An Evaluation of Hospital Based Youth Workers

Final Report

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MAYOR OF LONDON

OFFICE FOR POLICING AND CRIME

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About London's approach to Hospital Based Youth Workers

For more than five years, the Mayor's Office for Policing And Crime (MOPAC) has contributed funding towards embedding youth services that support young victims of violence and domestic abuse within a health setting. Initially this was within London's four Major Trauma Centres (MTCs), but it was rolled out and piloted in Accident & Emergency (A&E) departments to introduce hospital-based youth workers within this environment.

A total of £2.5 million from MOPAC, the Mayor's Young Londoners Fund, and the Violence Reduction Unit (VRU) was used to develop youth services within A&Es, situated in geographical areas experiencing high levels of knife crime. Services were delivered by **three providers** - across **seven A&E sites:** St Giles delivered within Whittington and Newham; Oasis delivered within North Middlesex and St Thomas' and Redthread delivered within the Queen Elizabeth, Lewisham and Croydon.

This is a final report from the **performance and process evaluation**, summarising findings from the two-year implementation period (April 2020 – end of March 2022).

Learning from London's Service Design

The evaluation encountered several challenges that have limited the conclusions which can be drawn from the service and prevented a robust examination of impact

- The evaluation has been impacted by **poor data quality** and **differences in recording** (i.e., gaps in outcome data, or missing data for those not engaged).
- **The need to increase data capture and sharing**, including motivation/expectation data and repeat presentations to the A&E (and wider NHS) would be crucial.
- This report has raised a **need for robust evaluation** - whilst the model has promising aspects, there continues to be no robust evidence base for the wider approach.

Engagement rates have improved from year 1, but withdrawal from service is still high

- Across the 2 years, providers **offered the service** to a **total of 1,995** young people, with an **overall uptake of 45%** (n894). However, of those who initially engaged with the service, 45% (n399) subsequently **withdrew** service before completion[1].
- Service engagement differed across the providers - Redthread had the highest initial rate (62%) followed by St Giles (47%) and Oasis (30%), although the proportion of young people 'completing' the service was similar across all providers – with an **overall completion rate of 17%** (n346) across the 2 years[2]. This is noteworthy given the local context differs across neighbourhoods and delivery models.
- Service providers engaged with more people in year 2 (n469) compared to year 1 (n324)[3], thought in part to be a result of the increased physical presence of youth work teams in A&E sites, as the impact of covid-19 lessened.

[1] These figures (from both years of provision) have been based on aggregate data given to us by providers.
[2] The remaining 149 are a mixture of missing data (33) and cases that are still live (116).
[3] The total figure (n793) engaged with for yearly comparisons is different to the overall total (n894) due to missing individual level data from providers.

- Of the young people who engaged in the service, 32% were not known to statutory services prior to the intervention.
- Individuals most likely to be **offered the service** were: **Aged 15-17** (42%); **Male** (60%); **Black** (40%); **Attending school, college or university** (72%); Living with **family, parents, carers, or guardian** (81%).
- Those who completed the service were most likely to be initially assessed as medium risk (49%). When comparing who did and did not engage[4], **15–17**-yr-olds were **most likely to be offered the service**, but a **higher proportion** of **18-22yr olds took up** the provision.

Service providers have addressed many of the challenges from year 1 implementation

- The service encountered many of the usual **implementation challenges** in year one – **awareness** of the service; **buy-in** from crucial advocates (e.g., clinicians); **technology** and **data** governance challenges; and understanding how **practically to deliver** the service (e.g., the importance of physical proximity to A&E). The **pandemic** accentuated difficulties and time to rectify solutions.
- Year two addressed many challenges, including better access to hospital IT systems and data sharing; dedicated spaces to work; and a greater physical presence.
- **Addressing challenges has reinforced support for the service** – with clinicians and strategic partners agreeing the youth workers are valued and viewed as part of the hospitals extended team, as well as improving both awareness of contextual safeguarding and aiding a more multi-agency holistic approach.

Some delivery challenges were not able to be addressed, for example:

- **A&E Staff turnover** - has meant youth workers need to continually promote the service to receive buy in.
- **Youth worker staff shortages** impacted delivery, some teams were not able to cover critical hours in A&E or due to clerical time had less time on the frontline. These staff shortages impacted data coordination, quality and resource allocation.
- **Getting referrals & engaging young people over 18** - youth workers reported barriers gaining consent / developing trust for this age group compared to those younger. It was also felt clinicians were more likely to refer under 18s due to safeguarding issues and a lack of service awareness in the hospital adult teams.
- **The continued need for training -** due to the high staff turnover in A&E.
- Commissioners, service providers and key stakeholder should consider if there is more that can be done regarding the key enabler of service 'awareness' (i.e., a dedicated resource), as reliance on youth workers to continuously promote the service directs resource away from their key role.

The service and reported 'tailoring to need' are seen as positive

- There was **positivity** towards the programme across service providers, stakeholders; partners; young people and their families.
- In the views of youth workers, their tailored work was especially welcomed, reporting they adopted a **flexible approach**, personalised to the individual and their needs, considering interests, and sequencing support.
- It is hoped future evaluation can collect **more granular data** regarding need and the services matched to them, to strengthen learning about this important aspect.

[4] Just for RedThread and St. Giles.

There were numerous significant improvements across perception measures including reduced risk, risk of harm and safety

- The top 3 reasons for hospital *presentation* were: assault (53% n724), mental health (19%, n357) and substance issues (7%, n97). The top three reasons for *referral* were: assault (46%, n633), risk of harm (24%, n327), violence (18%, n250).
- For individuals who engage with the service, **perceptions of risk** were assessed by the provider at the start (n582), end (n393) and during a follow up (n56).
- For individuals who[5] were assessed at start *and* end, the level of risk reduced, from 34% (n134) high-risk to only 7% High risk (n27) at final assessment.
- Services appear to be **helping young people to feel safe**[6] – for those *completing* the service (n141), there were improvements across self-reported feelings of safety, support network & well-being scores:
  - All measures **significantly increased**[7], with the greatest change in "*I could ask professionals for help if I needed it"* and *"I trust services could keep me safe"* (increasing from 6.9 to 8.3 and 7.0 to 8.3 respectively on a 1-10 scale).
  - Self-reported measures of **numbers of exposures to violence** significantly decreased at each stage of assessment (-0.5 for witnessing violence from 2.5 to 2 and -0.4 for personal involvement in violence from 2.2 to 1.7).
  - Average hospital attendance numbers for violence in last 6 months significantly decreased by -0.5 from 0.7 to 0.2 respectively).
  - Across all measures (safety; support networks; wellbeing; and violence exposure), there were **improvements** for individuals initially assessed as **high-risk *and*** those assessed as **medium/low risk.**
- Taken as a whole, the perception results are positive. However, due to a range of factors (i.e., lack of control group, sample bias, data issues) the evaluation cannot attribute any of these changes confidently to the programme.

Conclusion

This report completes the evaluation of the hospital-based youth workers programme, detailing what has been the largest attempt to deliver the teachable moment in England & Wales. Considerable learning has been generated that can inform future decision making. These can be grouped into:

- **Ensuring implementation** - implementation matured over the course of the programme, any future rollout should anticipate and make contingency plans to address these routine issues.
- **Addressing the withdrawal challenge** - commissioners and service providers should consider options to explore the retention of individuals. The ability to do this is grounded in better data collection and quality, as well as new research on attrition.
- **The need for robust assessment of impact** - Future delivery and/or roll out should focus on data capture, access and quality, as well as striving to achieve a robust impact assessment to enable an understanding of which aspects of the service are working and for who to benefit the wider evidence base.

[5] Those who complete will likely be the most engaged, the most motivated which may confound results here.
[6] Those who complete will likely be the most engaged, the most motivated which may confound results here.
[7] All measured through Wilcoxon test for between sample differences.

Contents

London's approach to Hospital Based Youth Workers 6

Hospital Based Youth Workers: Service Design 8

Service Evaluation 9

Methodology 9

Data considerations 11

Analysis 12

Results from Service Delivery 13

Who is using the service? 13

What does service engagement look like? 15

Service Delivery Improvements 20

Continued Service Delivery Challenges 22

Perceptions of Risk & Safety 25

Discussion 28

Appendices 30

Appendix A: Base sizes for individual level recorded data 30

Appendix B: Base sizes for outcomes data 31

Appendix C: Data issues and reporting considerations by service providers 32

Appendix D: Breakdown of qualitative interviews conducted by ORS 33

Appendix E: Start and End risk scores by provider 34

Appendix F: Start and end mean scores & mean score change 35

Appendix G: Mean score change by Service Provider and Initial Risk Level 35

Appendix H: Borough of residence of young people offered the service (percentage of young people per borough across all service providers) 36

Appendix I: Operating Models from service providers 36

References 38

London's approach to Hospital Based Youth Workers

Since 2015, the Mayor's Office for Policing and Crime (MOPAC) has contributed funding towards embedding youth services to support young victims of violence and domestic abuse (DA) within a health care setting. Initially this was within London's four Major Trauma Centres (MTCs), however the mayor's knife crime strategy published in 2017 included developing youth services within Accident and Emergency departments (A&Es), situated in geographical areas experiencing high levels of knife crime[1].

The decision to fund Youth Services in Major Trauma Centres and A&E departments in London was made against the backdrop of increasing knife crime and violence figures across the UK. In England & Wales, recorded knife crime increased year on year from 2013-2020. During the period April 2019 – March 2020 the total number of knife related offences was almost double (95% higher) than in April 2013 – March 2014.[2] The number of homicides amongst young people (Aged 5-24) had also increased significantly prior to the start of the pandemic. From April 2015-March 2016 there was a total of 99 homicides, while in 2016-17 and 2018-19 this increased to 181 both years.[3]

From a London perspective, prior to the start of the Covid-19 pandemic knife offences had been increasing every year, for the previous five years. During the early part of 2020 (January-March) knife crime was 7% higher on a rolling year average basis, than the same period one year earlier in 2019, and over 60% higher than the same period 5 years earlier in 2015.[4] The number of under 18s admitted to hospital with knife injuries also rose by a third between 2013-14 and 2017-18[5]. Although knife offences decreased significantly during the pandemic, as of early 2021 they have been on an upward trend [4]. The number of teenage homicides in 2021 were also the highest on record at 30 incidences[6]. In London, there are links between serious youth violence and group offending, with offences and victimisation specifically linked to tensions between gang members or affecting those on the periphery of gangs. MOPAC's Serious Youth Violence Problem Profile (SYVPP) found over half of all teenage homicides in the last 3 years had links to gangs. These findings indicate there is much more to do to keep London's young people safe[6].

The GLA city intelligence Unit (CIU) and MOPAC Evidence and Insight Unit profiled young victims (aged between 1-24) of serious violence in London and found rates of victimisation were highest amongst those aged 20-24, except for knife crime where rates were highest for those aged 15-19. Two thirds of victims of the 'most serious violence' in London were male (66%; female 34%). Young Black Londoners are disproportionately more likely to be victims for all types of serious violence[7], with the MOPAC SYVPP indicating over half of weapon enabled robbery (59%) and homicide (65%) suspects were Black. Victim profiles were more diverse (i.e., 56% of weapon enabled robbery victims were white) but most youth homicide victims were male (93%) and Black (61%)[6].

