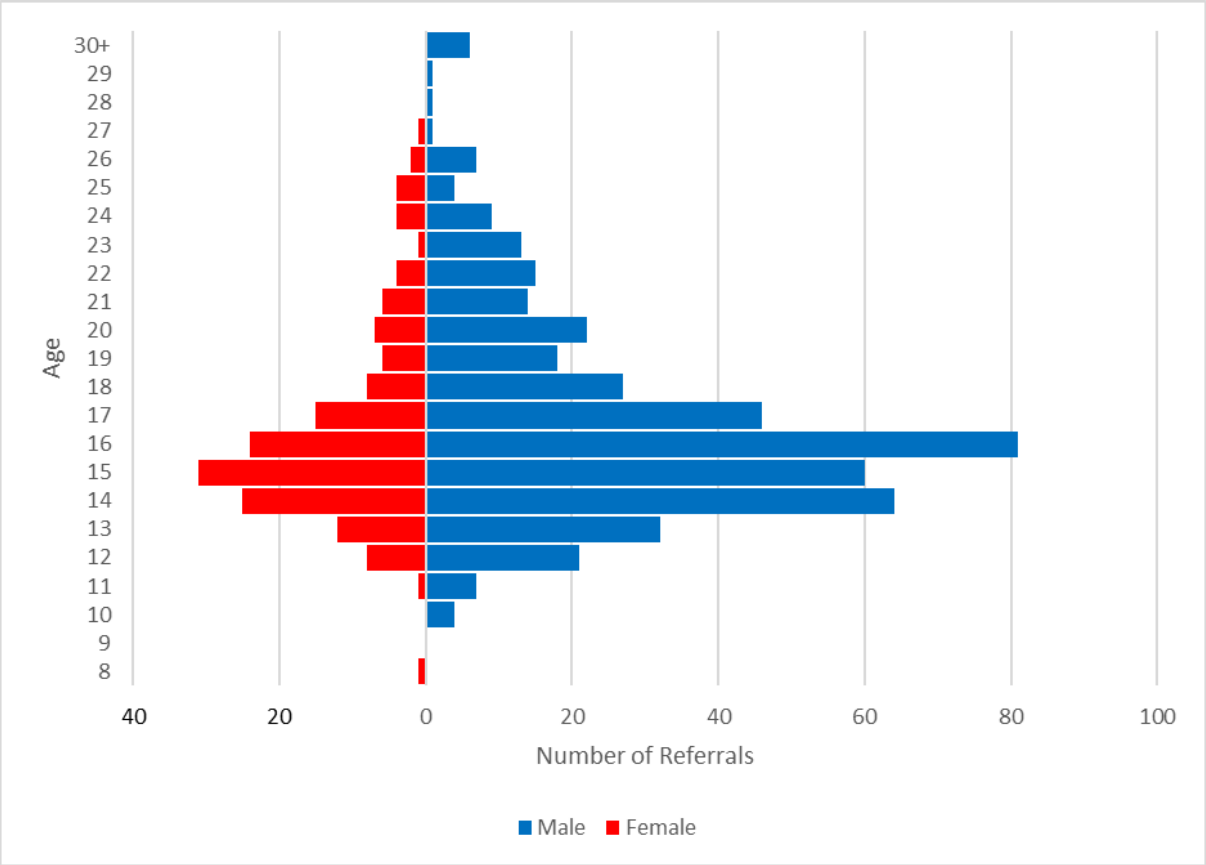

Figure 6: Population Pyramid of referrals to Navigators by Gender

Ethnicity

Figure 7, below, illustrates the ethnicity of the young people referred to the Navigator programme. Almost half (n=281, 44.1%) identified as White British, with smaller numbers identifying as Asian (n=56, 8.8%) or Black British (n=31, 4.9%). In many instances, the ethnicity of the young person was either not given or not recorded (n=217, 34.1%). It is difficult to make a direct comparison between these data and the populations (aged 10-25) of the communities surrounding the participating hospitals. In part, this is because a hospital's admissions may be from one any of the ten Greater Manchester local authorities, and in part also, because over one third of all referrals did not have an ethnicity recorded. Nevertheless, the Greater Manchester Ethnicity (Census 2021) proportions for the 10-25 age group are as follows: Asian = 17.7%; White British 63.6%; Black 6.3%; and Other 12.4%.

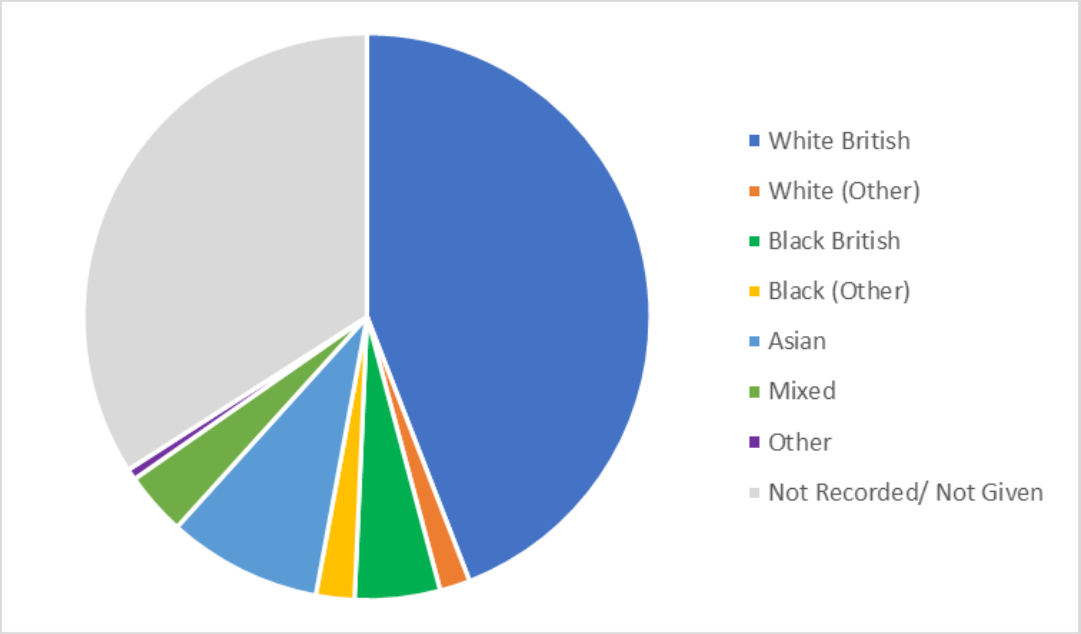

Figure 7: Ethnicity of referrals to Navigator

Engagement

Due to challenges with the engagement of young people, 276 unique participants received initial contact conversations (conversations where the service was offered) with a Navigator. 276 (43.3%) of the 637 referrals were received into the service. Thus, over half (56.7%) were uncontactable at this stage, even after multiple contact attempts. Of these 276 young people, 214 (77.5%) went on to receive one to one support and 269 (97.4%) had recorded professional sessions where the Navigator would have been involved with professionals and/parents in relation to the case. The 20% difference between those who had a professional session (97.4%) and those receiving one to one support (77.5%), are cases that didn't progress to where the young people being directly involved. There are also cases within this 20% in which support would have been given to parents or supporting professionals as the young person was not in a position to engage.

Baseline and Exit Questionnaire

A baseline assessment questionnaire was completed (by the Navigator team) with those young people who consented to engage with the Navigator programme. The assessment questionnaire was also completed with young people at the point they exited the programme. Comparison of the findings of these questionnaires enables the evaluation to assess the *distance travelled* by programme participants, i.e., the progress a young person makes measured against a set of soft outcomes. In reporting this data, it is important to note that not all young people completed questionnaires, with a

significant dropout occurring between the baseline and exit questionnaires. The Questionnaire consisted of three sections and including questions about:

- Lifestyles, feelings of safety and support
- Recent experiences of violence
- Mental wellbeing (using the Warwick-Edinburgh Mental Wellbeing Scales (WEMWEBS))[29]

At the point of referral, the Navigators also conducted a risk assessment of the young person based on three criteria: risk of harm from others; risk of harm to others; and risk of harm to self. These two sets of data (baseline assessment questionnaire and Navigator risk assessment) were combined by the Navigator team to calculate an Overall Case Risk of a particular young person.

In total, 75 participants (27.2% of those received on to the programme) completed a baseline assessment questionnaire. This number is lower than originally anticipated or hoped for. A large proportion of those young people referred to the programme did not enrol for formal engagement, even though they received advocacy and support to meet their needs, and so did not complete an assessment questionnaire. In other cases, and even when the young person consented to formal engagement with the programme, it was found that a Navigator required taking the time to build a trusting relationship with the young person before the issue of completing a baseline assessment questionnaire could be approached. The remainder of this section presents the findings of the baseline assessment questionnaires that were completed.

Lifestyle, feelings of safety and support

The questionnaire probed young people's lifestyles, feelings of safety and support. It asked them to assess how much they agreed or disagreed with a range of statements, basing their answers on a 10-point scale (i.e., completely disagree (1) to completely agree (10)'). Figure 8, below, presents the mean score generated for each of the ten questions on this theme included in the questionnaire. Key findings from this section of the questionnaire include: young people feel safer at home (mean score of 8.9) than when they are out in their local area (mean score of 6.8); young people feel supported by their family (mean score of 8.5) and can ask their family or friends for help (mean score of 8.4); and, though the mean scores are lower, trust that services can keep them safe (mean score of 8.0) and believe that they could ask professions for help if they needed it (mean score of 7.3).

[29] Warwick-Edinburgh Mental Wellbeing Survey (https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/)

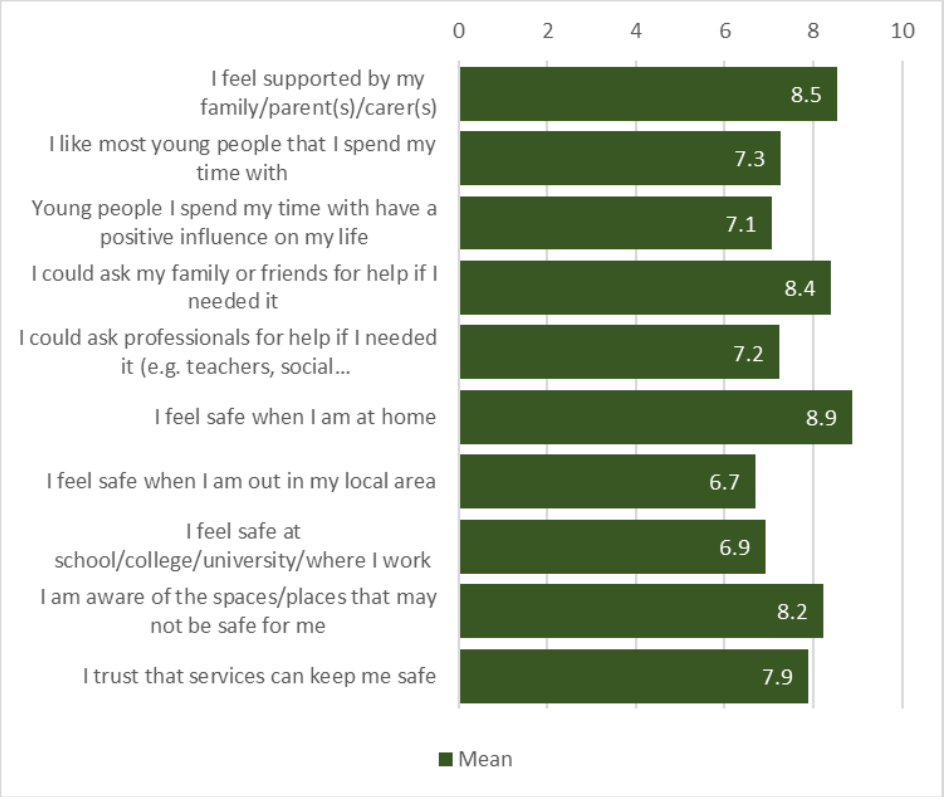

Figure 8: Mean scores for Baseline Questionnaire Question 1

Recent experiences of violence

Young people were asked if they had witnessed or been personally involved in violence in the last month and, if so, how often. Figure 9, below, illustrates the distribution of responses to these questions. Over half of respondents (50.7%) stated that they had witnessed (often / sometimes) any form of violence in the last month (n=75) and almost a third (32.0%) stated that they had (often / sometimes) been personally involved in or experienced violence themselves (n=75).