The House of Commons Serious Youth Violence report (2019) identified strong evidence to link serious knife crime and serious youth violence with deprivation and vulnerability, exacerbated by cuts to youth services; reduced police budgets; a growing number of children being excluded from school and taken into care; and a failure of statutory agencies to keep young people safe from exploitation and violence.[5] Studies have shown that violent injury is reoccurring and exposure to violence can increase the probability of an individual being both

a perpetrator and victim of future violence [8] [9] [10] [11]. Various linked factors such as substance use; poor school achievement; and mental/physical health concerns have also been found to increase likelihood of recurring violent injury[12] [13] [14]. Similarly, the MOPAC SYVPP demonstrated that deprivation metrics (i.e., IMD, food insecurity); school suspensions/absence; and low youth employment were all predictors of most serious youth violence[6].

An A&E hospital setting provides a unique opportunity for intervening with youth injured through violence before a child or young person reaches major trauma centres or before they are known by police or local authority services. Engagement can take place at the 'teachable moments' which are defined as 'naturally occurring life transitions or health events thought to motivate individuals to spontaneously adopt risk-reducing health behaviours'[15]. These situations have been recognised as the best opportunity to engage and where there is the greatest chance to changes lives. Interventions in a hospital setting can include mentoring; counselling services; individual or family assessment; and onward referral to services.

Promoting change in health behaviour during teachable moments has been explored and evaluated in a wide range of contexts including, sexual behaviours and HIV prevention; alcohol consumption; injury prevention; general lifestyle changes; smoking cessation; suicide prevention; and cancer screening [16] [17] [18]. In recent years there has been increasing interest in the youth violence context, particularly the role of youth work in Emergency Departments (ED) to take advantage of teachable moments and help change behaviour. Most models include contact at the initial point of entry to the hospital, but an additional longer-term effort to network young people into other kinds of support to reduce repeat presentation [19]. The NHS Violence Reduction Programme produced a guide for implementation of in-hospital Violence Reduction Services in 2022. A key contributor to this guide was the service specification on A&E commissioning that MOPAC developed with clinicians. The guide supports health care professionals working in partnership with local authority and third sector organisations and provides background information on public health approaches to violence, an understanding of in Hospital Violence Reduction Programmes and key recommendations to support service implementation. [20]

While current (primarily American) academic results have been inconclusive on the impact of youth workers in hospital settings, there has been some emerging evidence for crime reduction and positive responses from the young people involved in these initiatives. In the UK, hospital-based youth violence intervention programmes are gaining traction**Error! B ookmark not defined.** and a limited number of studies have described successful *implementation* of youth services in hospitals – including uptake of services; reduction in risk factors; and positive response from young people[21] [22] [23].

The most widely used model in the UK is run by Redthread, a third sector organisation that embeds Youth Workers within Major Trauma Centres (MTCs) to work with young victims of violence. MOPAC Evidence and Insight (E&I) team evaluated the Redthread Youth Violence Intervention Programme (YVIP) between April 2016-March 2017 and found tentative indications of benefit, including reduced risk scores for service users and positive response to the service from hospital staff and service users. [24] The St Giles Trust and the Oasis Programme are doing similar work in the UK with an evaluation of the Oasis Youth Support intervention

service at St. Thomas' hospital in London by Middlesex University identifying similar outcomes between service implementation and the benefits to young people's lives [25]. Nevertheless, despite attempts to expand the evidence base, there is still a lack of robust evidence regarding success of the approach[19].

This report details the performance and process evaluation from the two-year implementation period (April 2020 – end of March 2022) of London's Hospital Based Youth Workers service. Whilst the crime picture across London temporarily changed during the evaluation due to the covid pandemic, knife offences have begun to increase, so the need to evaluate the effectiveness of specialist violence prevention and intervention services has never been greater.

Hospital Based Youth Workers: Service Design

Combined investment from the Mayor in 2020/21 and 2021/22 for Hospital based youth work sits around £4m. To extend youth provision already in place in the four Major Trauma Centres (MTCs) and in North Middlesex (Oasis), Homerton (Redthread), and St Thomas (Oasis) hospitals, a demand analysis was undertaken by the GLA city intelligence Unit (CIU) to establish which A&E sites in London would be most suited for embedded youth workers. Several demand factors were considered including:

- volume of A&E incidents, caused by or classified as knife in the borough where hospital is based;
- volume of A&E attendees, recorded by emergency department staff / London ambulance service;
- proximity to Major Trauma Centres (MTCs) and other type 1 Emergency Departments;
- social demographics (Index of Multiple Deprivation and percentage of young population); and
- the presence of active gangs in the borough.

Based on the results, five new priority sites were selected to receive funding for services:

- The Whittington Hospital A&E;
- Newham University Hospital A&E;
- Croydon University Hospital A&E;
- University Hospital Lewisham A&E; and
- Queen Elizabeth Hospital.

MOPAC already provides additional funding to three A&Es (St Thomas' Hospital A&E, North Middlesex University Hospital A&E and Homerton University Hospital A&E). However, Homerton was excluded from the evaluation, as MOPAC only funded a small part of the service. Services were therefore delivered across **a total of 7 A&E sites**, by **three providers**. The below figure indicates the A&E location and delivery provider.

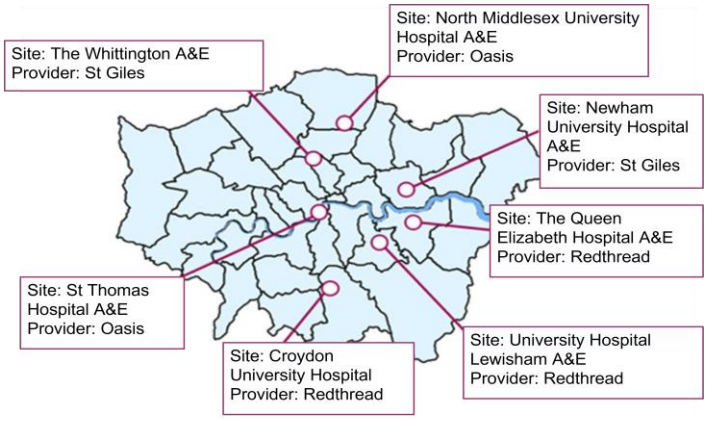


Figure 1: Location of the A&Es and youth work service providers

The underlying service rationale is that delivering a holistic intervention, through embedding specialist youth workers within A&E's; working with hospital staff; partners; and families will aid in delivery of 'teachable' moments and support victims of knife crime as outlined in the Mayor's Knife Strategy.

Specific service aims were to:

- **Improve identification** of young victims of violence or young people at risk.
- **Improve engagement** of young people with available support.
- **Reduce risk** amongst young people, (including short-term and long-term).
- **Improve feelings of safety & wellbeing** amongst young people.
- **Improve networks of support** & relationships amongst young people (including peers / family).
- **Reduce self-reported exposure to violence** amongst young people.
- **Reduce number & frequency** of young people coming to **attention of authorities** (e.g., hospital, police) in relation to violence.
- **Improve knowledge & awareness** of **contextual safeguarding**/service amongst **hospital staff**.
- **Improve knowledge and awareness** of **contextual safeguarding**/service amongst **wider stakeholders**.
- **Improve consistency and awareness** across **trauma-informed services**.
- **Improve understanding** of the **impact of the youth work** offer.

Although services broadly follow a comparable design, they were given the ability to apply local flex to the operating model, to fit with the working practice in each NHS trust. Whilst standardisation of measures and definitions were given to service providers by MOPAC these were interpreted differently by each organisation based on their own working practices. Therefore, throughout the report, comparisons across providers should all be viewed with caution (see Appendix I -Operating Models).

Service Evaluation

The Evidence and Insight (E&I) Unit - MOPAC's in-house social research and analytical team - were commissioned to undertake a multi-year evaluation of the Hospital-based youth services. The evaluation intended to look at learning from each provider, as well as overall delivery across a 2-year period (2020-2022), to understand the unique operating context; data on eligibility/throughput; demographics; onward referrals; risk assessments; training sessions provided to hospital staff; and the impact of covid on the service. Service implementation will be a focus, including challenges or barriers to delivery and how these have changed or been overcome from the first to second year.

This final report focuses on the **performance** of the service and **process learning** gained from a range of sources. It was not possible to robustly evaluate impact due to data quality.

Methodology

The current report draws upon a mixture of quantitative data analysis and qualitative feedback from service providers.

Service User Data

Data collected by the three service providers (Redthread, St Giles and Oasis) between April 2020 and end of March 2022 was analysed at the end of the second year of intervention (see analysis for more information).

Data Analysis

The results are taken from **aggregate and individual level** performance data provided by each service. The level of data recorded across performance measures differed by provider (see *data considerations*), therefore analysis has been limited by data availability and not all providers could be included in analysis for all measures.

Service User Outcome data

Self-assessed outcome and well-being measures were recorded by individuals at the start of intervention, end of intervention and at six-month follow-up (see data consideration section below for limitations). Individuals assessed their **feelings of safety** in different environments and their **trust and relationships with services, professionals, family and peers** on a scale of 1-10 and their **well-being** (e.g., feeling optimistic, useful, relaxed, close to others) on a scale of 1-5. They also recorded their **exposure to violence** (both witnessing and involvement) on a scale of never – often. Finally, the numbers of **hospital attendances** by the young person for violence in the last 6 months was recorded.

Service Data – Training for staff

Data on **hospital staff training**, delivered by the service providers was collected. Most training was directed at doctors and nurses. Redthread provided individual level data on 84 training sessions but indicated that a further 256 training sessions were delivered with no details available. St Giles provided individual data for 27 training sessions in total, Oasis North Middlesex recorded that 15 training sessions were delivered in total and Oasis Waterloo indicated that 29 recorded sessions were delivered in total.

A **survey** was distributed to clinicians to capture views on the training provided by youth workers. This survey was used to examine how familiar clinicians were with the service and how they can refer as well as the importance of the service. They were also asked whether they had received training from youth workers on a variety of different subject areas and if they had whether they thought this had improved their knowledge. This was a voluntary survey which was distributed out to clinicians across the hospital sites where contact details were known to MOPAC. A total of 29 clinicians responded to the survey. The total population of clinicians is not known, so it is not possible to pass comment on the response rate to the survey. The information provided by the clinicians was further supplemented by a range of qualitative interviews (see *qualitative data*).

Qualitative Data

The report includes qualitative data obtained from **interviews** with practitioners delivering the service; clinicians working in the hospitals; and young people and/or their parents using the service.

Surveys, Interviews & Focus Groups

Qualitative data adds crucial context to the quantitative - it aims to understand how embedded youth work services were being delivered in A&Es (including views on training), and to gather the views and experiences of youth workers; key stakeholders involved in the service; and service users (conducted by Opinion Research Services (ORS)).

Fieldwork was carried out between February - April 2021, and April - June 2022 and consisted of over **40 in-depth interviews and focus groups** during each wave. There was a mix of

participants across the three providers and the seven A&E sites including: youth workers; hospital staff; representatives of partnership organisations; those in strategic roles who have been involved in commissioning, mobilising, and delivering the service; and five young people (or parents of young people) who have been supported through the service. Service providers recommended participants for inclusion in the interviews and these interviews were undertaken on a voluntary basis (giving a limitation of selection biased). Discussions were centred around participants views on the success of the interruption of the cycle of violence among young people presenting at the funded A&E departments. A full breakdown of interviews conducted by ORS can be found in the appendix D.

Data considerations

There were several data challenges for the evaluation, mainly variations between providers summarised below:

Missing Data

Missing individual level data:

- Oasis did not provide any individual level data for service users that were contacted but did not engage in the service, or for 'reasons for engagement' and training data.
- For some measures, Redthread, St Giles or both providers did not provide data for non-engaged individuals (notably Redthread did not provide Ethnicity data for non-engaged individuals).
- Therefore, figures shown for key measures, such as demographics of the cohort and incident characteristics **are not representative of all individuals who were offered the service, only those for whom data has been provided.**
- For Oasis, summary or aggregate data has been used in place of individual level data for some measures.
- Comparisons between engaged and non-engaged groups have only been made for measures and providers where data has been recorded for both groups.

Missing data across fields (data unknown / not collected):

- There were missing fields at individual level in the datasets provided by all three service providers, where information was not collected or was unknown.
- Reported proportions are based on all individuals with recorded data for that measure, excluding individuals for whom information was unknown or not recorded.
- The **sample base size therefore differs by performance measure**. A full breakdown of the sample sizes used throughout this report is shown in appendix A and appendix B.

Missing outcomes data:

- Outcome measures were not recorded for every individual who engaged with or completed the service and not every outcome measure was recorded.
- Redthread outcome measures have been excluded from analysis due to insufficient data provided.
- Some analysis has not been possible or is indicative only, due to small or insufficient base sizes.

Inconsistent recording practices

Many reported measures were **not recorded consistently across service providers**, i.e., the response options differ and are not therefore comparable. Categories have been **grouped**

where possible for the purpose of analysis, but some categories recorded are specific to each provider. For some measures we have **not been able to make comparisons** between providers and have reported results only at total level (all providers combined).

Internal bias

The evaluation explored a variety of perception metrics (i.e., risk and harm). Whilst this can provide useful results – given the nature of the programme, these measures were only taken from those who completed. This raises the issue of bias – those who completed are only a selection of the wider population and will likely be the most motivated. Results should be caveated as such.

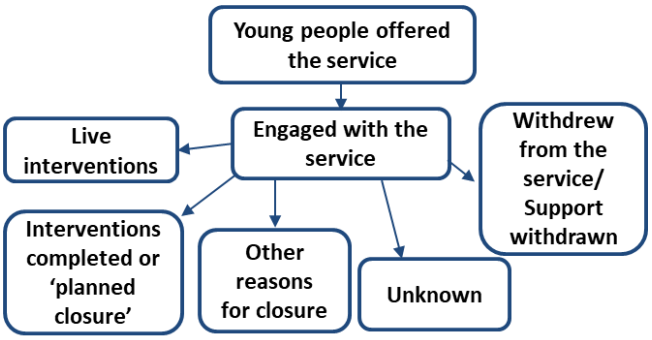
Appendix C provides a descriptive summary of the data provided, analysed and reported on for each measure.

Key *learning: Data quality, in addition to small base sizes, has affected the ability to draw conclusions and prevented an impact evaluation.*

Analysis

Salient findings are informed by aggregate and individual level performance data provided by each service at the end of delivery period. A full breakdown of the base sizes for each measure referred to below is shown in the appendices A & B. Testing has been used throughout to determine a significant change in or difference between two measurements. Where stated, a significant result is measured at 95% level of confidence ($p<.05$).

Data analysed includes **throughput** of the service, **demographics of the young people**, **incident characteristics** (e.g., reasons for referral), **service characteristics** (e.g., nature of interventions delivered), **risk assessments** and **outcome measures** (conducted at start and end of interventions).



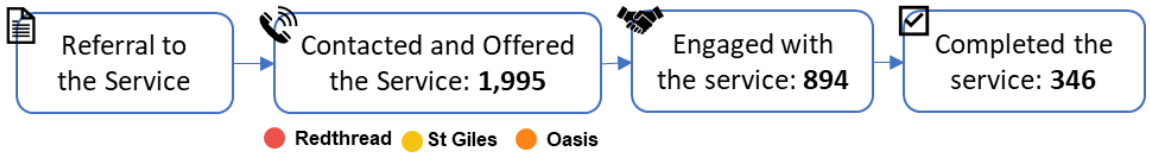
Analysis was conducted to understand:

- What the service looked like
- Who accessed the service and why
- Who was more likely to engage with the service
- Whether there were changes in the second year of delivery
- Whether the service impacted on perceived risk levels for young people
- Whether the service impacted on young people's feelings of safety, support networks, exposure to violence and wellbeing

To understand whether any individual demographic characteristics or incident characteristics were more or less likely to result in a young person initially **engaging** with the service or **completing** the service, logistic regression analysis was attempted. Due to small base sizes and missing data across providers the analysis did not produce significant findings of note and results have not therefore been included.

Results from Service Delivery

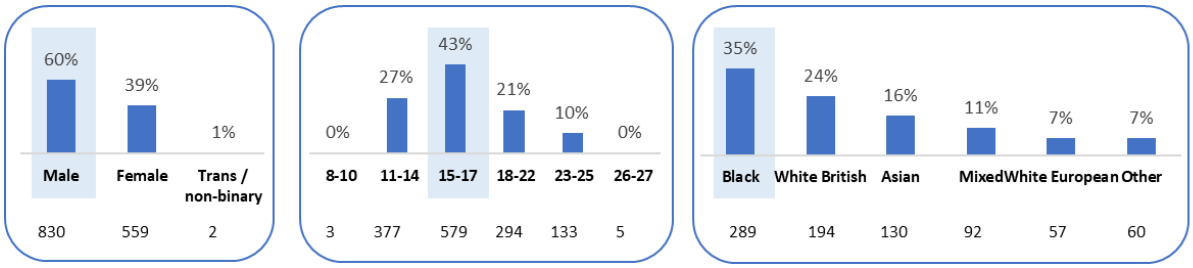
Across the seven A&E sites and three service providers, a total of **1,995** individuals were offered Embedded Youth Work services following referral by A&E staff.[8] Of these, a total of **894** individuals initially chose to engage with the service, and **346 individuals** completed the service.



Who is using the service?

Findings are based on all individuals who **engaged** or were **offered** the service.

- **Individuals** - across all three providers, those most likely to engage or be offered the service were **aged 15-17**, **male** and **Black,** but to note there was only data available for 1,391 individuals which is a limitation for understanding the sample.



- The profile of young people is different to those that engaged with the Redthread & St Giles Youth Violence Intervention Programme (YVIP) in MTCs from 2015-2017[24], A&E youth services appear to be engaging with a younger cohort, a higher proportion of females and a lower proportion of black young people.[9][10]

[8] We are unable to provide figures for the total number of individuals who were *referred* to the service by A&E due to differing recording practices and definitions of referrals across service providers. It should be noted however that a proportion of those referred were not contactable, and a further smaller proportion were contactable but not eligible for the service.

[9] Engaged figures have been used (rather than all those contacted and offered the service) in order to make comparisons with data reported in the MTC YVIP evaluation.

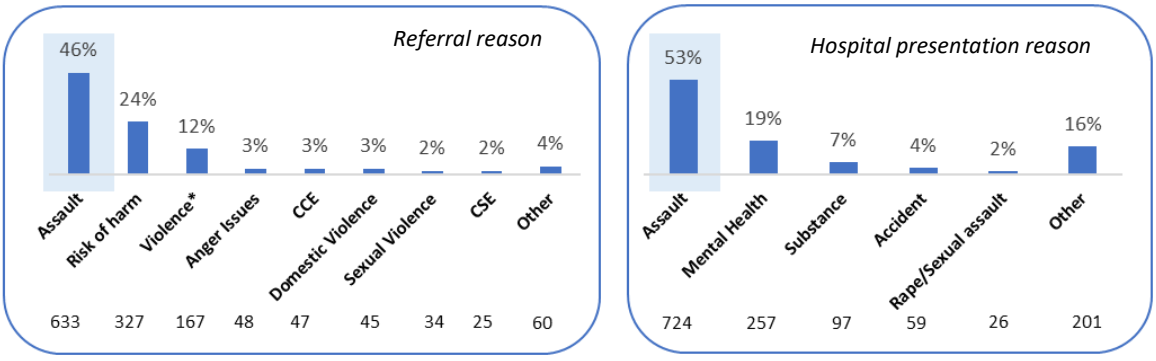
[10] For St Giles a significantly higher proportion of those engaged were under 18 (70%, n=140) in comparison with the MTC YVIP (44%, n=67) and a significantly lower proportion were black (31%, n=60, compared with 53%, n=51). For both providers a significantly higher proportion of those engaged with the A&E youth services were female (42%, n=183 for Redthread and 49%, n=98 for St Giles) in comparison with the MTC YVIP (9%, n=89 for Redthread and 3%, n=4 for St Giles). Individual age figures were not provided for Redthread in the MTC YVIP evaluation report but the average age for MTC YVIP engagement was over 18 while for A&E youth services it was under 18.

- **Boroughs of residence** - the top boroughs of residence for young people varied by provider due to differing hospital locations. At an overall level, **over 50% of young people with recorded data resided in Newham** (15%, n=213), **Greenwich** (14%, n=199), **Croydon** (13%, n=183) and **Lewisham** (10%, n=141) (see map appendix H).

- **Education & home** - whilst most young people **attended school, college or university** (72%, n=456) and **lived with family, parents, carers, or guardians** (81%, n=639), there are still large number who do not – 30% not at school, college or university and 20% living elsewhere.

- **Prior engagement with statutory services** - **68% (n=376[11])** of young people were **either presently engaged, known to, or previously known to statutory services,** with 32% (n=176) not known to statutory services. A breakdown relatively consistent by provider. The percentages of those who were known to statutory services did not significantly vary between the engaged (70%, n=318), withdrawn (74%, n=69) and completed (67%, n=185) cohorts.

- **Reasons for presentation & referral** - Assault was the most common reason for presentation, accounting for over half of presentations (53%, n=724). **Mental health,** and **substances (alcohol / drugs / OD) were the next most common,** together accounting for 26% of presentations (n=354). Assault was also the top reason for referral across providers, accounting for 46% (n=633). **Risk of harm** and **violence** (domestic, weapon, non-weapon, sexual, honour-based, witnessing) were the next most common, together accounting for 36% of referrals (n=494).[12]

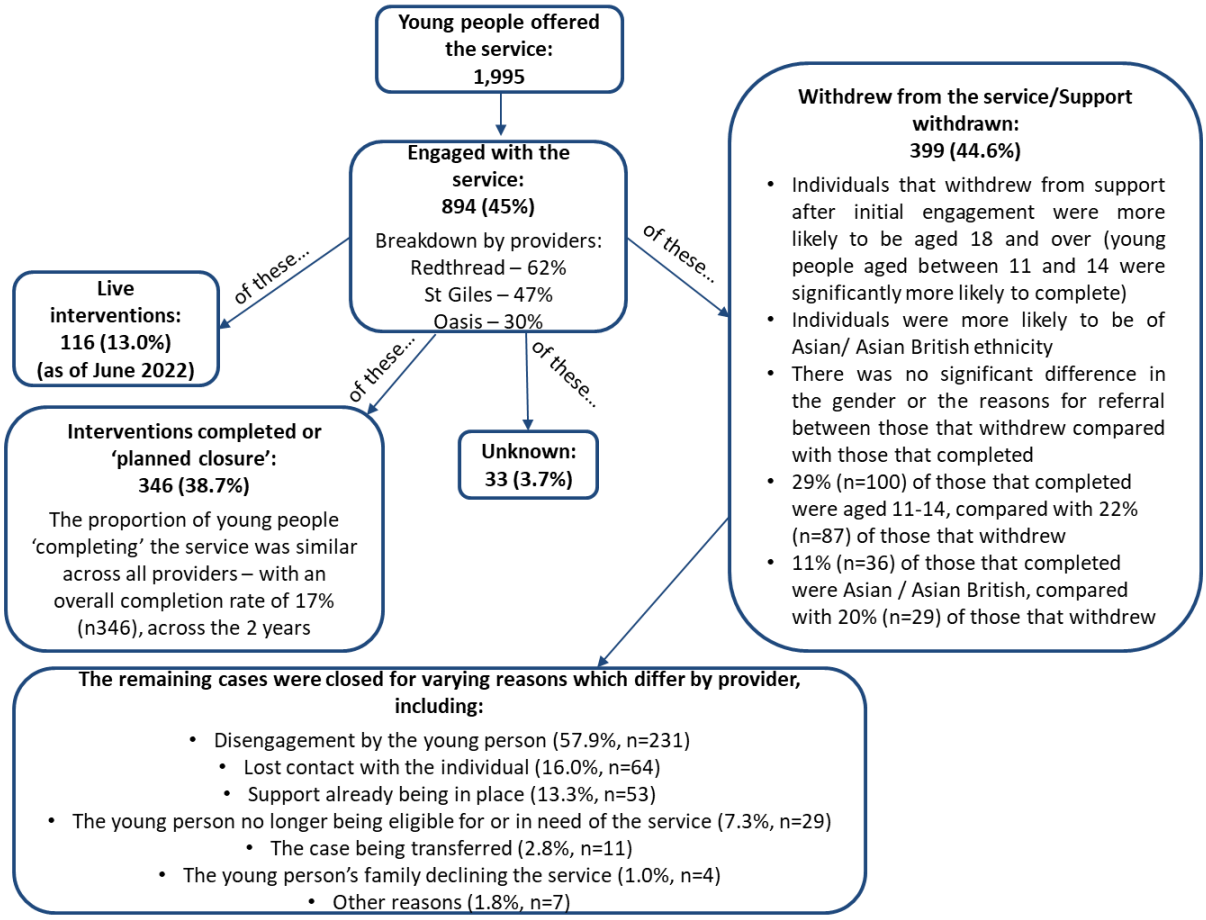


*Violence includes domestic, weapon, non-weapon, sexual, honour-based, witnessing