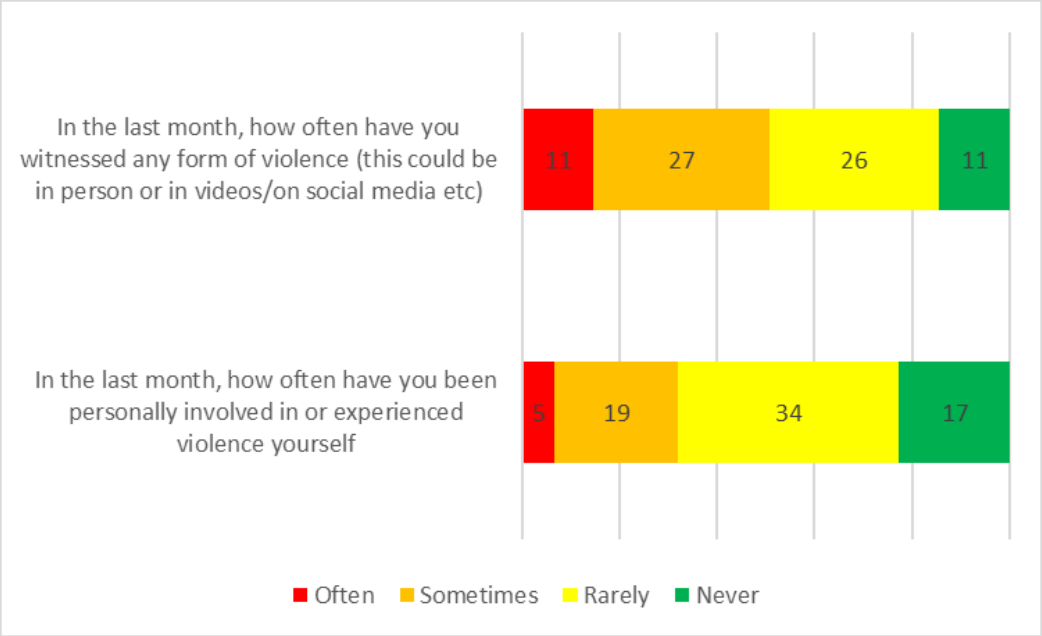

Figure 9: Distribution of Baseline Questionnaire Question 2 response scores to experience of violence

Warwick-Edinburgh Mental Wellbeing Scales (WEMWEBS)

The Warwick-Edinburgh Mental Wellbeing Scales (WEMWEBS) were developed to enable both the assessment of mental wellbeing in the general population and to support the evaluation of projects that aim to improve the mental health of a given population. A shortened, seven question version of this scale (SWEMWEBS)[30], was utilised in the baseline assessment of young people who had consented to formally engage with the Navigator programme. The young people were asked to respond to the questions by answering none of the time, rarely; some of the time, often or all of the time. Figure 10, below, illustrates the mean scores for each question generated by the 75 young people who completed the questionnaire. The mean scores range from 3.1 (*'been feeling relaxed'*) to 3.7 (*'been able to make up my own mind about things'*).

[30] Warwick-Edinburgh Mental Wellbeing Survey https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/

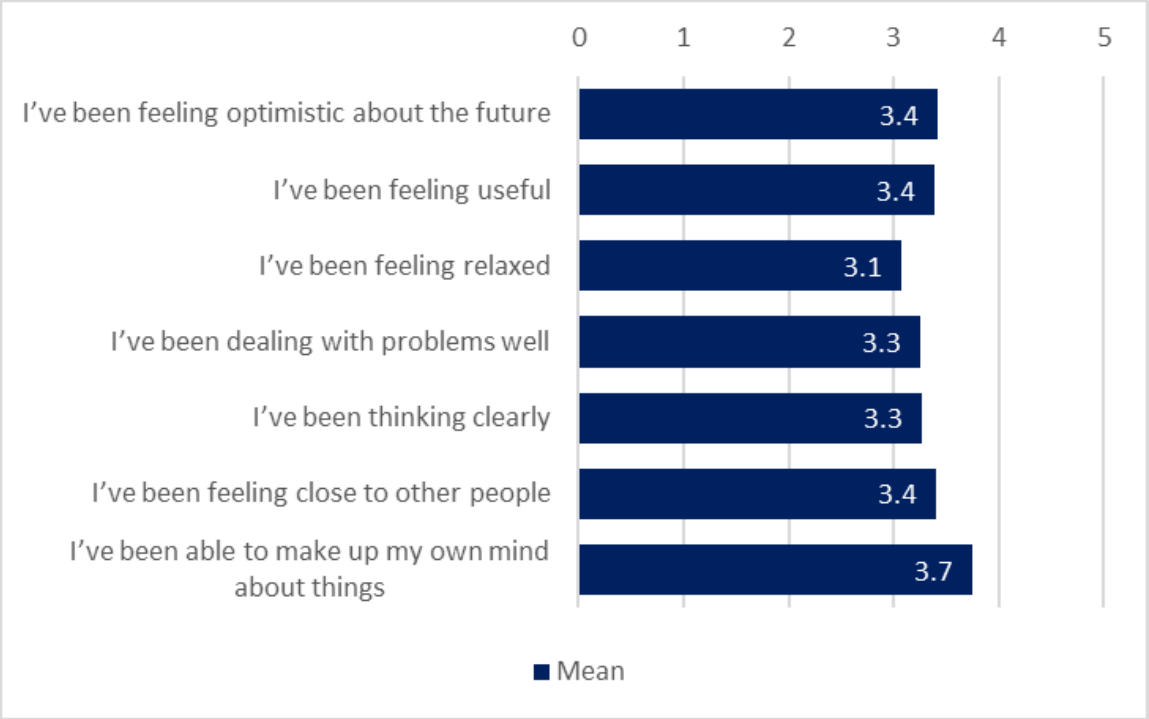

Figure 10: Mean score of WEMWEBS baseline scores

Risk Assessment

The Navigator staff completed a risk assessment for 73 young people. Figure 11, below, illustrates the findings of this exercise broken down by the individual questions comprising the assessment. Cumulatively, merging the responses to all four questions, the Navigators determined that 18 cases (24.6%) presented a medium overall case risk, with the remaining 55 cases (75.4%) presenting a low overall case risk.

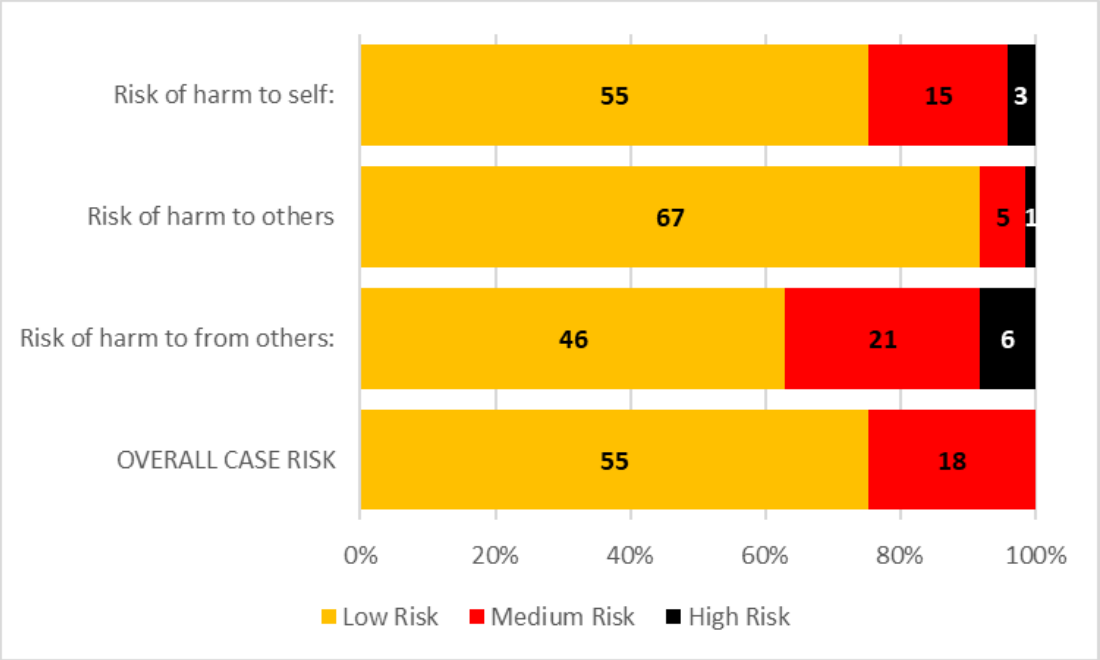

Figure 11: Distribution of baseline Risk Assessment responses

Outcome 'distance travelled measures'

On exiting the Navigator programme, young people were asked to complete the assessment questionnaire a second time. This enables a comparison of the responses between the two questionnaires, enabling evaluation of the progression or *distance travelled* by young people following their engagement with the programme. In total, 51 individuals completed the exit assessment, representing just over two-thirds (68.0%) of young people who completed a baseline assessment.

Lifestyle, feelings of safety and support

Figure 12, below, illustrates the mean score (based on a 10-point scale, ranging from completely disagree (1) to completely agree (10)), for the 51 individuals who completed a start and exit assessment.

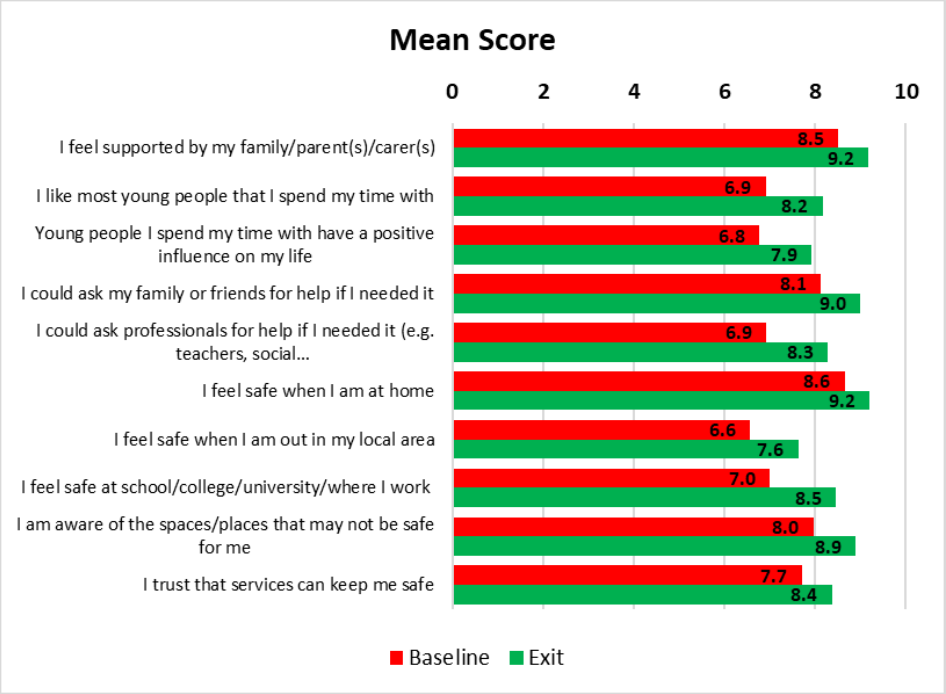

Figure 12: Average scores for start and exit assessments for Question 1: Lifestyle

In all cases there are improvements in the mean score. Figure 13 illustrates the mean difference (and confidence intervals, CI=95%) between the scores generated by baseline and exit assessments of the young person's lifestyle, feelings of safety and support. In overview, it is evident that the mean scores across all questions demonstrate an improvement from the baseline to the exit assessment. The largest mean difference change (1.45) occurred with reference to the statement *'I feel safe at school/college/university/where I work'*, and the second largest mean difference change (1.35) occurred with reference to the statement *'I could ask professionals for help if I needed it (e.g., teachers, social workers, youth workers)'*.

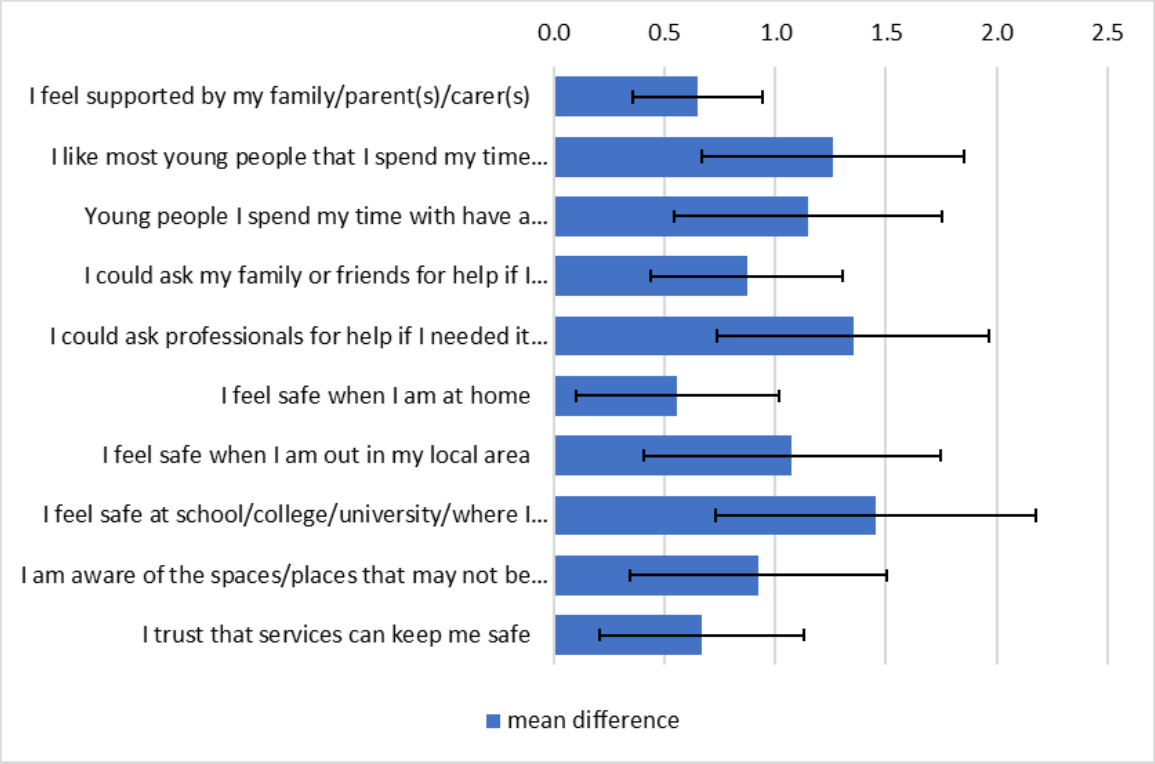

Figure 13: Mean difference between Question 1: Lifestyle baseline and exit mean scores

Recent experiences of violence

Figure 14, below, illustrates the mean scores generated between the baseline and exit assessments of the young person's recent experiences of violence. The responses were scored 1 (Often), 2 (Sometimes), 3 (Rarely) and 4 (Never). Therefore, a higher mean score represents a reduction in the young person's experience of violence. In overview, it is evident that programme participants experienced a reduction in their experience of violence.

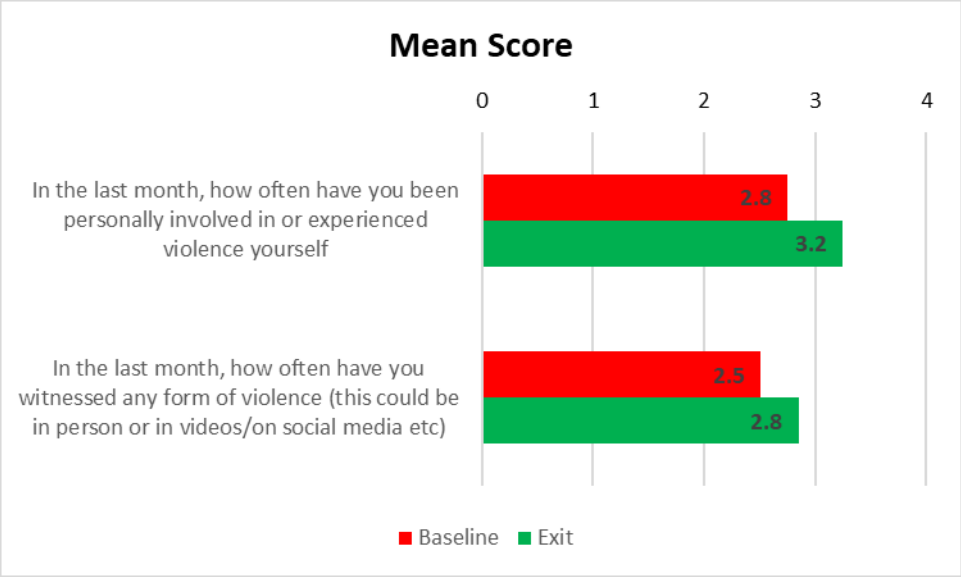

Figure 14: Mean difference between Question 2 response scores to experience of violence

Warwick-Edinburgh Mental Wellbeing Scales (WEMWEBS)

The SWEMWBS guidance[31] suggests that there should be 40 days difference between two SWEMWBS questionnaires being carried out, allowing a sufficient period for any intervention with a young person to have an impact on their wellbeing. Figure 15, below, illustrates the mean baseline and exit assessment scores (based on a 5-point scale, ranging from: none of the time (1); rarely (2); some of the time (3); often (4); or all of the time (5)), for the 51 individuals who completed both assessments. From these data it is clear that respondents reported improvements in their well-being (i.e., across all measures probed by the assessments) following their engagement with the programme.

[31] https://www.corc.uk.net/outcome-experience-measures/short-warwick-edinburgh-mental-wellbeing-scale-swemws/

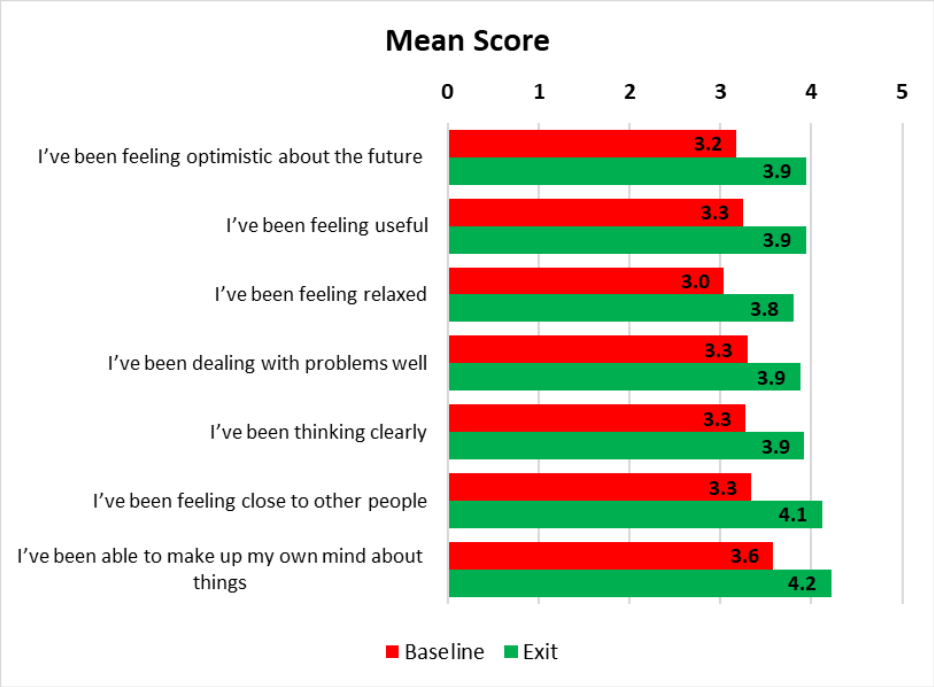

Figure 15: Mean difference between Question 2 response scores to experience of violence

Figure 16, below, illustrates the mean difference (and confidence intervals, CI=95%) between the scores generated by both assessments. In overview, it is apparent that the mean scores demonstrate an improvement from the baseline to the exit assessment. Specifically, the statements '*I've been feeling close to people'* and 'I've been feeling relaxed' evidenced the largest mean difference changes (0.78 and 0.77 respectively, whilst the statement *'I've been dealing with problems well'* evidenced the lowest mean difference change of 0.58. In summary, and whilst recognising the relatively small number (51) of responses to the exit questionnaire, there have been positive and significant changes (matched pairs t-test at P<0.01)[32] in the perceptions and experiences of the young people who consented to formal engagement with the Navigator programme.

[32] A paired t-test was performed to determine if the WEMWBS score between first response and last response was different. For example, for the 'I've been feeling useful' question, the mean increase in WEMWBS score (M=0.682, SD =0.93, N= 51) was significantly greater than zero, t(50)=-5.28, two-tail p = 0.001, providing evidence that the 'intervention' has improved the WEMWBS score. A 95% C.I. about mean difference is (0.43, 0.95)

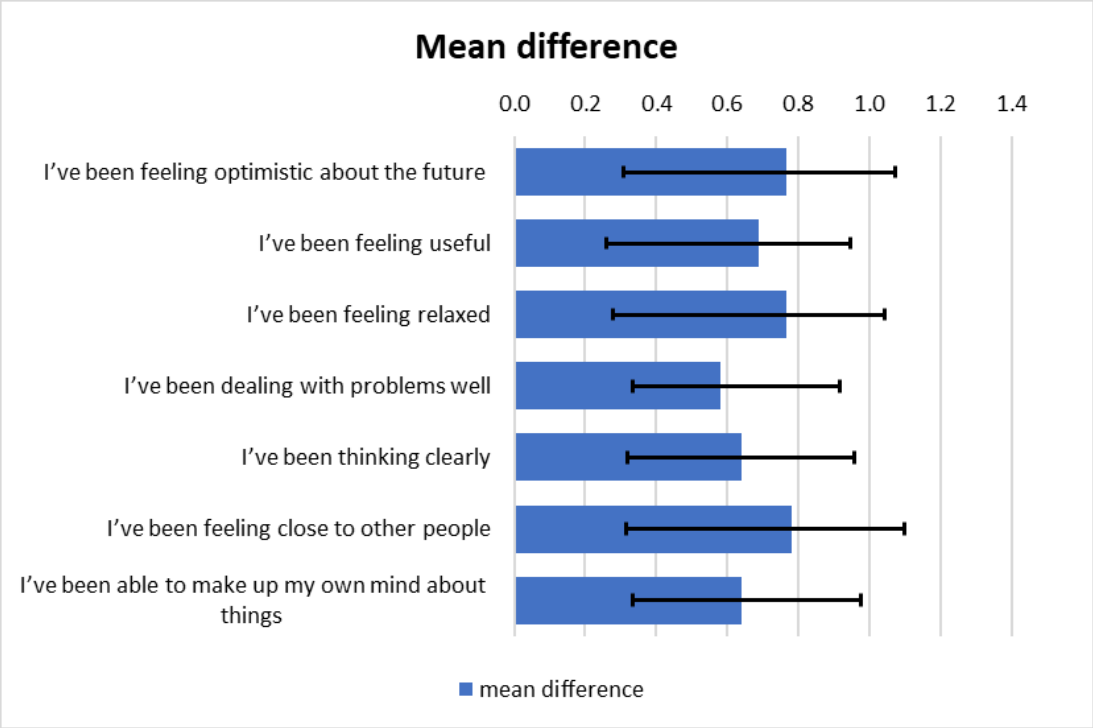

Figure 16: Difference between WEMWBS baseline and exit mean scores

Key insights

Over its first two years of operation, the Navigator programme has received 637 referrals. Over four fifths of referrals were made because of a young person attending the hospital with a violence-related injury. Almost three quarters of referrals were male, and most referrals were aged between 13 and 17 years old. Just under half of referrals were of White ethnicity, however, there were many referrals for which the ethnicity of the young person was either not given or recorded. 276 unique participants received initial contact conversations (conversations where the service was offered) with a Navigator. 276 (43.3%) of the 637 referrals were received into the service. 56.7% of young people were uncontactable at this stage, even after multiple contact attempts. Of the 276 young people, 214 (77.5%) went on to receive one to one support and 269 (97.4%) had recorded professional sessions where the Navigator would have been involved with professionals and/parents in relation to the case. Around one-quarter of young people (n=75 participants) received by the programme completed a baseline assessment, which was used to understand young peoples' lifestyles, feelings of safety, support, experiences of violences and mental well-being. The same set of questions were asked on exit for evaluation purposes, to assess the *distance travelled* by the young person. There were a relatively small number (n=51) of responses to all questions. However, the changes in the young people's responses were positive and statistically significant.

It is difficult to gauge the potential volume of demand (i.e., young people eligible to join the programme) presenting at EDs given the limited admissions data available. The evaluation found that the turnover of staff (leading to the breakdown in the Single Point of Contact) and the lack to resources to support consistent record keeping undermined record keeping practices. However, the data that has been made available is suggestive of a large variation in referral practices across hospitals and that the presence of a Navigator in a hospital at the time a young person presents is associated with a higher referral rate.

The formal (i.e., following consent) engagement of young people with the Navigator programme is low, given the number of eligible young people meeting the referral criteria that present at EDs with violence related injuries. Because of this, only a small number of young people have completed both the baseline and exit assessments. Just over one in ten young people completed the baseline assessment and two-thirds of these progressed to complete an exit assessment. However, those young people who completed both assessments evidence a positive and statistically significant improvement in their well-being. Unfortunately, the Navigator programme has not be able to undertake follow-up assessments (at 6 months) as was originally intended. This was primarily due to the lack of resource required to do so given the resource committed to working with young people who had engaged with the service.

8. Stakeholder perspectives

This section of the report presents the findings of the various qualitative research informing the evaluation. It commences by detailing the findings of semi-structured interviews with a range of key stakeholders in the Navigator programme. The interviews probed insights on the development of the programme, and the lessons learned over the course of the implementation. See Appendix A for a list of stakeholders interviewed and Appendix C for the interview schedule used in this exercise.