[11] Base size = 555, 3 respondents were recorded as 'other'. Due to missing data the base size did not equal the overall total number of respondents engaged (894). For further information please see missing data section.
[12] Findings are based on all individuals with recorded data across service providers, including individuals who engaged with the service and those who were offered the service but did not engage.

What does service engagement look like?

Of the **1,995 individuals who were offered Embedded Youth Work services** following referral across the two-year period[13], 894 initially engaged with the service and 399 (44.6%) individuals withdrew. Within the relevant literature, withdrawal rates in similar hospital based scheme were not widely stated, those that were tend to have a lower attrition (3-11%)[22] [25] than this programme, but with the current data there is no way to unpick a cause. This withdrawal rate may not be surprising given the cohort services are working with, however future work should explore what best supports retention or reasons for disengagement (e.g. the amount of waiting time to receive the service).



When comparing **who did and did not engage**[14], it was found although **15–17**-yr-olds were **most likely to be offered the service**, a **higher proportion** of **18-22-yr-olds took up** the provision. This uptake of the service provision in the 18-22 age group reflects the age/crime curve where engagement in crime decreases with age in adulthood[26].

15-17 year olds

57% engaged (329 out of 579)
43% not engaged (250 out of 579)

18-22 year olds

72% engaged (209 out of 292)
28% not engaged (83 out of 292)

[13] We are unable to provide figures for the total number of individuals who were *referred* to the service by A&E due to differing recording practices and definitions of referrals across service providers. It should be noted however that a proportion of those referred were not contactable, and a further smaller proportion were contactable but not eligible for the service.

[14] Just for Redthread and St. Giles.

This programme data contrasts with views from staff, who felt it was a continued challenge to engage with youths aged over 18, specifically obtaining consent and gaining their trust. Youth workers anecdotally attributed this to the ingrained lack of trust in services, whereas younger individuals or those with a parent present, who may want support for the wider family, were more receptive. The perceived challenge of engaging with the older cohort was thought to be amplified by the lack of referrals for this age group from clinicians – as they were more likely to refer under 18s due to safeguarding concerns and there was still a lack of awareness of the youth service in the A&E adult teams.

'Trying to engage adult safeguarding teams in supporting victims of violence over the age of 18 is quite often a challenge because often those people won't meet a threshold for adult safeguarding, despite the fact it's a clear safeguarding need. So, there can sometimes be that conflict between third sector working, acting appropriately in wanting to safeguard someone and the barriers of where safeguarding thresholds sit.'
(Strategic Stakeholder)

'I think the children we're very good at picking up are under 18. The harder age group is the 18 to 25… because they have more autonomy, and often they are a bit past the intervention in some ways. By then, those behaviours, those challenges in life are so deep that it's hard for them to get out of those…'
(Clinician, St Giles Trust, Whittington Hospital)'

Challenges gaining consent

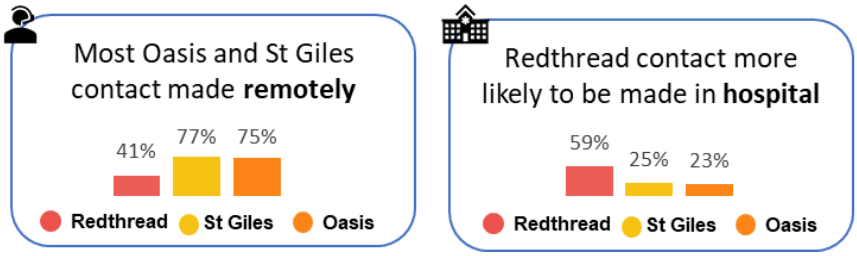
Service providers have identified several challenges facing youth workers in gaining consent from the young person to initially engage or sustain engagement with the service. According to service providers, face to face engagement between the youth worker and the young person at the critical moment within A&E often results in better engagement with the service. Face to face opportunities can be missed as…

- **Service operating times do not always match demand for the service** – referrals made to the service by clinicians outside of youth worker operating hours often result in lower engagement rates due to a lack of physical presence and timely contact with the young person in the A&E setting.
- **Referrals from clinicians are not always timely and sometimes referrals are missed altogether (particularly for the over 18 cohort)** – missing the best window for engagement with the young person.
- **The window of opportunity for face-to-face engagement in hospital A&E settings is smaller** than in MTCs as patients have less serious injuries and are discharged sooner.

Consequently service providers have developed ways to maximise engagement with young people by…

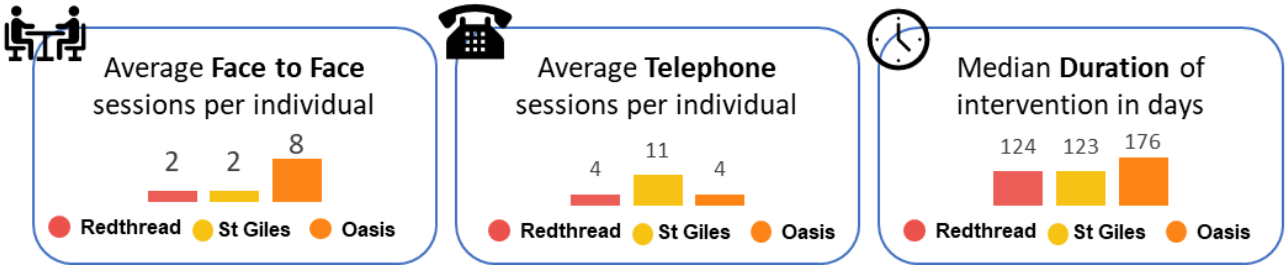
- **Flexing the service operating hours based** around demand analysis and recruiting more staff to improve visibility during peak times.
- **Providing consistent training to clinical staff** to raise awareness of the service and age range, to promote referrals, and to emphasise the importance of gaining consent for the service to contact the young person post discharge,.
- **Screening hospital systems for missed referrals,** notifying clinicians of the eligibility criteria and the missed referral.
- **Partnership working across safeguarding teams in hospitals and across other professionals within the child's network** to ensure any missed referrals for under 18s are still picked up by teams and the hospital gives permission to override the lack of consent to contact for children

Following a referral, young people were **contacted** by youth workers **in hospitals** or **remotely** - 75% of contacts by Oasis (n=187) and 77% of contacts by St Giles were remote (n=328). For Redthread, a higher proportion of referrals were made in hospital (59%, n=417).

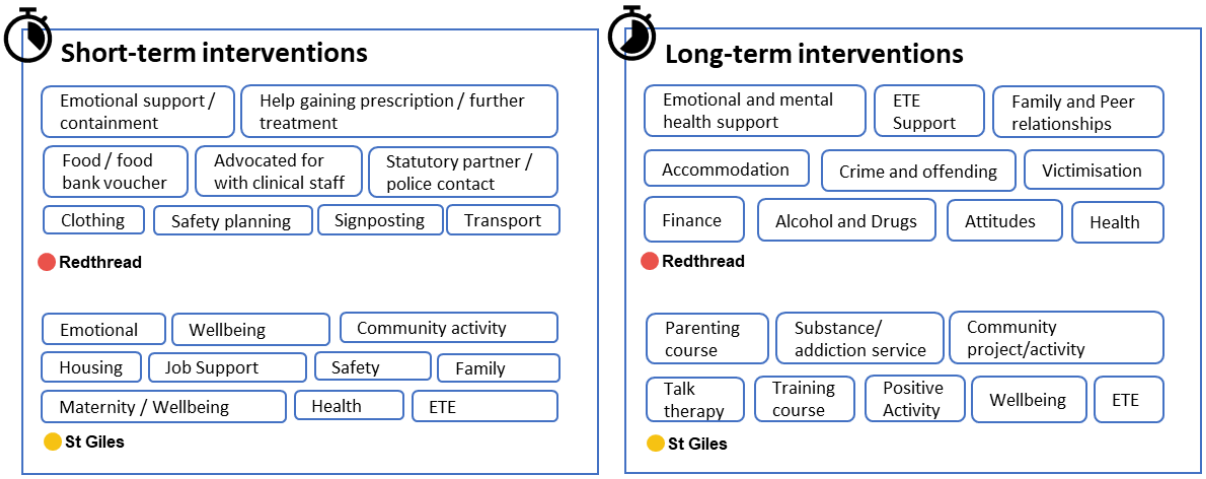


Providers delivered face to face and telephone sessions with individuals who engaged with the service. The number of telephone conversations per individual ranged from 1-34 and the number of face-to-face conversations ranges from 0-26. **Oasis offered more face-to-face sessions per individual on average than other providers,** while **St Giles delivered more telephone conversations.** Redthread also recorded details of text and email conversations with young people and family members. Due to the service implementation occurring in the covid-19 pandemic there was a higher likelihood that contact was made remotely such as on the telephone during this period.

For completed cases[15] (cases where the young person did not withdraw or the case was not closed prematurely) the median duration of intervention was **similar across providers,** suggesting consistency in the length of time young people were supported for, **averaging at a of 4-6 months**[16]. However, the range of time was extremely wide, with data suggesting between 0-524 days[1718]. This could be data error (as there were also 'unknown' intervention lengths), but it also indicates the service varies substantially depending on the individual.

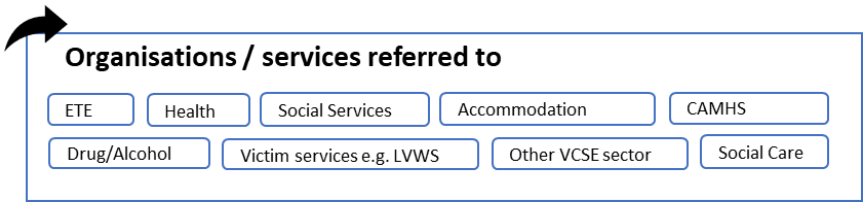


[15] Base size <100 for St Giles (Oasis:132, Redthread:138, St Giles:71.
[16] Based on individuals with completed interventions only.
[17] 11 young people engaged prior to April 2020 (project start date) but received the service during the evaluation period – their data increased maximum duration of support to 1030 days.
[18] Telephone range: 1-34; Face to face range – 0-26.



Emotional support was the most common short-term intervention[19] - offered for both Redthread and St Giles (Redthread offered to 76%, n=188[20], St Giles offered to 64%, n=70[21]). For Redthread, **Emotional and Mental health was the most common long-term intervention** (offered to 80%, n=148), followed by ETE support (educational, training and employment) (offered to 63%, n=116) and Family and Peer Relationships, offered to 59% (n=109).[22] For St Giles, the most common long-term interventions were **ETE** (26%, n=6) and **Positive Activity** (26%, n=6).[23] Oasis did not provide details of the nature of short and long-term interventions offered[24].

All three service providers **signposted / referred individuals to other organisations** or services. Where specified[25], Oasis referred individuals in 86% of cases (n=184), Redthread in 39% of cases (n=169) and St Giles in 32% of cases (n=19). Referrals were most often made to ETE (25%, n=88), VCSE sector (25%, 88), Victim services (21%, n=73), Health services (18%, n=64), Accommodation (9%, n=32) and social services (9%, n=32).



[19] Differences in provider labels is due to data inconsistencies.
[20] Redthread recorded full details of long-term interventions offered, with some young people being offered multiple interventions.
[21] St Giles recorded only one short term intervention was per person.
[22] Redthread recorded full details of long-term interventions offered, with some young people being offered multiple interventions.
[23] St Giles recorded only one long term intervention was per person.
[24] Base size <100 for st Giles (Redthread:184, St Giles:23).
[25] Base size <100 for st Giles (Oasis:213, Redthread:433, St Giles:59).

Engagement differed across providers - when looking at the number of young people who were eligible and were offered the service, Oasis had the highest figure (n861) (see figure 2). However, when comparing engagement **rates** Oasis has the **lowest** at 30% and Redthread the **highest rate** of 62% (see figure 3). Whilst potentially interesting, as outlined earlier, services had somewhat different approaches to design, so caution should be used when comparing across in this way. Redthread had a larger criterion compared to the other two providers and therefore their engagement levels are considerably higher.

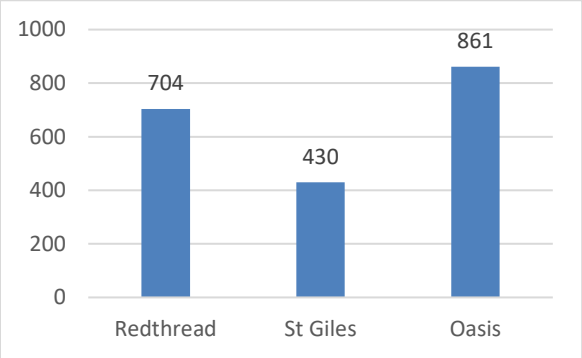


Figure 2: Young people contactable and offered the service by provider, April 2020 – March 2022
As of data collection in June 2022, Redthread had 28 interventions that were still live, St Giles had 24 and Oasis had

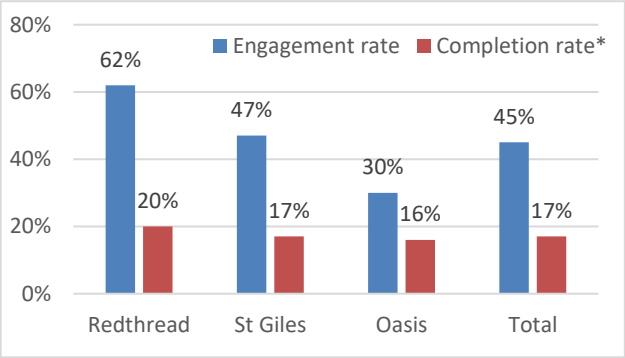


Figure 3: Young people who engaged with the service, and completed the service by provider, April 2020 – March 2022
**Completion = completed the intervention / contacted and offered the service As of data collection in June 2022, Redthread had 28 interventions that were still live, St Giles had 24 and Oasis had 64.*

Delivery period	Redthread	St Giles	Oasis	Total
Year 1	**186**	**75**	**63**	**324**
Qtr2-20		6	12	30
Qtr3-20	35	10	17	79
Qtr4-20	67	19	20	126
Qtr1-21	84	40	14	152
Year 2	**247**	**97**	**125**	**469**
Qtr2-21	89	37	37	200
Qtr3-21	41	16	38	133
Qtr4-21	65	18	23	129
Qtr1-22	52	26	27	132

Table 1: Number of engaged young people by quarter

Nevertheless, despite differences in engagement rates, the percentage of young people who **completed the intervention** is **similar across providers**[26]**.** Whilst the provider interpretation of 'initial engagement' could still play a role, the data also suggests Redthread had a higher dropout rate (Redthread had a significantly higher proportion of individuals who were recorded as having initially engaged and then withdrawn than Oasis or St Giles).

When attempting to understand 'dropouts' or disengagement with the service, most **users were recorded as 'due to personal choice'**, with young people stating they simply decided not to[27]. Additional reasons highlighted by providers were around losing contact with the young person[28]; or the intervention was not required due to multiple professional involvement[29]. Future work should examine the underlying reasons for non-engagement (i.e., more in-depth work with staff, youth, wider services), so providers can provide a more targeted approach to sustain service delivery.

[26] completion rates based on closed cases only, excluding live cases.
[27] Redthread: Did not want to engage 48%, n=129, St Giles: Didn't need the service 52%, n=120, Oasis: Declined/dropped 26%, n=29.
[28] Redthread: 21%, n=56 and Oasis: 20%, n=22.
[29] St Giles: 15%, n=35.

When assessing delivery across the years, service providers **engaged with more people in year two** compared to year one[30]. Reasons for this could be the unblocking of multiple service implementation challenges (see *service delivery challenges*), including the increased physical presence of youth work teams in A&E sites, as the impact of covid-19 lessened.

Analysis explored whether there were differences between those who engaged in the first year of service delivery (April 2020 – March 2021) and the second year of delivery (April 2021 – March 2022), with a **key difference found to be a significant increase in the proportion of 11–14-year-olds engaging in the second year of delivery** across all providers. This could indicate a focussed improved of targeting of this younger group over time[31].

'I think we've done really well, especially launching it in the middle of the pandemic, having a backlog of referrals, having to adapt to the stresses of COVID, the limitations being created, having to work with our young people initially.... able to maintain really good numbers, we've had some really good success stories as well.' (Youth worker, Redthread, Lewisham Hospital)

Key *learning: Engagement rates have improved from year 1, but withdrawal from the service is still high*

Service Delivery Improvements

Most programmes will likely encounter implementation challenges when embedding a new service and the A&E youth workers project was no exception. The initial set-up was disrupted in year one by covid-19, although year two saw many improvements and staff were generally positive about the scheme. Although some long-standing challenges were not able to be remedied.

One of the largest blockers in the first year was a **lack of dedicated spaces** for youth work teams to talk within the A&E departments. With a more **prominent presence** and a **greater buy-in at a trust level** (compared to this point last year), it was felt this issue has largely been resolved, with processes, contracts and dedicated spaces now in place to ensure the youth teams were fully embedded in the hospital environment. The linked process barriers around **accessing hospital systems**; **data/information sharing and governance,** thought to effect referrals to the service have also been resolved, leading to a freer exchange of information and more joined up approach between youth workers and hospital staff. In year 2, youth workers were able to access the hospital systems to identify young people that may be eligible for their service.

'We had some real issues with the data protection side of things and barriers originally, and we managed to successfully overcome that.' (Clinician, St Giles, Whittington)

[30] The total figure (n793) engaged with for yearly comparisons is different to the overall total (n894) due to missing individual level data from providers.

[31] 11–14-year-olds: 22% of those who engaged in Year 1 (n=72), 29% in year 2 (n=134).

A key finding from the first-year report was the struggle to implement the service due to the **covid-19 pandemic**. To illustrate, delivery models had to change and 'hot and cold zones' set up in response to the pandemic limited the youth workers access to hospital space.

However, the relaxation of COVID restrictions allowed for an increased physical presence - therefore more opportunities to engage with young people & hospital staff. The **increased physical presence of youth work teams** has allowed coverage across a range of hours, to see young people when they are most likely to present in A&E departments. As a result, most survey participants felt the youth work teams had **successfully embedded in each site** and commented on their ability to 'catch' the young person at the teachable moment, due to being in the hospital setting.

'…because you're there for them in that moment you become someone they can trust, and you can really build that relationship really quickly and just create better rapport and better engagement across the board.' (Youth worker, Redthread, Croydon Hospital)

'It's very good for visibility of the service. We rely on clinicians to refer into our service a lot, especially whenever we're not here or out of hours…' (Youth Worker, Redthread, Queen Elizabeth Hospital)

'The staff are more engaging with them, and they are part of the team. We refer to them, we speak to them, they are part of our safeguarding meetings, our handovers and our huddles.' (Clinician, Redthread, Lewisham)

'They'll take referrals any which way; they can be referred on our computer system, they can be referred in person, they can be referred by a phone call. They were very much open.' (Clinician, Redthread, Croydon University Hospital)

'It's a vital service which can change the course of young peoples lives for the better.'
'They are an excellent resource that we are patients are very lucky to have access to.'
'This has been an invaluable service to the department and local area.'
(Comments from clinicians from the survey)

In year one, there was a lower than predicted referral rate, assigned in part to the lack of physical presence of youth workers. In year 2, youth workers have been able to take advantage of both **formal and informal interactions** with clinical staff (e.g., delivering **more face-to-face training)**, to promote awareness of the service. Examples of training clinicians was identified as: speaking in safeguarding sessions; presenting at ward rounds; and ensuring new staff are made aware of how to facilitate the referral process. Youth workers felt training was still crucial for buy in among clinical and hospital staff.

Clinicians and youth workers now feel **referral numbers have increased or remained consistently high in most hospitals**. Hospital staff feel youth work teams are **more visible** and have embedded better since last year – something reflected in the feedback that the 'champions' identified in the year one report, required to promote the service, have been needed less.

In addition to a greater awareness and buy-in of the services, an array of **flexible referral pathways** were developed, to maximise accessibility for hospital staff. Most interviewed staff/stakeholder said the referral process **works best using several different options** to receive and seek out referrals, such as a blend of email, phone call, face to face and paper options. Results from a clinician's survey revealed most think the service is very important; that they

understand the criteria for referring a young person; that most had made a referral; and many disclosed they were very satisfied with the process.

As a result of improvements and changes to covid practices, during year two, many interviewed staff and stakeholders were **satisfied with delivery progress** and commented the service is **in line with what was originally planned.** There was praise for the **flexibility of the teams,** particularly during the pandemic, and that youth workers were **friendly,** had a **strong work ethic** and **added value.**

Key learning: Service providers have addressed many of the challenges from year 1 implementation.

Continued Service Delivery Challenges

Whilst awareness and buy-in have improved, the greatest challenge continues to be around **high A&E staff turnover**. Interviewees still expressed concern over the continued need to build awareness of their work, with rotating staff effectively 'taking their connections with them'. The fast staff churn means youth worker resource is being diverted from their front-line delivery role. Many youth workers said that clinician **training is an on-going, regular process to secure buy-in**, as the make-up of ward staff is ever-changing. This has led to occasions when **there are gaps in knowledge**, with some staff concerned that training can be piecemeal and dependent on their own identification of opportunities. Some hospital staff still report an **unawareness of the importance of contextual safeguarding** and some staff did not recognise the need for **contextual safeguarding in the 18+ age group**.