8.1 Stakeholder interviews

Interviews were undertaken with a range of key stakeholders (n=14), comprising both hospital and VRU staff (see appendix A for full list and their professional roles) These stakeholders had prior knowledge of hospital-based violence intervention programmes in the UK. The stakeholders informed the design and implementation of the Navigator programme. In overview, the stakeholders welcomed the development of the GM Navigator programme and were hopeful that it would make a significant difference to young people at a time of crisis and vulnerability in their lives. Moreover, they were convinced that the Navigator programme would contribute to the development of more holistic violence services in GM hospitals. Finally, the stakeholders were very positive about the Navigator programme staff, including their enthusiasm, flexibility, and ability to engage with vulnerable young people. The remainder of this section reports the insights of the stakeholders, from the development of the programme to date.

Development, aims and objectives

Whilst stakeholders had a prior knowledge of hospital-based violence intervention programmes, prior to the establishment of the VRU in GM it had not been possible to secure funding to develop such a programme.

> *"…I started to make some sort of general inquiries with a [provider] in London and talk to them quite a bit, but it became clear that we wouldn't have funding that they needed to support".* [Major trauma nurse]

The initial VRU commission enabled the establishment of a Navigator pilot programme in four hospitals. Subsequent commissions have not only supported the continuance of the pilot but extended its remit to involve the North-West Ambulance Service (NWAS) and establish a community-based offer.

> *"You're getting the service originally commissioned and then over time it's evolved, [and it] has expanded from its original remit of being a hospital-based service to being a much, much wider service."* [VRU clinical lead]

The stakeholders consistently described the Navigator programme as a 6-week support intervention for young people, aged 10-25 years old, who have been involved in violence. They recognised the ambition of the programme as aiming to reduce violence and retaliation, as well as violence-related re-presentations at hospitals.

> *"[The] Navigator project is…where we bring in youth workers into the emergency department as a way of attempting to stop…the recurrence of violence of young people who are coming to the emergency department by intervening when they present to the emergency department."* [Hospital consultant]

> *"To reach young people at a time of acute vulnerability, at that teachable or reachable moment…if they presented to hospital with an injury."* [VRU clinical lead]

Demand for the Navigator programme

Stakeholders perceive that the Navigator programme addresses a pressing need for such a service but that the demand for programme is not being fully met by the current level and deployment of Navigator staffing.

> *"It's difficult, isn't it? Because I think the demand is so variable and I think there's an issue with the project being split over a small team, over multiple hospital sites…I think the service works very well and there's probably better engagement of the service, or uptake of the service and engagement with young people when the Navigators are present on site".* [Hospital Consultant 1]

> *"I think we were worried at the outset that that to cover four hospitals, and that they were very thin on the ground".* [Major trauma nurse]

Stakeholders have suggested having dedicated teams of Navigators in each hospital emergency department as a possible solution to meet demand.

> *"In my eyes you should be having a whole team dedicated to each hospital, not just spread out between four hospitals. So, some of the problems I think are with engagement and people understanding what the actual project is, probably, because we don't have enough staff in the in the [ED] department. It's certainly not for the lack of enthusiasm and by the Navigators themselves."* [Hospital consultant 2]

Stakeholders perceive that this would also allow for earlier intervention with a young person and serve to improve the integration of Navigators with medical teams.

> *"When you have the Navigator within the department, they sit in the reception area, so they are right at the beginning of their [young person's] journey. So, they pick up on the patients that come through,*

that are aware right from the start of their presentation, and they'll intervene or introduce themselves, engage with the with the young people, even while they're sat in the waiting room sometimes…And I think that works really well." [Hospital Consultant 1]

Set against these insights, stakeholders also realise the challenge of identifying young people that meet the appropriate criteria for referral to the Navigator programme, especially whilst staff are on duty in a busy emergency department.

"…a fault of the healthcare staff, that I think that referral to the Navigator project probably isn't foremost in their mind in the middle of a busy emergency department. Whilst you're dealing with a young person who's had an injury whilst also trying to do every other aspect of your job, I think that the kind of arranging that follow up with the Navigator, because it's such a new service...gets forgotten about." [Hospital Consultant 1]

Current referral system

Stakeholders believe that the presence of Navigators in the hospital emergency department is helpful in supporting an effective and smooth referral process. Further, that being able to make an immediate referral means that young people are more likely to engage with the programme.

"I think there is some probably good evidence that supports a higher level of engagement at the time. Whilst a young person is in the emergency department, in the midst of their traumatic episode, they're more inclined to engage with non-healthcare professionals than maybe they are two or three days down the line when it's become less of an issue, and they're not so interested in that now, because their life is carrying on." [Hospital consultant 1]

However, and reflecting both the level of Navigator staffing and variable demand (i.e., the number of referrals varies across sites according to the time of day / day of the week) for the programme, Navigators are not always present in hospitals. Currently, a vulnerable young person can be referred to the Navigator programme when they present to the medical staff at a hospital or in an ambulance. Even though the referral criteria might not always be clear to the medical staff, Navigators seek to engage quickly with the young person, even when other agencies are involved. If a Navigator is not present, an endeavour is made to contact them the following day. However, with the pressure on and turnover of hospital staff, this can lead to a breakdown in the referral process.

"It will rely upon the nursing staff, primarily or the medical staff that are looking after them to think about if, actually this child fits the criteria for the Navigator project. You then send a referral on, and they will contact them the following day." [Hospital consultant 2]

"It just requires a lot of manpower to try and remind new staff for about the presence of the project. Had we got [Navigator] staff regularly in the department, on the shop floor and visible to staff, that

would be much easier, but because we don't, it requires myself and a few other keen people to keep reminding people of the presence of the service." [Hospital consultant 1]

"There is probably some variability in the…referrals coming through from the different hospitals. Because, I think one of the keys to getting referrals, is the local drive to raise awareness when staff are constantly rotating and changing." [VRU clinical lead]

There was a concern amongst stakeholders, when the service was first established, that level of engagement with the Navigator programme might be diminished if referral was made without a Navigator being present on site. However, stakeholders have developed growing confidence in the delivery of the programme in such situations.

"I think that it was not clear how effective the referral process would be when they [Navigator workers] weren't physically present. And, to my mind, that's been better than expected." [VRU clinical lead]

"You know, they were doing well, and they were having some good contact with them [young people]. So, I think we don't always tend to know how it all works out in the end. But yeah, we've generally found that that they're pretty responsive." [Major trauma nurse]

Stakeholders also praised the Navigators for the way in which they have engaged and managed relationships with other agencies working with young people.

"We've generally found that even when there has been other agency involvement, the Navigators have been willing to, you know, make those initial contacts and, if it's not appropriate for them to remain engaged, then they will step away. But we've never felt that there is any sort of barriers to any of our referrals. Generally, they will always go and talk to them. They will always make that first response." [Major trauma nurse]

Enhancing stakeholder working practices

Stakeholders believe the Navigator programme has served to support their own working practices. The Navigator programme has supported vulnerable young people with safeguarding and complex needs to engage with both medical staff and social services, even in cases where threshold for referral to the Navigator programme would not be met.

"The Navigator [workers] have…introduced themselves to some complex patients…they have that different level of engagement that you will not get with healthcare staff, because there is a level of suspicion, I think. Particularly in the groups of young people that there is a criminal element to their injuries, whether its gang related…I think there is a level of nervousness around interacting with uniformed professionals, whether they are healthcare professionals or whether they're police. And I think the Navigators avoid that, because they are not attached to us, they're not a health service. They are Youth Workers, and they have a different approach, I think, to working with the young people. And

I've seen that first hand where they've definitely managed to build a far better rapport with a young person in a complicated situation, actually, than I ever would have been able to as a healthcare professional." [Hospital consultant 1]

"…all of these assaults get referred into social services, they will often not meet threshold, or they will not engage with social services, and cases will be closed. And we worry about those young people… we know now if we can really encourage a referral to the Navigators, that we know that patience and persistence will pay off, somebody will be checking in with them even if they say no initially, they'll check in with them again" [Major Trauma Nurse]

A positive view of the Navigator programme

The Navigator programme is regarded as providing medical staff, who do not have enough time to engage with the young people beyond addressing their medical needs, with reassurance and confidence that the psychological impact of the violence-related trauma is not neglected.

"I'll fix their injuries but then there is also the ongoing safeguarding element to this…the Navigator project adds an extra layer of safeguarding that we probably didn't have before in this age group". [Hospital consultant 1]

"…having a service that we can offer to those more vulnerable adolescents; I think has been invaluable! Normally we would just be sending them away without any follow up, so to know that we've got the Navigators who can follow them up in the community has been extraordinarily helpful." [Hospital consultant 2]

"…being able to support them; whether it's an understanding of the incident, preventing mental health problems in the future, as well as being able to understand and process what's happened to them and have someone to talk. But also as well, to give them the ability to make the right choice in the future rather than…being involved in gangs. And as well, it supports the family and siblings with that as well." [Advanced Paramedic]

Stakeholders praised the enthusiasm and flexibility of Navigator staff, as well as their ability to engage with vulnerable young people.

"I think I have no doubt that it's worked very well…the numbers aren't massive. But I think the impact that the service has had on those relatively small numbers… the [way] navigators interact with these patients afterwards has been really key." [Hospital consultant 1]

"…all of the youth workers have been fantastic. They're all enthusiastic, passionate, really, about doing a fantastic job they've engaged in. In parts of the job which not necessarily fit within their remits, they're flexible. And they've just been a joy to work with and that's why it's sad that they can't be there more regularly to really be incorporated as part of our team." [Hospital consultant 2]

Stakeholders have also felt that the programme has been well managed and coordinated.

> *[Supervision], I have to make a special mention, has coordinated the service extremely well. [Supervision has] come from a non-NHS background into complexities of Emergency Department and has done this extremely well. So, I think that needs to be mentioned."* [Hospital consultant 2]

Stakeholders have also perceived the programme to have reduced retaliation and helped several vulnerable young people who suffered injuries because of violence.

> *"I went to an incident the week after [a]…death and they were going to retaliate as well. Actually, the intervention, the Navigators, really stop that. Intervention stopped the retaliation at that point."* [Advanced paramedic]

Finally, integration of the referral process into the hospital system and the broad referral criteria of the programme itself have been found helpful in accessing the programme. The Navigator youth workers are regarded as being helpful in supporting interventions (in the community), and signposting young people to other services when the referral criteria to the Navigator programme have not been met.

> *"…the service has been responsive to all the referrals where the young person has chosen to engage with the Navigator service."* [VRU Clinical lead]

> *"I know that the hospitals can sometimes serve a broader geographical catchment area than GM…when they had occasional referrals for a young person who doesn't live in GM, my understanding is that Navigators have still made contact with them and then you know, try to signpost them to some local services."* [VRU clinical lead]

> *"We've been interacting in schools and with the Safer Streets [Initiative]. We've been visiting colleges and the Navigators would come with us…and we've had young persons that have been involved in violence, and haven't really sought help, but then have disclosed quite a lot to ourselves, and we've assisted them with the Navigators to give them that increased sort support and even though we weren't directly involved in that instance."* [Advanced paramedic]

Scope for improvement to the service

In thinking about ways to improve the programme, Stakeholders highlighted the benefit of Navigators being present in the hospital EDs. To this end, stakeholders suggested that there should be a team of Navigators present for longer hours at each hospital, believing that this would ensure greater recognition of the programme by hospital staff and support an improved referral process.

"I think that it should be hospital based across the peak times. Because I think that's where we see the maximum benefit and I think they're a great addition to our team when they're there as well." [Hospital consultant]

Confidence in the benefits of the programme led stakeholders to recommend that it should it extended to include hospitals that were not part of the pilot.

"I'm a big proponent of this…I feel that it's a fantastic service…[and] it'd be great if it could be extended out to other hospitals within the region." [Hospital consultant 2]

Stakeholders recognised that access to patient data remains a barrier to the effective working of the programme. Whilst noting progress (based on a considerable amount of work), they recognised that there was variability in data access across the hospital sites.

"I think we need to break some of those barriers around health protectionism. I think around systems and access. Bear in mind it's patient data, but actually, these people are there to help our patients. And I think that's how we need to look at it." [Hospital consultant]

Stakeholders firmly believed, given the nature of the vulnerabilities of young people presenting in hospitals as a consequence of a violence-related injury, that increasing the Navigator intervention time from its current 6 weeks period would allow for better engagement with and outcomes for young people.

"…six-week window is always kind of felt a bit short! Knowing what some of these young people are like. It's just sometimes felt like it might take them three or four weeks to really get an in with them." [Major trauma nurse]

The stakeholders would also like to receive some feedback on the outcomes achieved with the young people that they referred to the Navigators programme, believing that this would also help promote the Navigator programme and encourage a higher level of referrals (including self-referrals) to the programme.

"So, six weeks later, if there was a way of saying, you know, way of communicating back [to Hospital staff]…You'd have to work out what information is gonna be shared with whom. But at the moment, there's potential for people to feel like they're referring into a black hole, and they have no idea whether anything happens with it. And that could lead to disengagement and people stopping referring…you need to think about what information gets shared back with stakeholders." [VRU clinical lead]

"we're looking at new ways of being able to get information out to young people to sort of be able to self-refer, get that help and just have a lot more of a preventative and holistic approach to violence for these young people. Because we don't have the time to be able to do it ourselves in the health service." [Advanced paramedic]

Finally, and given the belief of the benefit of the Navigator programme, stakeholders were concerned about the sustainability of the programme once its VRU funding is no longer available. Stakeholders argued for the need to develop a strategy to ensure the sustainability of the programme.

> *"I think my worry is that somebody, sometime will suddenly decide that we don't need the money and we don't need the service and that it's all gone away."* [Major trauma nurse]
>
> *"We need more! We need to continue! They are the guys!"* [Advanced paramedic]
>
> *"…this was supposed to be a pilot, and it feels like the pilot has worked. But surely if the pilot has worked, then we're looking at a staged expansion. It could be a targeted expansion. I'm not saying go out to every hospital, everywhere in GM, and give it to them. Where else are getting significant numbers of these sorts of presentations, and where is the next greatest need to expand pilot?"* [Major trauma nurse]

Key Insights

The stakeholder interviews provided valuable insight of the perceived need for, and development of, the Navigators programme. They also serve to inform how the programme can be further enhanced. The key noteworthy findings of this exercise are that:

- Stakeholders regard the Navigator programme as meeting a pressing need for such a service. However, they are concerned that the demand for programme is not being fully met by the current level and deployment of Navigator staffing.
- Stakeholders believe that the presence of Navigators in hospital emergency departments is helpful in supporting an effective and smooth referral process. However, Navigators are not always present in hospitals. Stakeholders suggested that there should be a team of Navigators present for longer hours at each hospital, believing that this would ensure greater recognition of the programme by hospital staff and support an improved referral process.
- Stakeholders praised the Navigators for the way in which they have engaged, and managed relationships, with other agencies working with young people. They regard the Navigator programme as having served to support their own working practices.
- Stakeholders felt that the programme has been well managed and coordinated, praising the enthusiasm and flexibility of Navigator staff, as well as their ability to engage with vulnerable young people. Navigators are regarded as being helpful in supporting interventions (in the community) and signposting young people to other services when the referral criteria to the Navigator programme have not been met.
- Stakeholders perceived the programme to have reduced the motivation for retaliation by young people and helped others to cope with their vulnerabilities arising from experiencing violence.

- Stakeholders recognised that access to patient data remains a barrier to the effective working of the programme. However, whilst noting progress (based on a considerable amount of work), they recognised that there was variability in data access across the hospital sites.
- Stakeholders were concerned about the sustainability of the programme, once its VRU funding comes to an end. Stakeholders argued for the need to develop a strategy to ensure the sustainability of the programme.

8.2. Navigator Perspective

Interviews were held with Navigator staff towards the beginning of the pilot programme. A focus group was held with the Navigator team (Navigators, Administrator and Strategic / Operational leads) towards the end of the implementation evaluation period. The interviews probed insights on the development of the programme, whereas the focus group sought to explore the lessons learned over the course of the implementation period and the recent development of the community-based Navigator programme. The insights generated by the interviews and focus group span a range of themes: referrals to the Navigator programme; Navigator presence at hospitals; barriers to effective working; Navigator champions; the expansion of the Navigator programme; presence at hospital 24/7; consent-based service; patience; and sustainability. We present an account of each of these themes in turn. Out with the formal interviews and group interviews with Navigators, there were regular project meetings between MMU and Navigators. These have been used to inform and qualify the findings.

Referrals to Navigator Programme

At the start of the Navigator Programme, Navigators worked with hospitals to develop relationships with key staff and to establish a referral system. Due to the diverse nature (i.e., emergency department environment, staff, information systems) of the four pilot hospitals, unique referral processes were established in each hospital. For example, at Royal Bolton Hospital, a written referral is made via a consultant, whilst at Manchester Royal Infirmary a Navigator referral link has been developed in the hospital IT system. Navigators, therefore, have had to adapt to differing ways of working in each site. This proved a challenge over the duration of the programme, particularly with changes to Navigator and hospital staffing, hospital staff priorities, as well as changing hospital IT systems. Consequently, Navigators have been required to make a significant investment of time in communicating to hospital staff their role and the referral criteria of the programme.

> *"We used to be known as the knife guys, but by being there and educating clinicians and staff… we can take referrals for a wide variety of reasons and not just knife crimes."*

> *"…if they're dealing with somebody with a stab wound or anything really like it, it is the last thing on their mind, it's an afterthought…after that person is clinically okay, then if they remember to do it, they will do."*

Navigator presence at hospitals

The visibility of Navigators at any given hospital emergency department was found to be influenced by the size of the hospital. In smaller sites, the Navigators felt that they had greater visibility. Relatedly, there were more opportunities for direct interactions with hospital staff, enabling the development of relationships. In larger sites, the Navigators faced the challenge of moving between buildings, limiting their visibility. In such situations, the Navigators required to make a greater effort to engage effectively with both clinicians and patients. By working with clinicians, as they managed 'live' cases, the Navigators sought to promote awareness of the types of cases suitable for referral to the Navigator programme. They did so with the ambition that this would help hospital staff refer appropriate cases when they were absent from a hospital.

> *"It's always been like a massive part of what you do while you're at the hospital, is walking around just talking to people. Telling them about the project, so I think that will continue to be a really important part of the time we spend at the hospitals."*

> *"…when we had access, we could see people come in, we could then go and speak to the clinicians and say this person meets our criteria. Like they're in this age category, they live in this area, this is the type of violence that they've been a victim of, or at risk of… It's not just going in to give a presentation, saying these are the people that we look for, you are giving them an exact case as well."*

> *"…establishing that relationship [with staff], especially at Children's [Hospital], because you know we've got a visual friendship, relationship, with the professional…if something is 'ringing alarm bells'…they'll still come back to us and say there's something not right here."*

As the programme developed, the Navigators began to appreciate the importance of developing working relationships with the more 'permanent' non-medical members of staff, given the turnover (and shift work) of clinicians. They perceived that this helped to improve the appropriateness and rate of referrals to the programme. Emergency Department (ED) receptionists were recognised as a key resource in influencing clinicians to refer young people to the programme.

> *"…reception staff, that's sort of like…a golden ticket for us! Because reception staff are far more, like loyal to a position, like they're more long-term…they stay there for longer, so actually, they can potentially remind clinicians and doctors and nurses and staff to make a referral. Because they once they understand the projects…and they don't leave so actually engaging with other people at the hospital."*

Barriers to effective working

The Navigators identified several barriers to the effective working of the programme in hospitals. The Navigators found obtaining honorary contracts (enabling them to wear a hospital ID card) to be a long process. In some cases, it took over 12 months to receive one. Not possessing an ID card was perceived to undermine the trust of clinicians in Navigators, particularly if the clinician was new in their role. Further, it served to create a barrier to accessing patient data and engaging with non-clinical staff.

> *"…we've got honorary contracts [with EDs], that sometimes are really difficult to get signed off and there are all these kind of like barriers to us being integrated into the hospital system."*

> *"I can feel sometimes, with new clinicians, as you're talking to them, even though you tell them, to explain the service, you can feel them staring at your staff pass. You know they're just checking [that] you do work there."*

> *"Even though an honorary contract should mean that you're seen as a staff member… we're an external agency…[there are] issues around access to tracking boards, and case files and EPR [Electronic Patient Record] systems. So…if we put [Navigator] staff into a hospital that doesn't have access to an EPR system, there's no way for any of these staff members, apart from visually and having conversations to identify who is eligible. That's already like a massive barrier to us."*

A significant endeavour was made, at the start of the programme, to embed the Navigator referral process into hospital IT systems. However, following the commencement of the programme Manchester University NHS Foundation Trust (which includes Manchester Royal Infirmary and the Royal Manchester Children's Hospital) invested in a new computer system (Hive – Electronic Patient Record, September 2022). Its full integration is still pending, preventing automatic referrals to Navigators to be generated. The lack of an automatic referral was perceived to leave medical staff frustrated when cases are not promptly picked up and to have led to a decline in referrals.

> "*And you know that we're having problems with Hive at Manchester Royal… The old system…you'd press a button, we'd get the referral, and we could instantly see what they'd been in hospital for, and then we could send [a triage], it'd go through the [referral] process, [and] that's all gone now."*

> *"…because you've got so many clinical staff that might see that button, and press the button, not realising that we [Navigators] can't actually access them in the 'carer' roles."*
> *"…with the amount of clinical staff there are, it's basically impossible to speak to every single person and say we can't use HIVE at the minute."*

"…where the clinical leads have come and said, "We've referred these, and you've not seen them." Obviously, if we're aware that the other person is on site, what we do is we'll try and send a staff member in that day."

Navigator champions

Whilst the high turnover of hospital staff was perceived to inhibit the effective working of the Navigator programme, key emergency department staff who have actively championed the programme were regarded as actively enhancing its effectiveness.

"…because you had a person on the shop floor, that was such a strong champion, in it [the pilot] completely…in fact it was more powerful than having access to the EPR [Electronic Patient Record] system, and she worked so hard that those staff members really embraced us."

" [] started to attend like the major trauma consultation meetings that happen weekly so that we can pick up, they can identify people that we can go and approach. There's the clinical psychology team that are now interested…I think the longer we're there, the more likely people are going to click into, oh this could be helpful."

The expansion of the Navigator programme

The Navigator programme has undergone several changes since its launch. Significantly, it has expanded from an hospital service to incorporate community commissioned referrals. The additional (staffing) resource that this has attracted has enabled a more robust and efficient triage process to be established. A new role has been created; two Navigators are responsible for determining the appropriateness of a referral before a young person is assigned to a specific Navigator for support. The consent of a young person to participate in the programme is now obtained at this stage, unless a Navigator is physically present at the hospital and obtains consent at that moment. The Navigators now use an allocation system, adopting a traffic light system, to determine the priority of cases to engage with. Most cases are noted as falling in the "green" (i.e., low) category. However, individuals that are identified as falling in "red" (i.e., high) or "amber" (i.e., medium) categories receive priority attention. At the time that the group interview was undertaken, the Navigators reported that given the volume of hospital and community referrals, that there was a four-week waiting list.

"…we also have triage roles…to filter out the ones that are inappropriate…so by the time they get to the youth development workers, you know that it's a young person who's consented to the service and is eligible for [Navigator] criteria."

"[Navigator Admin triages] referrals…and if they are appropriate [the Navigator workers] will contact the young people…we normally do two calls and then a letter and then we close…which never sits comfortably with me…so we always try and get hold of them."

Presence at hospital 24/7

As noted earlier, clinicians would prefer that Navigators be present at hospital sites on a frequent basis. Navigators however note that when they are present at hospitals, they often find that a significant portion of their time is not dedicated to supporting young people. This is primarily due to the irregularity of demand and extended period before a patient is referred to Navigator workers by hospital staff. Thus, Navigators do not perceive that being onsite in an emergency department (ED) frequently and for an extended period to be an effective use of their resource. Increasingly, and reflecting the expansion of the programme, Navigators prefer receiving referrals from the community. Moreover, and perceiving that the root of a young person's problems lies within their community setting, with the hospital presentation merely representing the culmination of these problems, Navigators perceive that an endeavour to identify and address the young person's problems earlier (i.e., in the community) has the prospect of being a more effective approach to violence prevention.

"We could go into a hospital, and they say that, 'It's been so busy for a while, but there's nobody for us!' Then we could go home, and they tell [us] later, that 'one person does come in.'"

"I think having the focus in community, you can help address the social issues as well. And, also be a presence within hospitals. I think it's important to do so, but to solely just kind of rely on that. I don't think it would work, no matter how many of us are in there or how permanent they're in there because ultimately where the issues are coming from, it's not the hospital."

"…as a doctor, to support a young person who's been affected by knife crime, once I patch them up and they're stable and they're fit to go home, I've done my job! I've supported that young person! But, kind of where we're coming from is…we don't want you returning for the same issues. And a doctor can't fix someone's housing, or they can't fix poverty. That does really stay in the community. And if you're a young person who's maybe involved in gangs, or really badly affected by poverty and you're selling drugs and you get mixed up in a fight and [they] actually stab you. You're going to go back to that community where you're still in, that's your life."

Consent-based service

Navigators stressed the significant volume of informal (i.e., prior to or instead of formal engagement with the programme) support offered to young people. This led to a revision of the original client

journey (reported earlier). Navigators believe that young people respond more positively to a service that allows them to give their *consent* before participating in a programme. The sense of being in control and having the ability to influence the nature of the assistance provided is regarded as significant for young people. Typically, if young people encounter situations where they are compelled or obligated to engage with social services or attend programmes, Navigators believe that they perceive these as unhelpful. Navigators recognise that it takes time for some young people to 'be ready' to participate in the programme, that they require to be flexible and to empower young people to make their own decisions.