'It had embedded brilliantly, until we lost all the staff. I think now we've got to start again and really try and work on it.' (Clinician, Redthread, Crovdon)'

'That's something we have to do quite regularly and hand over meetings for new staff' (Youth Worker, Oasis, St. Thomas' Hospital)

'… We learn something new every day. To have a different perspective than a medical perspective… it gives us an understanding of what to signpost, what to see and what to look out for' (Clinician, Redthread, Croydon University Hospital)

Nevertheless, **for those who have received it, training is perceived as useful by hospital staff**. A clinician survey found that 19 of the 29 clinicians said they were very familiar with the service; and 17 agreed/strongly agreed the service had improved their knowledge of identifying vulnerable people. Redthread delivered the most training sessions and 'Safeguarding YP exposed to violence' training most frequently (67 times). St Giles provided awareness of service/introduction/promotion to service training most frequently (15 times).

Suggestions for **new processes to increase awareness** were considered, including shadowing and joint working between providers to share learning; youth workers attend council briefings; increasing the circulation of their newsletter; getting MOPAC to promote the service; improved hospital communication, including via posters, newsletters and publicity on the intranet.

Although the increased presence of youth teams in A&E was identified as an enabler of engagement with young people across a range of hours, the impact of **youth worker staff shortages and lack of staff to cover peak times** (when young people are likely to present at A&E), has still affected service delivery. There was concern some **eligible young people** were **'falling through the gaps',** with **fewer referrals** occurring when **youth workers were 'off duty'** (i.e., nights or weekends) and those times covered by A&E bank staff (supply staff). This was also picked up by interviewed parents and young people who said, despite the positive impact the youth workers have had, there were **challenges to provide support** due to **working practices** and **resource restrictions**. Another 'A&E environment' challenge was the **short amount of time** the youth worker initially spends with the young person, which does not facilitate building relationships, disseminate information and promote the service.

In addition, some youth workers also mentioned the amount of administration they must do (including data collection for partners working in violence reduction), takes their time away from 'on the ground' work. The youth workers suggested more investment in administration to reduce the burden on frontline workers.

'our day to day team youth workers are also covering quite a lot of the admin that they wouldn't usually be involved with' (Youth worker, oasis north Middlesex hospital)

Key learning: Some delivery challenges are yet to be addressed.

'I think [name] really listened… and adapted her responses to what she was hearing from me and what she was hearing from [name]. It's just an absolute godsend. It was just having someone else to help us at a time when we'd run out of ideas, and we just felt very very lucky' (Parent)

'We can challenge professionals…the multi-agency working has really changed…It's a lot more advocacy work, watching the advocacy work and trying to build a picture of youth service that should be involved or who needs to be communicating more…' (Youth worker, Redthread, Queen Elizabeth Hospital)

Perceptions of the Service

Overall, there was positivity towards the programme across service providers, stakeholders and partners, which was mirrored in feedback from the young people and their families. In the views of youth workers, their tailored work was especially welcomed, reporting that regardless of who engaged they adopted a **flexible approach, personalised to the individual and their needs**, considering interests, and sequencing support (as outlined by the case studies provided below). This would involve a developed plan put in place at the beginning with specific goals related to **immediate support**, focusing on precise requirements, such as housing or employment. Staff also drew upon both formal and informal methods, focusing on what the **young person or the wider family needs.**

Youth workers were reported to be '**safe adults'** in an A&E setting, able to act as role models, build trusted relationships, and be there to handhold; guide; listen to; advocate for; and support the young person. A key role was

'it could be going into school with them, having the meeting in school with them, having support networks, relationships with their parents even.'
(Youth Worker, Oasis, North Middlesex Hospital)

'She was looking at property with me, she referred me to a social worker…she chased the council to see if they could offer me a place. She tried to get him medication, she tried to get him a job. She did a lot of things for our family. Throughout coronavirus she provided food… Whatever I need, I call and she does it…' (Parent)

identified to be **advocating** with professionals and attending important meetings, which helped to build relationships and put young people at ease.

Interviews with young people and their parents who have accessed the support similarly highlighted the positives and benefits of having a tailored individually led support programme and how **diverse the support can be**. This approach has been made possible by the youth workers **building networks with agencies within the community** to refer young people to. In the views of staff, this kind of 'bridge' has been missing for many young people, so this support can help break down the distrust they have with professionals. It is hoped future evaluation can collect more granular data regarding need and the services matched to them, to strengthen learning about this important aspect of service delivery.

Key learning: The service and reported 'tailoring to need' are seen as positive.

Case study A: Person A presented at A&E after experiencing bullying, anger issues and fights at her school. Initially sessions with her youth worker were focused on her self-esteem and friendships however as these sessions progressed, Person A was able open-up about her home life and the complicated relationship she has with her mother. The youth worker was able to refer Person A and her mother to Early Help to stabilise and rebuild their relationship. During Person A's support she also disclosed sexual abuse, a toxic relationship with a boyfriend which resulted in a pregnancy and was facing a lot of allegations from her family including drinking alcohol, stealing and believing she has a personality disorder. As a result Person A's relationship with her family completely broke down and she was at a real risk of homelessness. Her youth worker helped with accommodation, working with services including CAMHS and social care and supported her through her termination. Throughout the pandemic Oasis has maintained virtual contact supporting Person A to deal with her trauma.

Case study B: Person B is a 21-year-old man who is well known to hospital services, with Emotionally Unstable Personality Disorder (EUPD), Attention Deficit Hyperactivity Disorder (ADHD) and a mild learning disability and has a history of significant risk to self. Treatment teams who work with him have been concerned about his escalating level of risk. He was referred to the service after being raped and assaulted by an older man who would sometimes supply him with drugs. Although the crime had already been reported to the police, the youth worker made a safety plan and a referral to victim support and rape crisis services to provide further support around the court proceedings.

A good rapport was built with the youth worker and Person B is being helped long-term including mending relationships with his mother as well as learning to live independently and helping to improve his self-worth and confidence. Person B has said the following about his youth worker: "He is a very good and polite person, and he always makes time to speak to me and go through my problems and gives me some really good advice. I don't really get on with men, but I have this good vibe and I feel I can trust him when we speak. He is really good at his job and I'm happy that I am working with him, he makes me feel safe and comfortable talking to him about my problems without being paranoid he will judge me. I'm happy that he is working with me, he's great at his job."

Perceptions of Risk & Safety

Over time service providers reported that young peoples' risk reduced [32] - for measures of **overall risk**, **risk of harm from others**, **risk of harm to others** and **risk of harm to self**, there was a significant decrease in the proportion of individuals assessed as being 'High' risk and a significant increase in the proportion of individuals assessed as 'Low' risk between initial and final assessment (see figure 4). It is noteworthy to highlight the split of risk levels, with over half of youth initially categorised as medium/low risk (66%) – this maybe unexpected given they are attending A&E with injuries and involvement in violence and again may relate to the potential bias as these assessments were only conducted on those youths engaging.

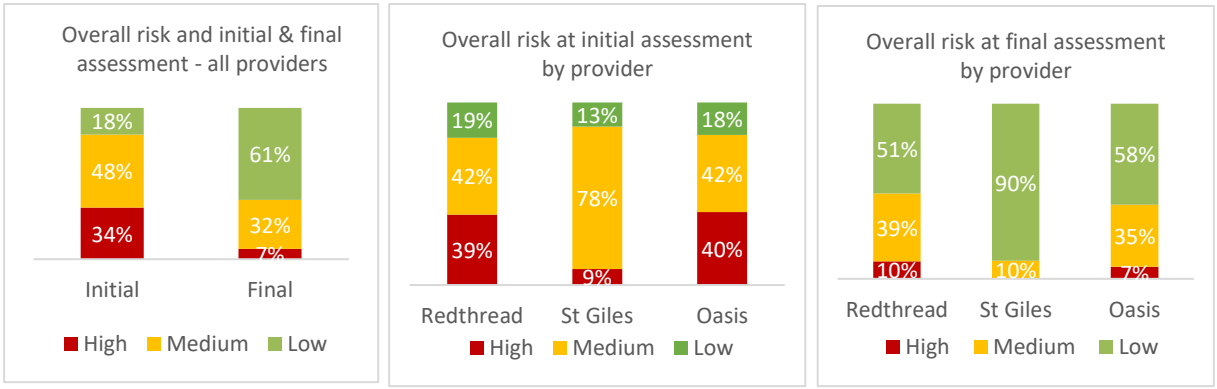


Figure 4: Overall risk assessment scores at initial assessment and end assessment for service providers combined (1) and providers individually (2 & 3) – Engaged individuals only, includes only those that completed initial and end risk assessments
Based on 'Overall risk at initial assessment (H/M/L)' and 'Overall risk at final assessment (H/M/L)' from individual level data. Excludes individuals for whom data was not recorded or was unknown

[32] Most risk assessments conducted (n=582) were with young people who chose to engage in the service and analysis has been completed based on engaged young people only. When comparing start and end risk measures, analysis has been completed only on those who have completed both start and end assessment. See Appendix A for base sizes used.

For overall risk, these changes were also significant at service provider level[33], suggesting for all three service providers, **individuals were perceived to demonstrate a lower risk of harm to themselves, to others and from others** after completing the service (see Appendix E for breakdowns by individual risk measure by provider).

Young people who withdrew from the service post initial engagement were more likely to present as low risk at initial assessment (34%, n=45) vs those who remained engaged with the service (19%, n=65), suggesting they may have been less 'in-need' of the support.

Services also appear to be helping young people to feel safer[34] - as when comparing self-assessed outcome measures at start and end of interventions, there was a significant improvement in the average score across **all safety and support network measures** and most **wellbeing measures.** For safety measures, the greatest increase was for 'I trust that services can keep me safe' - a mean score increase of 1.3. For support networks the greatest increase was seen for 'I could ask professionals for help if I needed it' - a mean score increase of 1.4. For wellbeing, the greatest increase was seen for **'I've been thinking clearly'** - a mean score increase of 0.8. There was also a significant decrease in the mean score for **both violence exposure measures** (witnessing violence and involvement in violence) and for the number of hospital attendances for violence[3536].

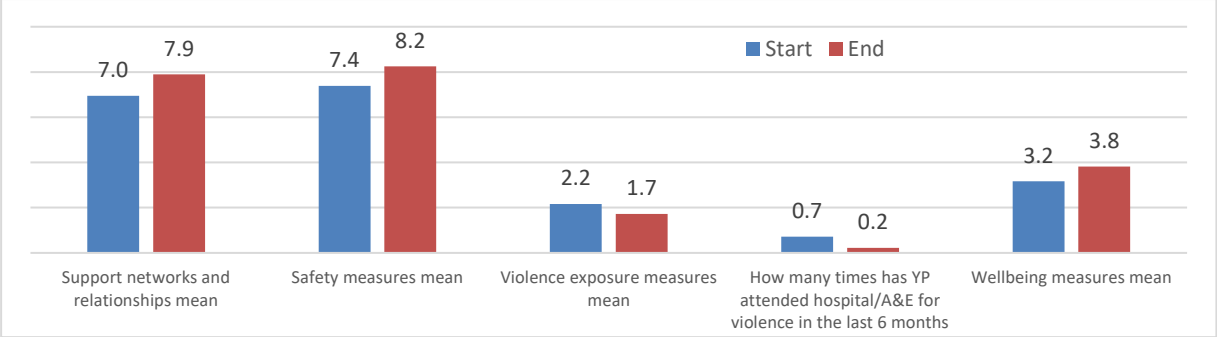


Figure 5: Mean outcome and well-being scores grouped by category at start and end assessment. Includes only individuals who completed both start and end assessments).