> *"…when it comes to advocacy for young people, because we are consent based, that's a good thing. If a young person wants to engage with us, it allows us to support the young person in the best way possible because they consent to that support."*

> *"There are so many services they don't have a choice, what to engage with. They have to go to school. If they've been arrested, they have to, like, speak to the police or social workers. They don't have choices, as much, as an adult may have. So, giving them that choice, it's a selling point almost. 'Cause we're there just to listen to them and help support them."*

> *"If they've not consented…as long as you've had a positive engagement with them, and that had a conversation, whether it be a short conversation or a ten-minute conversation. Where you've sat with them and left them with a card or a leaflet. If they decide they want that support in a few weeks, they can pick up the phone, and gives a call and we have to open it."*

> *"I'm kind of working for you, and [I] keep that power in their hands, and make them believe that, okay, well, 'now I'm like, I'm the boss, so if I need this, you can help me do that… this is what I need to do to live better, avoid this…and…you help me with that'. And then it's my job to go and do it, come back to them with options and results."*

Patience

In most cases, the support provided to young people by a Navigator takes place over 6-week period. However, there are a small number of cases that take longer to process. The Navigators believe that the duration and complexity of cases demand numerous personal qualities, including persistence, resilience and being non-judgemental and open-minded. Moreover, the Navigators reported that the nature of their role (working with young people who have experienced significant trauma and working across multiple public services) was emotionally demanding.

"Some young people will just take a longer period of time before we even understand what's going on. But ultimately for that young person to thrive, we need to create a sustainable support network, which will not be us. So, it's just about being mindful…and going at their pace"

"I think you need the passion for it as well. 'Cause you need that energy…'Cause it's a hard job… we're gonna be [with] people…I think, in some of the worst situations, situations that I would never find myself in."

"I think you really need to kind of have the passion and just to have the energy to keep going when it does get tough for you from the personal side of the profession, as well as kind of when you're in the thick of it and you are dealing with young people here in crisis, and maybe they're kind of cutting themselves or they're just having a really, really difficult time, you can get kind of from all angles".

"It's a tough job. Like sometimes you feel like you're fighting these big systems and you can feel really small in it. So, if they're sort of being excluded from school, or there's criminal issues or whatever, and you can see that there's injustices in there, or somebody's not listening, that can feel really like when you're passionate about equality that can feel very, very oppressive."

Sustainability

Finally, the Navigators acknowledge that the existing VRU funding of the programme is of a short-term nature. They believe that by demonstrating the programme's ability to prevent hospital admissions, crimes, or re-arrests it paves the way to receiving long-term funding from the NHS or the criminal justice system. However, and in stating this, the Navigators recognise the significant challenge in obtaining the long-term outcome data necessary to demonstrate the effectiveness of the programme (via a formal impact evaluation).

"…the VRU which, obviously is not a sustainable source of funding...if we were properly embedded in hospitals, like, I think that there is the potential that we can stop people from re-presenting, and that saves money. There's potential that we can stop people from going into criminal justice, which saves money… but you probably would need those [services] to be putting money into…the service base."

"But we do appreciate we need to evidence the impact, and it's hard to. It's really challenging to demonstrate something that hasn't happened. How can I tell you that I've stopped that person from presenting to hospital. So, it's inherently challenging and again that's partly our issue for us to overcome."

Key insights

The Navigator focus group provided valuable insight into the Navigators programme. The findings of this exercise illuminate an evolving and expanding programme. The development of a community-based Navigator programme and its interface with the hospital programme has been broadly welcomes as a valuable advance. The key findings of the focus group can be expressed as follows:

- The Navigators have devoted a substantive amount of time to fostering trusting relationships with hospital staff and promoting awareness of the programme. Both are seen as vital to the efficacy of the programme.
- The Navigator programme was designed to support the assessment and referral of young people presenting with violence related injuries in hospital. However, and in practice, Navigators have been drawn in to providing extensive informal advocacy and support on behalf of those young people who do not formally consent to enrol on the programme. This large group of young people do not complete a baseline assessment. This proves a barrier to determining the overall need for the programme and the endeavour to demonstrate its efficacy. There is a firmly held belief amongst Navigators, however, that it is necessary to develop a trusting relationship with a young person prior to them being willing, or it being appropriate, to undertake a thorough baseline assessment.
- The flexibility of the Navigator staff (in the initial developmental phase of the programme) has enabled the identification of scenarios in which young people need and desire support but are unable to access it. These span situations in which familial gatekeepers and / or the hospital environment inhibit engagement, to situations in which young people are fearful to leave their home to access support.
- Navigator access to hospital IT systems and data has remained problematic throughout the implementation phase of the programme. This has inhibited the identification and tracking of eligible young people presenting at hospital. The limited access to, and poor quality of data, to Navigators also poses a barrier to the establishment of a robust impact evaluation.
- The volume and severity of cases being managed by Navigators has an impact on the health and well-being of Navigator workers. Appropriate support structures need to be established and maintained.

9. Case studies

This section of the report presents a series of client case studies (vignettes). They have been developed by the Navigator and research teams. The case studies are intended to illustrate the spectrum of clients that engage with the programme and the journeys that they take. The case studies have been anonymized, meaning that the names and personal details presented do not reflect individual clients. Rather, the case studies are composites of multiple individuals. To an extent, the case studies are self-explanatory. However, and cumulatively, it is possible to draw a core set of observations pertinent to the delivery and outcomes of the Navigator programme. First, the case studies provide a clear indication of both the diversity and complexity of needs with which young people present to the programme. They are indicative of the very challenging situations in which Navigators first seek to support young people. Second, not all young people are willing to engage with Navigators at the point of their initial contact. Many of the young people are distrustful of helping agencies and / or the circumstances of their presentation are not conducive to productive interaction. However, through providing multiple opportunities for engagement, the Navigators have been able to access and work with a larger cohort of young people. Relatedly, and given their distrust of other agencies, it takes time for Navigators to develop trusting relationships with young people. Finally, the client journeys are non-linear and often (by necessity) lengthy. Given the deep-rooted problems that underly the crisis leading to a young person presenting in an ED, this is unsurprising. Supporting young people takes time. Their progress is often interrupted by new crises. Not all the potential solutions to the problems being experienced by young people can be addressed in a timely manner. Navigators spend extensive periods of time negotiating with other agencies and convincing young people of the value of engaging with them, given their past experiences. Here, it is important to highlight that whilst some young people presenting in hospitals were unknown to helping agencies, many held extensive prior engagement with them. In overview, the case studies emphasise the requirement of Navigators to engage with and support young people far beyond the initial 6-weeks planned in the design of the programme.

Case Study 1: Katie (20 years old) presented at an Emergency Department after being involved in a road traffic collision (RTC). Katie was a passenger in a car that had been driven recklessly and it was believed that the driver was under the influence of substances. A referral was made by the clinician as they felt concerned that Katie was vulnerable to exploitation and that she was involved in risk taking behaviour.

After initial engagement over the phone, Katie cancelled a number of planned visits with the Navigator. After 6 weeks, however, she attended an appointment and worked with a Navigator to identify some goals that she wanted to achieve. Katie's main goal was to move out of a hostel that she was living at. The hostel offers semi-independent living for adults, many of whom have complex social needs. Katie's belongings were being stolen and she found it very stressful living at the hostel.

Katie has a limited support network and, as the hostel was not frequently staffed, she was unsure what she needed to do to secure alternative housing. The Navigator supported Katie to apply for social housing and in doing so established that Katie was a care leaver and had been known to Social Care by a previous name. Katie was unaware she was entitled to support from Leaving Care services, who are currently looking into whether she is eligible for a grant to support her to secure more suitable accommodation near her college.

Case Study 2: Ben is 14 years old and was brought into A&E with multiple stab wounds to his chest. Ben was attacked outside his home by a large group of males from the local area. His behaviour was challenging on the ward. He was abusive to staff and reluctant to receive support. After a short stay on the ward, he was deemed medically fit and discharged. Ben has a social worker, but she reports that he does not engage well. He is known to engage in antisocial behaviour in his home area and is regarded as making consistently bad lifestyle choices.

Ben's home is not secure as during the incident the windows and doors were smashed. Temporary boards have been put up. It was agreed that it is best for him to go and stay with a relative out of area for his personal safety.

After a few days, Ben's mum decided that it was best to return home and get on with things. Ben is unhappy to return to the property, which he vocalises to the Navigator. The Navigator discusses this with Ben's mum and social worker, and advocates for a safety plan to be put in place. This included asking the police to flag the address on their system, to ensure that if they do return home and there is a further incident that there will be a quick policing response.

Over time the Navigator works to challenge the social workers perspective recognising that, despite Ben's initial reluctance to engage, he is persistently saying he does not feel safe and that he wants life to look different for him. This change in perspective really starts to improve his relationship with the social worker, who engages in proactive support to identify and overcome Ben's concerns.

Ben has not left the property since the incident as he is fearful of another attack. He has been out of education for 3 months and doesn't see friends. The alleged perpetrator lives nearby, and Ben tells the Navigator that he and his friends regularly pass his home as a means of intimidation. Ben feels anxious all the time, for which he self-medicates with cannabis. Ben decides to give a witness statement to the police. The Navigator goes with him and his sister to support him through the process. As Ben is wanted in connection to other offences, the decision to do this also means that he is arrested and interviewed in connection with other crimes.

3 months on and no action as yet has been taken in relation to the named perpetrator. The Navigator provides Ben with updates and liaises with the police to ensure that he knows what is going on whilst they are gathering information relating to the incident.

2 months after he is stabbed Ben is arrested on suspicion of committing a crime in the community, the charge for which is later dropped. Ben is really upset about this as he hasn't felt safe to leave his home since the incident and thinks that it is a malicious claim made by the person who stabbed him. He also received a caution for cannabis that was found in his room when the officers came to arrest him.

The Navigator requests a strategy meeting to look at how to support Ben back into education, looking at practical ways to reduce his fear that he may be attacked on the way to or from school. Ben is now back in education and although it has been challenging, he is rebuilding his confidence to be around other young people. The Navigator continues to work with him to set new challenges and goals.

Case Study 3: Alex is 15 years old and is brought into A&E after he collapses outside a local shop. When he is brought in a large knife is found concealed in his clothing. Alex was stabbed in his chest 6 months earlier in an attempted robbery and a few months later witnessed the murder of his friend. Since this time, Alex's family report that he has become withdrawn. Alex does not work with any support agencies, though he was referred to some services following the murder of his friend. His case was closed due to lack of

engagement. He hangs out with a group of older males known to be involved in criminal activity and regularly smokes cannabis and his family believes that he may use other substances. Alex was also issued with a Threat to Life Notice 6 months ago.

On meeting the Navigator he states that he is fine and doesn't need any support. Alex finds it difficult to hold a coherent conversation, which medical staff believe is due to him being under the influence of a substance. The police confiscate the knife, a safeguarding referral is made to Children's Social Care and he is deemed medically fit to leave and returns home with his family.

The next morning the Navigator receives a text from the family asking for help. Alex's behaviour has become more erratic and concerning. The family would like a mental health assessment as they believe that he needs constant supervision. They request that the Navigator sets this up for them. A referral is made through the GP for an assessment from the community mental health team and Social Care are contacted to update them with regard to these concerns. The family are advised, by Social Care, to return to A&E for a mental health assessment as there is not enough capacity to send someone out to meet them. Social Care also advise that they are reviewing the referral but feel that Alex's support needs are best met through health services. At A&E the situation escalates and Alex absconds, resulting in the police and security being called to locate Alex as he is deemed at risk.

The Navigators and medical colleagues advocate for Alex and his family to ensure that his vulnerabilities are being considered by Social Care. A strategy meeting is called in which Social Care detail their decision to close the case as Alex's needs are deemed best met through other services. This decision is challenged and it is agreed that the case meets S47 threshold.

Alex asks the safeguarding nurse where the support was when he needed it 6 months ago. The Navigator continues to support the family and try to engage with Alex. The Navigator recognises that Alex has a deep distrust of services and that this relationship will not come easily, that consistency is key, and that the most important thing is that Alex knows there is a service there and how to access it as and when he is ready.

Case Study 4: Rob is a 20-year-old male. Rob's difficulties began at an early age. He was excluded from school and attended a Pupil Referral Unit. He does not regard the help he received as very supportive. When asked what he thought would have helped, he responded "a miracle". Around the age of 17, Rob was diagnosed with ADHD and medicated for this. However, he believed that he didn't need the medication and stopped taking it. Looking back, he realises that this was a mistake. Throughout these early years Rob recognised that he did not have a "positive" or "mature" social circle. Following multiple short-term employment experiences he joined the army, which he described as being a "good time in his life". After leaving the army, Rob felt as though he was "falling backwards" and "went straight back to square one". He fell back into using illegal substances, became surrounded by a "negative" social circle and engaged in a range of offending behaviour. There is an on-going case for one of these crimes.

Rob was first referred to the Navigator team after he witnessed the murder of a close friend, an event that he recognises had a significant impact on his mental health. However, he chose not to engage at this stage. He withdrew from his social circle, attempting to leave the "negative influence" of his peers behind. Later, he presented in hospital having been the victim of an assault. He was once more referred to the Navigator team and, both at this point and going forward, he was more open to receiving support. He engaged well with the team and with his youth worker. Yet, he subsequently took an overdose for which he was hospitalised once more. He then experienced a period of homelessness. The Navigators supported Rob during this period. They offered advice to enable Rob to develop more positive social relationships and made referrals to a range of community services. The Navigators also referred Rob to a homeless advisory agency, enabling him to secure accommodation. He has become more positive about life and has secured a new job, which he is excited to begin. He now feels that he has the support that he needs and the confidence to seek additional support by himself if this is needed.

Case Study 5: Lucy is a 14-year-old female. She was adopted at an early age. Lucy's relationship with her mother was initially good but has deteriorated as she has grown older. Her mother says that she now "doesn't listen and does whatever she wants". When Lucy started high school, she started to see a psychologist to support her mental health and well-being. Nevertheless, she has been excluded from school multiple times. Lucy disagrees with the reasons she has been given for being excluded. Her mother and father are confused as to why Lucy has been excluded so many times, but because it has happened so many times have grown accepting of it. During this time, Lucy was referred to a social worker, but this relationship broke down when she refused to engage. Lucy began to self-harm. She doesn't remember exactly why she had started to do so, but "it didn't let her feelings out".

Lucy was referred to the Navigator team having been involved in a fight at school. She engaged well and said that she "now had someone speak to, someone who could understand her" and that she could now "speak openly". The Navigator helped Lucy to learn how to control herself in difficult situations and notice red flags in relationships with others. She has grown in confidence and believes that she has begun to "take steps forward". The Navigator is also helping Lucy to improve the relationship with her mother.

Case Study 6: **Alisha** is a 13-year-old female. Growing up, she frequently witnessed her parents fighting. In one such instance, her father punched her mother in the eye. When 8-years-old, Alisha was hit by her father, resulting in deafness in one ear. On occasions, her father forced her brother to sleep outside. These experiences made Alisha feel "weird". She says that she is not really bothered by these events anymore but says that she "cannot tell if that's the right way to be loved or treated". At primary school, Alisha felt that she was supported and had someone (a trusted teacher) that she was able to speak to about how she was feeling. At home, however, Alisha witnessed her brother and father having physical fights. She says that at this stage she "was used to it" and whilst it made her feel "sad", she also felt "numb to it". At high school things began well, but soon Alisha was involved in several fights. She feels that she was targeted and bullied. She became scared of a particular child who had threatened to "break her head". She told a teacher about her concerns but thinks that they did not believe her. During this time, Alisha felt "drained, weird, sad and stressed". It was at this point that Alisha was referred to the Navigators team. The team, having spent time talking with Alisha about her needs, referred her to a counselling service. Alisha now feels that she has someone to speak to that she can trust. The Navigators team maintained contact with Alisha and supported her to rebuild relationships with staff at school. They challenged teacher perspectives of Alisha's support needs and encouraged actions to be put in place to enable her to move forward with her education.

Case Study 7: Callum is a 14-year-old male. He moved to a new area in 2019 and began to get involved in illicit drug use, fighting and anti-social behaviour. He did not do these things prior to this move and puts it down to "socialising with the wrong crowd". Callum was allocated a social worker; he does not remember why but feels that this was not that helpful. Callum says that the social worker "kept going over the same things" such as safety. At this time, he had an altercation with Mum. He also got "jumped" by two people, leading to him not wanting to leave the house. After some time, he began going out again but was anxious about being around people he didn't know. Callum began smoking and drinking alcohol to "relieve stress". He drank alcohol about two to four times a week. He noticed the negative impact of this upon him and made the decision to quit.

Callum was referred to the Navigators team following his assault for which he required attending hospital. At first, he was concerned that the Navigator was "another social worker" and did not what they could do to help. Through time the Navigator built a trusting relationship with Callum, and they began to explore the challenges he faced and how to work through them. Callum thinks that this relationship has served to improve how he feels and has raised his confidence. However, he feels that he needs on-going support because of "other situations" that are likely to arise. The Navigator helped Callum to access an Early-Help worker, someone that Callum now regards as a trusted adult. The Early-Help worker has worked with Callum's mother, aunt and grandmother, and Callum feels that his relationships with them have improved.

Callum now feels more resilient and optimistic about life. He feels comfortable with the Navigator team closing his case, providing that he can reach out to them if he “needs it”.

10. Key findings and recommendations

This section of the report details a set of key findings and recommendations derived from the 2-year implementation evaluation of the Navigator pilot programme in Greater Manchester. The evaluation spans the set-up and roll-out of the programme. It captures the development of the programme as it has responded to both operational challenges and opportunities (i.e., the extension of the pilot funding period and the broadening of the Navigator programme remit), as well as the findings of an initial 5-month implementation evaluation. The key findings and recommendations are derived from the assessment of emergent Navigator client data and interviews with both stakeholders and the Navigator team.

Key findings

The Navigator programme was established with reference to the operational remit and theory of change guiding the Violence Reduction Unit in Greater Manchester. Its development was informed by recognition of the (perceived) large number of young people in Greater Manchester presenting at emergency departments with violence-related injuries and of the promise offered by hospital-based violence interventions to redress this problem. The programme was designed with reference to pre-existing (national and international) hospital-based violence interventions and delivered by an organisation (Oasis) with experience of this type of intervention.

The Navigator programme received 637 young people referrals during its first two years of operation. The vast majority of young people referred to the programme, were referred as a consequence of presenting in an ED with a violence related injury, therefore, matching the original referral criteria for the programme. Three quarters of people referred were male, with most aged between 12 and 17 years old. These young people have presented with a spectrum of needs, demanding individualised support packages to be developed. The Navigators have spent considerably more time and resource, than initially envisaged in supporting clients who do not formally enrol to engage with the programme when they present in the ED. Whilst utilising this service, the programme has been unable (i.e., due to a lack of consent, the brevity of engagement or issues with following up young people) to capture data on this cohort of young people. Of the 637 referrals, 276 (43.3%) young people were received into the service, 214 (77.5%) of these went on to receive one to one support and 269 (97.4%) had recorded professional sessions where the Navigator would have been involved with professionals and/parents in relation to the case.

To measure the impact of the Navigator programme, young people who enrolled onto the programme were encouraged to complete baseline and exit assessments of their lifestyles, feelings of safety, support, experiences of violence and mental well-being. Around one-quarter of young people (27.2%) received by the programme completed a baseline assessment. A smaller number completed the exit assessment. Comparing the responses to both assessments enabled the evaluation of the *distance travelled* by a young person during their engagement with the programme. It was found that the young people who completed both assessments had achieved positive (and statistically significant) improvements across all issues probed.

Stakeholders believe that the programme has been well managed and that it serves to meet a pressing need. Hospital staff hold high regard of the personal attributes of, and the role being performed by, Navigators. They believe that the presence of Navigators in emergency department settings helps improve hospital staff engagement with vulnerable and traumatised young people. Indeed, and beyond supporting those young people presenting with a violence-related injury, hospital staff reported that Navigators play a valuable role in cases beyond those solely shaped by a violence-related injury, believing that young people were more likely to engage with Navigators than hospital staff, building the trust necessary to progress to positive interventions. Hospital staff (and other stakeholders) would prefer to see an increased Navigator presence in EDs, i.e., Navigators being on site more frequently.

The positive reception of the programme by hospital staff has helped Navigators to become embedded within hospitals, to develop relationships with staff and to access to hospital record systems for patient details. Communication about the nature of the programme, and its offer, has supported hospital staff to engage with the programme. However, the continued turnover of hospital staff (including those in supervisory roles) has demanded that the promotion of the programme be an ongoing process. Navigators have become embedded within hospital delivery structures, attending meetings with hospital teams, other than emergency departments, and providing expert advice and support to other professionals. Stakeholders, believing the programme to be successful, would like to see it rolled out to other hospitals across Greater Manchester.

It was initially planned that the Navigators perform a longer-term supporting and onwards referral role with their clients. This has not been advanced in most cases. Beyond the large volume of cases in which informal advocacy and support has been offered, the Navigators have been unable to capture longer-term outcome data on their clients for two key reasons. In some cases, the chaotic lifestyles

and difficult living circumstances of the young people inhibited longer term engagement. In other cases, and after initial contact with advocacy and support at the 'teachable moment', longer-term engagement has been deemed as not necessary. Cumulatively, these factors have posed a significant challenge to data collection and recording for both operational and evaluation purposes.

Recommendations

Based on the insights generated by the implementation evaluation, the following recommendations can be made. The recommendations presented include those which were made in the interim 5-month evaluation report, where they are consistent with the findings presented in this report. The recommendations address both strategic and operational issues, as well as the feasibility of developing an impact evaluation. Where actions to address the recommendations have already been undertaken (by the VRU, Oasis UK and the Navigator team), these are noted.

The Presence of Navigators in Emergency Departments (ED)s: Hospital staff perceive substantive value in Navigators being present on site. It is seen as vital that Navigators are on site when vulnerable young people present at the hospital, not least in that it ensures that hospital staff are aware that the programme is operational. Navigators are recognised as providing both informal and formal timely advice to emergency department and hospital staff. Relatedly, and in recognition of the significant turnover of hospital staff across all sites, a Navigator presence is seen as performing a briefing function to hospital staff on the Navigators programme. However, Navigators, recognising the infrequency of demand for their services, do not regard a prolonged presence in emergency departments being a cost-effective use of their time. Navigators perceive that their time is better used in dealing with existing cases. The development of the community-based component of the Navigator programme has heightened this perception, particularly due to the volume of cases being referred through this route.

Recommendation: It is essential that a clear and consistent approach is developed to guide Navigator presence in hospitals and to balance this role alongside the other activities (i.e., work in the community) that Navigators perform. The Navigator programme requires to maintain both promotion and relationship building, given the high turnover of hospital staff. It may be appropriate to embed Navigator programme information in hospital training and briefing documentation. In the on-going context in which operational information sharing between hospital staff and Navigators is inhibited (see below), the importance of this issue cannot be stressed enough.

Longer lead-in and operational periods: Many of the young people presenting in hospitals (and in the community) have chaotic lifestyles and struggle to engage with Navigators (at the point of their presentation) due to their wider vulnerabilities and mistrust of helping agencies. Most of the young people presenting in hospitals do not consent to formal engagement with the Navigator programme. However, both hospital staff and Navigators see significant value in the informal advocacy and support being provided to this cohort. Moreover, being able to work informally and over an extended period has enable Navigators to develop a trusting relationship with young people and to overcome situations in which familial gatekeepers and / or the hospital environment inhibit their formal engagement with the programme. Being able to work with those young people who formally consent to engage with the programme would also serve to support Navigators conduct a thorough needs assessment (utilising existent Navigator programme tools), advocacy and mentoring, and follow-on referrals to helping agencies. The case studies presented in this report demonstrate the successes achieved through longer engagement.

Recommendation: To provide an effective intervention, sufficient time must be allowed to enable Navigators to build up a trusting relationship with a young person (prior to their potential formal engagement with the programme) and to commence the address of their challenges. This requires being comprehensively budgeted. Engagement with a young person requires to extend beyond contact in emergency departments and hospital wards to include contact in community settings. To ensure (and demonstrate) the sustainability of any improvement in a young person's well-being, more resource should be devoted to a longer-term follow-up. Information on a young person's outcomes should also be incorporated into a formal feedback process to ED staff. Data should be collected from such client follow-ups to inform an impact evaluation.

Navigator integration into hospital teams and access to patient data in hospitals: There is benefit, in terms of client relationship building, in Navigators being seen as 'different' or 'separate' to hospital clinical staff. However, to perform effectively, Navigators need better integration into Hospitals. This spans the timely granting of honorary contracts (i.e., to gain staff ID cards) and access to IT systems (i.e., for client data). The absence of these permissions is currently impacting both referrals and the time taken to gather information, undermining the performance of the programme.

Recommendation: Navigators require being given honorary contracts to enhance their acceptance by other staff in the hospital. Navigators require being granted access to hospital IT systems (subject

to confidentiality and permissions) in a timely manner, so that they can independently generate referrals to the programme.