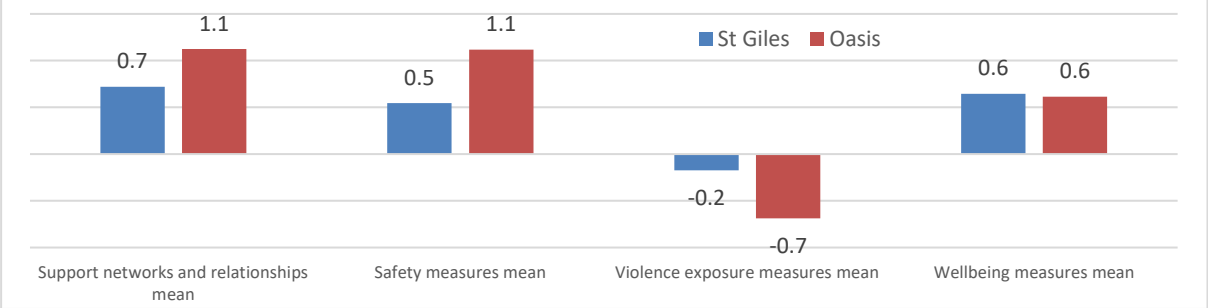


Figure 6: Mean start-end score change for grouped outcome and well-being measures by service provider. Includes only individuals who completed both start and end assessments.

Hospital / A&E attendance in last 6 months could not be compared due to insufficient sample at provider level

Start-end score changes were calculated for everyone who participated in both start and end assessments. Mean score changes based on all individuals were calculated for each outcome and wellbeing measure.

[33] 95% confidence.

[34] When comparing start and end outcome measures, analysis has been completed only on those who have completed both start and end assessment. See Appendix B for base sizes used.

[35] Base size<100: 72 for hospital attendance.

[36] It was not possible to break down measures to assess differences across groups (e.g. age, gender, ethnicity).

At a provider level - improvements in mean scores from start-end assessment for all outcome measures were significant[37] for Oasis and St Giles. The greatest improvement for Oasis was seen in support networks and safety measures which saw an increase score of 1.1. For St Giles the greatest score increase was in support networks, which saw an improvement of 0.7 (see figure 6, see appendix G for full breakdown by individual measure).

When digging deeper into any differences across those service users initially assessed as being high-risk or those as medium/low risk, there was an **improvement in score for all safety and support network measures, most wellbeing measures[38] and both violence exposure measures**, suggesting the service is delivering consistently regardless of risk level (see figure 9, see appendix G for full breakdown by individual measure), although these findings are indicative as only based upon very small sample sizes[39].

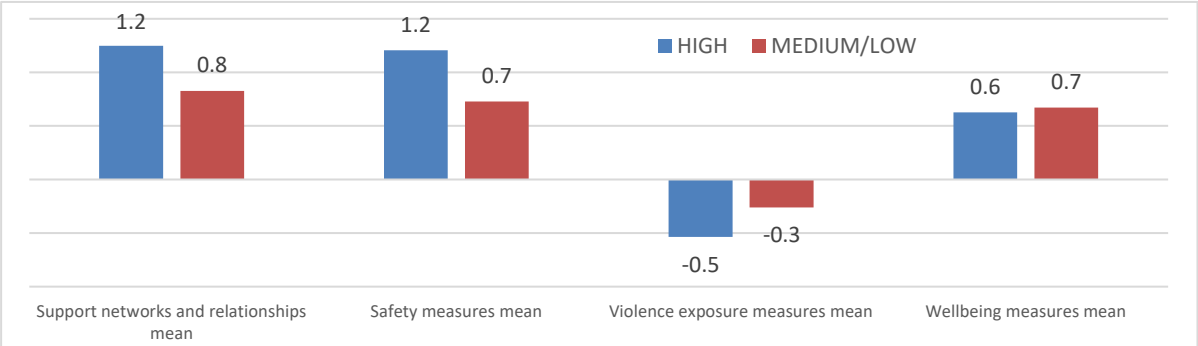


Figure 9: Mean start-end increase for outcome and well-being scores grouped by category according to initial risk. Includes only individuals who completed both start and end assessments.
Start-end mean change in score were calculated for everyone who participated in both start and final assessments. Mean scores based on all individuals were calculated for each outcome and wellbeing measure.
Medium and low risk have been combined due to insufficient sample sizes for individuals initially assessed as low risk.
Hospital / A&E attendance in last 6 months could not be compared due to insufficient sample at provider level.

Taken as a whole, the **perception results are positive**. However, due to a range of factors (i.e., lack of control group, sample bias, data issues) the **evaluation cannot attribute any of these changes confidently to the programme.** These results could be an outcome of service delivery, or a *perception of reduction* by the youth worker or driven by sample bias (i.e., only incorporating those youth to complete). It is hoped that future opportunities to explore more robust impact are taken up to strengthen the evidence base.

> *Key learning:* There were numerous significant improvements across perception measures including reduced risk, risk of harm and safety.

[37] 95% confidence.
[38] For medium/low risk individuals there was a significant improvement in mean score for all wellbeing measures, for high risk individuals there was a significant improvement in mean score for all wellbeing measures except 'I've been feeling close to other people' which increased but not significantly.
[39] 28 individuals assessed a high risk, 86 individuals assessed as low/medium risk.

Discussion

A total of £2.5 million from MOPAC, the Mayor's Young Londoners Fund, and the Violence Reduction Unit (VRU) was used to develop youth services within A&Es, situated in geographical areas experiencing high levels of knife crime. Running alongside the delivery of embedding youth workers, London has seen a sustained backdrop of rising youth violence – with the number of teenage homicides in 2021 the highest on record at 30 incidences[27]; knife offences increasing from 2021 and returning to higher than pre-2018 figures[28]; and links between serious youth violence and group offending, with over half of all teenage homicides in the last 3 years had links to gangs[6]. This restates the continued need to address immediate and future risk for London's young people.

A wealth of findings have been documented in the evaluation. Overall, it is worth reflecting upon several areas that emerged in more detail. These are *ensuring implementation*, *addressing the withdrawal challenge* and *the need for robust assessment of impact.*

Ensuring implementation

Almost all schemes will encounter implementation issues of one type of another. The Hospital Based Youth Worker programme was no exception. This is an imperative to bear in mind, as the evidence is clear - those schemes with better implementation are more likely to achieve the desired outcomes[29]. The importance of implementation regarding the current scheme was of course complicated by covid. It is therefore no surprise the first year did not achieve the desired programme fidelity. However, to the credit of the staff, results demonstrated that year two saw a wealth of improvements (i.e., improved awareness, buy in from staff, information sharing and data access), which *by and large* has resulted in staff believing the programme is now being delivered as originally intended. As outlined, implementation challenges are commonplace within programmes, and any attempt to refine or extend the current scheme should seek to pre-empt similar issues from the outset to ensure effective programme integrity. The reported effect of staff churn and the knock-on consequence to service awareness and therefore referrals rates are something for future consideration. Directing youth workers resource from their 'key role' is not efficient and warrants thought over a dedicated resource.

Addressing the withdrawal challenge

A key finding was **45%** of young people withdrew from the service after initial engagement, largely attributed to the young persons 'personal choice'. It is difficult to place this into a wider context, and within the literature withdrawal rates are not generally stated[22] [25]. Staff were mixed on the reasons and spoke of older groups being *harder to engage, presenting trust issues*, whereas formal programme data outlined it was the younger groups that were less *likely to engage*. High withdrawal maybe somewhat expected, given the target youths are appearing within a hospital setting and likely to present a range of complex needs, for example:

- Research indicates any engagement may be complicated by the overlaps between victimisation and offending (i.e., SYVPP majority of teenage victims (63%) and suspects (87%) accused of homicide had been previously arrested by police)[6];
- It has been found young people who are victims/offenders are likely to be socially disadvantaged across many domains (individual, family, peer, school, community); and

- Potentially these young people hold negative attitudes towards police, are anti-authority and/or have an aversion towards engaging with formal services[30].

Ultimately, there could be a variety of reasons why certain groups may be less '*ready*' for the teachable moment than others and it would be hoped more could be done to explore the motivations and needs of those who do and do not engage within any future programme. The ability to do this is grounded in better data collection and quality - documenting specific needs that could assist tailoring the offer and support as well as new research on attrition.

The need for robust assessment of impact

One theme to emerge from the wider academic literature, as well as the findings from the current research, is the lack of robust outcome analysis. Generally, research in this area documents findings from the programme implementation rather than robust 'impact'. Likewise, the current evaluation was not able to explore impact due to issues with data quality (i.e., notable inconsistencies in recording practice; missing data for individuals who did not engage; and data in relation to outcomes for those who did engage; the impact of COVID upon implementation). Whilst the subjective measures of success reported are to be welcomed – they cannot be confidently ascribed to the service.

The need for a robust impact assessment is still very much needed and future delivery / roll-out should focus on data quality to enable robust assessment of which aspects of the service are working and for who. A Pan London approach or wider roll out would provide opportunities to build such an evaluation *into the design* - ensuring policy and practitioner support throughout; resulting in clear outcomes; effective data capture; and the development of a counterfactual.

On a related point, the need for increased data capture and access would be an essential step forward for the programme. This would not only assist future evaluation, but aid youth workers within their practice. To illustrate, capturing need; motivation; expectations of service data; and repeat presentations to the A&E; would all be crucial in understanding where a young person is in their unique 'journey', assisting the initial tailored pitch and the understanding if those who are refusing the service or dropping out are presenting multiple times, have higher risk or different support needs. Data would be best serviced by a bespoke case management system harmonised across service providers, or at least by a process bolstered with data quality checks and staffing. Such information could then feedback on a routine manner for accurate performance data and contract management.

Conclusion

The report details the largest implementation and assessment of the 'teachable moments' approach in a UK health setting. The research has identified numerous promising aspects - a generally positive response to the programme; implementation issues being addressed over maturation of the programme - albeit it was not possible to fully address some issues. The service was valued by providers; stakeholders; and the young people and their families who engaged. Significant positive perception findings on harm, risk and safety were reported (although we are not able to ascribe these changes confidently to the programme). It is hoped the key lessons documented will be able to inform future iterations of the programme.