Improving client data: There are significant deficiencies in the data collected by hospitals and the Navigator programme. From an operational perspective, Navigators have inconsistent access to client data across the four hospital sites. From a systems perspective, hospitals must do more to account for both the volume of young people presenting in hospital and the number of referrals made to the programme. hospitals are currently unable to provide these data because of limited resources and a high staff turnover. Data provided to this evaluation also differs substantially from the TIIG data provided by Liverpool John Moores University (LJMU) to the VRU. There is also an evident large drop-off (depreciation) of data, as a young person progresses through the Navigator programme (i.e., from referral to initial and final assessments). Only a small proportion of young people complete a baseline assessment and even fewer complete a follow-up exit assessment. Currently, no data is collected on client referrals to other organisations, nor the outcomes of these referrals. Collectively, these shortfalls inhibit the capacity to demonstrate the volume of demand for the programme and the evaluation of its efficacy.

Recommendations: It is necessary to improve the quality of data available for operational and evaluation purposes. New data capture procedures require being established. These include:

- **The use of Hospital Admissions data (not available to this evaluation) to calculate consistent referral rates to the programme across participating hospitals.**
- **The Navigator team improving their capture of both the baseline and follow-up assessment of young people, as well as identifying the number of young people who do not (formally) engage with the programme.**
- **Implementing a resourced (VRU) data management strategy to capture the onward referrals to helping agencies and six-month follow up assessments of young people (i.e., those have engaged with Navigators and exited the programme / or received support from other agencies).**

Up scaling the programme: The stakeholders would like to see the programme extended beyond the current hospital pilot sites. However, and given the extension of the Navigator programme to community settings, it is essential that the operation relationships between Navigators in community and hospital settings are clearly delineated prior to this taking place. Relatedly, it is important to assess the demand for Navigators emerging from both settings to ensure that resources are used efficiently. The decision to upscale / rebalance the programme will have implications for the impact evaluation

of the programme. Delaying the extension of the programme to other hospital settings would enable the development of a robust quasi-experimental or comparative evaluation design.

Recommendation: Assess the (potential) demand for the Navigator programme arising from different referral routes and settings. Consider the implications of the expansion of the programme (e.g., into the community) upon the endeavour to undertake an impact evaluation.

Low referral rates: The evaluation discerned different referral rates across the hospital settings. Given the number of eligible young people presenting in hospitals, the overall referral rate to the Navigator programme is low. This finding mirrors that found in the evaluation of the Merseyside programme (Quigg *et al*., 2022).

Recommendation: **Investigate the reasons underlying the low referral rates to the Navigator programme in hospitals.**

Sustainability of the programme: Both stakeholders and Navigators acknowledge that the existing VRU funding of the programme is of a short-term nature. Both stakeholders and Navigators are concerned about the sustainability of the programme.

Recommendation: The VRU must determine a strategy to plan for the continuance of the programme.

Duty of care to Navigator Staff: Due to the volume, complexity and severity of cases being managed by Navigators, there are undoubted risks to the health and well-being of Navigators. Navigators reported that the nature of their role was emotionally demanding.

Recommendation: The VRU / Oasis must ensure that appropriate support structures for Navigators are established and maintained.

Recommendations from the interim 5-month implementation evaluation: This evaluation report made numerous recommendations. Here, we review these recommendations and the progress made in their address. It was recommended that improvement be made to core Navigator data collection and recording (data fields). This recommendation was successfully addressed by the Navigator team. It was also recommended that data capture required being adjusted to accommodate the increased

scope of the project (i.e., to capture the extensive informal advocacy being provided to those who did not consent to engagement with the project). It has not been / is not possible to address this issue with respect to client data (i.e., consent being a barrier to such data capture). However, **the Navigator team still require developing mechanisms to capture the volume and more detail on the types of informal advocacy undertaken** with this cohort of young people. Relatedly, these activities are out with the original scope of the programme (and its evaluation). Thus, **it is necessary to consider whether the programme requires formal revision of scope going forward**. As recommended in the interim report, the client journey has been modified to incorporate young people who do not formally consent to engage with the programme but receive informal support and advocacy. The client journey has also been amended to take account of the expansion of the programme into community settings.

Feasibility of an impact evaluation

A core ambition of the VRU commissioners has been to undertake a robust impact evaluation of the Navigator programme, such as a Randomised Control Trial (RCT). It was recognised, however, that prior to an impact evaluation being undertaken that the programme required being successfully implemented and 'stable'. There are multiple challenges faced in undertaking a 'robust' evaluation of hospital-based violence interventions (see, Webster *et al*., 2022; Sutherland *et al*., 2023). Drawing on this literature, we identify some of the key issues facing the progression to an impact evaluation of the GM Navigator programme are listed:

- The need for a period of intervention stability prior to undertaking an impact evaluation. There has been a lot of change in the programme within its first two years of operation.
- There are substantive differences between programme delivery across the 4 hospital sites (i.e., referral rates, staffing, access to IT systems).
- There are ethical and practical challenges to developing a suitable randomization process (i.e., consent, inclusion / exclusion from the programme), or to develop a series of comparison groups with patients from other hospitals using a quasi-experimental design.
- There requires being greater clarity of the intention to treat (i.e., should this span informal advocacy and formal engagement with the programme?)
- It is essential that more young people are encouraged to formally consent to participate in the programme. Relatedly, the number of young people completing baseline and exit assessments requires being increased.
- The short-term outcome measure (i.e., SWEMWBS) utilized in this evaluation requires being augmented by longer-term outcome measures (i.e., onward referral outcomes, repeat hospital presentations and police recorded offending / victimization data).

Sutherland *et al* (2023: 46) assessed the feasibility of undertaking a robust impact evaluation of the Thames Valley VRU concluded that "An evaluation of this programme that meets conventional levels of statistical power and has no threats to internal validity is highly unlikely to be possible. However, we believe that it is possible to run a pragmatic evaluation that would 'provide evidence of promise; of the Navigator programme".

Recommendation: Establish a working group to consider the merits of undertaking an impact evaluation (given the above noted challenges of doing so). This will require the active engagement of the VRU commissioners, hospitals, Oasis (as the service provider), the police and the agencies to which young people are referred. It will also be necessary to consult with service users (i.e., young people). This group should liaise with other VRUs that have developed or are developing similar interventions to assess the feasibility and potential benefits of collaborating in an impact evaluation.

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Appendices

Appendix A: A list of the key stakeholders contacted for interview

Hannah Barton – Oasis GM Navigator – Project Coordinator
Laura Walsh - GMCA supported with DPIA toolkit
David Gilbride - Victim lead Violence Reduction Unit
Elizabeth Walton - NHS CCG Salford supported us with Safeguarding requirements
Jane Shlosberg Clinical Lead Royal Bolton Hospital (*)
Lyndsay Pearce - Clinical Lead Salford Adults
Nathan Griffiths - Clinical Lead Salford (Paeds) (*)
Katie Cole - Clinical Lead MRI
Caroline Rushmer- Clinical Lead RMCH (*)
Kirsten McDermott - Senior Paramedic North West Ambulance Service (*)
Michael Phipps- Community Lead for Violence Reduction Unit
Rachel Jenner - VRU Clinical Lead also consultant at RMCH (*)
Candida Wallis - Representative of Community Safety Partnership
Henry Galletta - Doctor at RMCH and MRI (has referred into the project)

(*) stakeholder interviewed a second time

Appendix B: Oasis Staff at focus group

Angela Maher – Navigator Administrator (*)
Hannah Barton – Navigator Co-ordinator (*)
Shaun Tomlinson – Youth Development worker (*)
Christopher Hughes – Senior Community Development worker (*)
Malachi Martin – Youth Development worker
Nathan Reilly – Youth Development worker
Ava Lennard – Domestic Violence Youth Development worker
Peter Oladipo – Youth Development worker
Jacqueline Hughes – Triage worker
Dani Gilbride – Triage worker
Ammaarah Patel – Senior Educational worker
Ashleigh O'Hara – Youth Development worker

Plus
Janet Berry – National Director of Oasis Community Partnerships (*)
Andrew Smyth - Oasis Community Partnership Director, North West Cluster and Oldham Hub Leader (*)

'* staff attending original workshop

Appendix C: Navigator stakeholder interview questions

Background

- What is your current role? Agency?
- How did you become involved with navigators?
- When did you become aware of navigators?
- What is your understanding of the aims of the navigator programme? Who made you aware of this?

Involvement with navigators

- What does a general involvement with navigators look like for you?
- At what point in the navigators process do you become involved?
- How many young people that present at ED departments do you see directly?
- How time consuming is navigators to you in hours per week?
- When is the "peak time" for young people presenting at hospitals?

Opinion of navigators operationally

- In your opinion are there enough members of navigator staff to meet the demand effectively at these times?
- More generally is the demand of young people presenting on navigators met well?
- Do you think the current method for referral works?
- Who is the first point of contact for a young person in the navigator programme?

Efficiency of navigators

- Do you think the information exchange between staff involved is effective?
- What happens when a young person represents at hospital?
- How frequently do you see familiar faces in terms of young people representing at hospital?
- What happens when a young person refuses to engage in navigators?
- Do you think the visibility of navigators is good/bad? What could be done to improve this?
- Do you think young people are being helped effectively by navigators?

Factors preventing engagement?

- What factors stop engagement with navigators from the perspective of a young person?
- Do you have issues obtaining consent from the young person or their family for your work?
- Do you have issues surrounding engagement of the young person or their families?
- Is there anything you wish to add?

Appendix D: ED Attendances and Navigator Referral data

Manchester Royal Infirmary

Month	Total number of attendances	Number of attendances of CYP aged 10-25	Number of attendances of CYP aged 10-25 with injuries	Number of attendances of CYP aged 10-25 with assault injuries	Navigators Referrals	Referral Rate
Apr-21	10,563	2,671	730	26		
May-21	11,852	3,231	818	28	7	25%
Jun-21	11,663	3,127	897	38	9	24%
Jul-21	11,240	2,637	690	22	4	18%
Aug-21	11,252	2,527	551	48	3	6%
Sep-21	11,808	3,271	798	35	10	29%
Oct-21	12,363	4,125	910	50	4	8%
Nov-21	11,792	3,799	854	47	3	6%
Dec-21	10,653	2,892	592	53	8	15%
Jan-22	10,742	2,858	611	41	8	20%
Feb-22	10,695	3,336	739	48	1	2%
Mar-22	12,383	3,723	823	26	5	19%
Apr-22	10,971	2,918	570	34		
May-22	11,830	3,405	744	37		
			Totals	436	62	14.2%

Bolton

Month	Total number of attendances	Number of attendances of CYP aged 10-25	Number of attendances of CYP aged 10-25 with injuries	Number of attendances of CYP aged 10-25 with assault injuries	Navigators Referrals	Referral Rate
Apr-21	10515	2061		16		
May-21	11399	2225		16	1	6%
Jun-21	11896	2495		26	13	50%
Jul-21	12519	2459		24	9	38%
Aug-21	10882	2100		25	5	20%
Sep-21	10832	2239		16	18	113%
Oct-21					20	
Nov-21					13	
Dec-21	10572	1928		17	12	71%
Jan-22	10304	2083		28	18	64%
Feb-22	9972	1939		16	9	56%
Mar-22	7806	1608		14	22	157%
Apr-22						
May-22						
			Totals	182	107	58.8%

*Missing data for October / November 2021 not included in calculation

Trauma & Injury Intelligence Group (TIIG) Surveillance System operated by Liverpool John Moores

Data were subsequently provided by the Trauma & Injury Intelligence Group (TIIG) Surveillance System operated by Liverpool John Moores by the Violence Reduction Unit (VRU); however, these were markedly different (in both volume and trends) to data provided by hospital SPOCs.

- Royal Bolton Hospital – April 2021 to April 2023 – 674 presentations of CYP aged 10-25 with assault injuries.
- Salford Royal – April 2021 to April 2023 – 723 presentations of CYP aged 10-25 with assault injuries.
- Manchester Royal Infirmary – April 2021 to August 2022* – 469 presentations of CYP aged 10-25 with assault injuries.
- Royal Manchester Children's Hospital – April 2021 to August 2022* – 81 presentations of CYP aged 10-25 with assault injuries.

*Due to changes in IT system at Manchester Royal Infirmary / Royal Manchester Children's Hospital, data has not provided to TIIG since September 2022.

Table D: Referral rates in comparison with TIIG data

Hospital	May 21 to May 23			May 21 to August 22*		
	TIIG	Referrals	Rate	TIIG	Referrals	Rate
Royal Bolton Hospital	674	271	**40.2%**			
Royal Manchester Children's Hospital				81	118	**145.7%**
Manchester Royal Infirmary				469	72	**15.4%**
Salford Royal Infirmary	723	119	**16.5%**			

* - data wasn't provided to TIIG from September 2023 for Manchester hospitals due to IT changes

There are some significant variations between hospitals, especially in RMCH.

Comparisons with SPOC data for:
Royal Bolton Hospital: May 21 to March 22 (excluding Oct-21 / Nov-21) 58.8%
Manchester Royal Infirmary May 21 to March 22 – 14.2%