Appendices

Appendix A: Base sizes for individual level recorded data

Base sizes for each measure reported on: excludes blank, unknown and not recorded fields												
	Did not engage				Engaged				Total			
	Oasis	Redthread	St Giles	Total	Oasis	Redthread	St Giles	Total	Oasis	Redthread	St Giles	Total
TOTAL	N/A	271	230	517	233*	433	200	866	258*	704	430	1392
DEMOGAPHICS												
Age	N/A	271	230	501	N/A	432	200	632	258	703	430	1391
Gender	N/A	271	230	501	N/A	433	200	633	258	704	430	1392
Ethnicity	N/A	N/A	213	213	N/A	N/A	191	191	245	173	404	822
Borough of residence	N/A	271	227	498	N/A	432	196	628	258	703	423	1384
ETE status	N/A	N/A	109	109	N/A	N/A	88	88	251	185	197	633
Known to or engaged with statutory / non-statutory services	N/A	N/A	86	86	185	182	89	456	197	183	175	555
Living arrangements	N/A	N/A	202	202	214	182	177	573	228	183	379	790
SERVICE CHARACTERISTICS												
Reason declined (non-engaged only)	N/A**	269	206	475	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Time from referral to closure (completed only)***	N/A	N/A	N/A	N/A	132	138	71	341	N/A	N/A	N/A	N/A
Reason for closure (complete, withdrawn etc.)	N/A	N/A	N/A	N/A	231	432	198	861	N/A	N/A	N/A	N/A
No. face to face sessions (completed only)	N/A	N/A	N/A	N/A	133	112	70	315	N/A	N/A	N/A	N/A
No. telephone conversations (completed only)	N/A	N/A	N/A	N/A	95	124	71	290	N/A	N/A	N/A	N/A
Short term intervention offered (Y/N)	N/A	N/A	N/A	N/A	139	433	146	718	N/A	N/A	N/A	N/A
Long term interventions offered (Y/N)	N/A	N/A	N/A	N/A	188	433	53	674	N/A	N/A	N/A	N/A
Please specify which short term interventions	N/A	N/A	N/A	N/A	36	229	109	374	N/A	N/A	N/A	N/A
Please specify which long term interventions	N/A	N/A	N/A	N/A	153	184	23	360	N/A	N/A	N/A	N/A
Referred / signposted to other organisations (Y/N)	N/A	N/A	N/A	N/A	213	433	59	705	N/A	N/A	N/A	N/A
Organisations referred to	N/A	N/A	N/A	N/A	184	150	16	350	N/A	N/A	N/A	N/A
Did the young person engage with the onward support? (Y/N)	N/A	N/A	N/A	N/A	177	33	22	232	N/A	N/A	N/A	N/A
INCIDENT CHARACTERISTICS												
Whether initial contact was made in hospital or remotely	N/A	270	228	498	N/A	432	199	631	248	702	427	1377
Reason for hospital presentation	N/A	271	228	499	N/A	433	199	632	241	704	427	1372
Reason for referral	N/A	270	228	498	N/A	433	199	632	256	703	427	1386
Whether attended A&E for assault / exploitation / self-harm in last 5 years	N/A	18	228	246	N/A	98	199	297	258	704	430	1392
Who referred from	N/A	271	228	499	N/A	433	199	632	258	704	430	1392
Who referred from (other)	N/A	166	127	293	N/A	219	100	319	255	704	427	1386
RISK ASSESSMENTS												
Overall risk - Start & End completed	N/A	N/A	N/A	N/A	175	150	68	393	N/A	N/A	N/A	N/A
Harm from others - Start & End completed	N/A	N/A	N/A	N/A	127	150	73	350	N/A	N/A	N/A	N/A
Harm to others - Start & End completed	N/A	N/A	N/A	N/A	128	150	74	352	N/A	N/A	N/A	N/A
Harm to self - Start & End completed	N/A	N/A	N/A	N/A	128	150	75	353	N/A	N/A	N/A	N/A

Base sizes only shown for measures used for analysis and findings in this report.

*For Oasis aggregate summary figures provided by the service provider were used to report on total contacted and referred (861) and total engaged (261) as these were understood to be more reliable for calculating engagement rates. For all other analysis included in this report figures have been based on individual level data.

**Oasis Waterloo provided reasons for declined as aggregate summary data.

*** Calculated based on duration between date of referral and date of closure.

Appendix B: Base sizes for outcomes data

	Start & End completed	Start & End completed - **Oasis**	Start & End completed - St **Giles**	Start & End completed - **Medium / Low Risk**	Start & End completed - **High Risk**
I feel supported by my family/ parents/ carers	140	71	69	86	28
I like most young people that I spend my time with	140	71	69	86	28
Young people I spend my time with have a positive influence on my life	140	71	69	86	28
I could ask my family or friends for help if I needed it	140	71	69	86	28
I could ask professionals for help if I needed it	139	70	69	86	28
I feel safe when I am at home	140	71	69	86	28
I feel safe when I am out in my local area	140	71	69	86	28
I feel safe at school/ college/ university/ where I work	123	65	58	77	26
I am aware of the spaces/ places that may not be safe for me	140	71	69	86	28
I trust that services can keep me safe	141	72	69	86	29
How often have you witnessed any form of violence	140	71	69	86	28
How often have you personally been involved in or experienced violence yourself	140	71	69	86	28
How many times has YP attended hospital/A&E for violence in the last 6 months	72	N/A	N/A	N/A	N/A
I've been feeling optimistic about the future	138	71	67	86	27
I've been feeling useful	138	71	67	86	27
I've been feeling relaxed	137	71	66	85	27
I've been dealing with problems well	136	69	67	86	26
I've been thinking clearly	138	71	67	86	27
I've been feeling close to other people	138	71	67	86	27
I've been able to make up my own mind about things	134	71	63	83	26

Base sizes only shown for measures used for analysis and findings in this report. Excludes blank, unknown and not recorded fields.

Appendix C: Data issues and reporting considerations by service providers

Performance measure	REDTHREAD	ST GILES	OASIS
Referred to service	Figures not reported due to differing recording practices and definitions of referrals across service providers		
Contacted and offered the service	Individual level data provided and used in reporting figures.		Individual level data provided for only 16 individuals who did not engage with the service. Aggregate summary data used in reporting figures.
Engaged	Individual level provided and used in reporting figures		Individual level data provided. Aggregate summary data used in reporting figures for consistency with above.
Status (complete, withdrew, live)	Individual level data provided and used in reporting figures		
Reasons for non-engagement	Individual level data provided and used in reporting figures.		Oasis Waterloo provided summary figures for reasons for non-engagement. Oasis North Middlesex did not provide reasons for non-engagement.
	Reasons for non-engagement were not recorded consistently across providers and lacked detail.		
Reasons for closure	Individual level data provided and used in reporting figures. Reasons for closure were not recorded consistently across providers. Categories have been grouped for the purpose of analysis, but some categories recorded are specific to each provider. We have not therefore made comparisons between providers.		
Demographics	Individual level data provided and used in reporting figures. Engaged and non-engaged comparisons made. Redthread did not provide Ethnicity, ETE Status, Living Arrangements or Statutory Services data for non-engaged individuals so engaged vs non-engaged comparisons for these measures are based on St Giles only.		Individual level data provided and used in reporting figures. Engaged and non-engaged comparisons not possible due to insufficient data for non-engaged individuals.
	ETE status and living arrangements were not recorded consistently across service providers. Categories have been grouped where possible for the purpose of analysis, but some categories recorded are specific to each provider. We have not therefore made comparisons between providers.		
Incident characteristics	Individual level data provided and used in reporting figures. Engaged and non-engaged comparisons made.		Individual level data provided and used in reporting figures. Engaged and non-engaged comparisons not possible due to insufficient data for non-engaged individuals.
	Reasons for referral, reasons for hospital presentation and source of referral were not recorded consistently across service providers. Categories have been grouped where possible for the purpose of analysis, but some categories recorded are specific to each provider. We have not therefore made comparisons between providers.		
Training	Individual level training data provided and used in reporting figures (one row per training session). Redthread provided individual level data on 84 training sessions but indicated that a further 256 training sessions were delivered with no details available.		Individual level data not provided. Aggregate summary data used for reporting figures.
Service characteristics	Individual level data provided and used in reporting figures. Data mainly provided for engaged individuals across all providers. Analysis based on engaged individuals only.		
	Details of the nature of short-term and long-term interventions offered were not recorded consistently across providers, so we have not made comparisons between providers. Redthread was the only provider to record full details of both short-term and long-term interventions for all individuals offered, with some individuals being offered multiple interventions.		
	Organisations referred to were not recorded consistently across service providers. For St Giles, referral information was recorded for only 16 individuals.		
Risk measures	Individual level data provided and used in reporting figures. Data mainly provided for engaged individuals across all providers. Analysis based on engaged individuals only.		
	The number of individuals who completed risk assessments at six-month follow-up was small across all providers (56 in total). Findings relating to improvements in risk level of young people from start-end-follow-up are therefore indicative.		
Outcome measures	Insufficient data provided. Excluded from analysis.	Individual level data provided and used in reporting figures. Analysis based on individuals who completed the intervention only.	
		The number of individuals who completed outcome assessments at six-month follow-up was too small across providers for analysis to be reliable, therefore change in outcome score from start-end-follow-up has not been included in this report.	
		Improvements in outcome measure scores from start-end have been compared at service provider level (Oasis and St Giles) and risk level (Individuals initially assessed at High Risk and individuals initially assessed as Low Risk). Due to small base sizes for each group findings relating to improvements in outcome scores are indicative.	
		The number of individuals with recorded data for hospital attendance ('How many times has YP attended hospital/A&E for violence in the last 6 months') was sufficient only at total level for analysis on change in score start-end. Improvements in this measure have not therefore been analysed at service provider or risk level	

Appendix D: Breakdown of qualitative interviews conducted by ORS

Breakdown of youth worker teams by service provider and A&E site:

Provider	A&E Site	No. of interviews and focus groups per site
Redthread	Croydon University Hospital	1 x interview with youth worker
	The Queen Elizabeth	2 x interviews with youth workers 1 x interview with youth team leader
	University Hospital Lewisham	2 x interviews with youth workers
	All Redthread Sites	2 x interviews with programme managers
St Giles	Both Newham and Whittington Sites	1 x focus group with youth work team and leam leader (6 participants in total)
Oasis	North Middlesex	4 x interviews with youth workers 1 x interview with project coordinator
	St Thomas	1 x interview with youth team leader

Breakdown of frontline hospital staff by service provider and A&E site:

Provider	A&E Site	No. of interviews	Total
Redthread	Croydon University Hospital	1 x interview	6 x interviews
	The Queen Elizabeth	2 x interviews	
	University Hospital Lewisham	3 x interviews	
St Giles	Newham	Not able to secure any interviews, one strategic stakeholder had overview of every site as a clinically based VR lead	3 x interviews
	The Whittington	3 x interviews	
Oasis	North Middlesex	1 x interview	1 x interview
	St Thomas	Not able to secure any interviews, one strategic stakeholder had overview of every site as a clinically based VR lead	

Breakdown of young people and parents by service provider and A&E site:

Provider	A&E Site	No. of interviews	Total
Redthread	Croydon University Hospital	Not able to secure any interviews	0 x interviews
	The Queen Elizabeth		
	University Hospital Lewisham		
St Giles	Newham	Not able to secure any interviews	2 x interviews
	The Whittington	2 x interviews (1 parent, 1 young person)	
Oasis	North Middlesex	2 x interviews (2 parents)	3 x interviews
	St Thomas	1 x interview (1 young person)	

Appendix E: Start and End risk scores by provider

Start and End risk scores for 'harm from others', 'harm to others' and 'harm to self' by provider

For Oasis, there was a significant increase in the proportion of 'Low' risk and a significant decrease in the proportion of 'High' risk cases between start and end for 'harm from others, 'harm to others' and 'harm to self'.
For St Giles, there was a significant increase in the proportion of 'Low' risk cases for 'harm from others' and 'harm to self', there was not a significant decrease in proportion of 'high risk' cases across any risk measure (note – St Giles had a low proportion of high-risk cases at start of intervention).
For Redthread there was a significant increase in the proportion of 'Low' risk and a significant decrease in the proportion of 'High' risk cases between start and end for 'harm from others' and 'harm to self'.

Appendix F: Start and end mean scores & mean score change

Start and end mean scores and mean score change (start – end) for outcome measures across all service providers

Outcome measure	Start mean score	End mean score	Mean score change
I feel supported by my family/ parents/ carers	6.8	7.6	0.8
I like most young people that I spend my time with	7.0	7.9	0.9
Young people I spend my time with have a positive influence on my life	7.0	7.9	0.9
I could ask my family or friends for help if I needed it	7.0	7.7	0.8
I could ask professionals for help if I needed it	6.9	8.3	1.4
Support networks and relationships mean	**7.0**	**7.9**	**0.9**
I feel safe when I am at home	7.8	8.4	0.6
I feel safe when I am out in my local area	6.9	7.7	0.8
I feel safe at school/ college/ university/ where I work	7.6	8.4	0.8
I am aware of the spaces/ places that may not be safe for me	7.6	8.5	0.8
I trust that services can keep me safe	7.0	8.3	1.3
Safety measures mean	**7.4**	**8.2**	**0.9**
How often have you witnessed any form of violence	2.5	2.0	-0.5
How often have you personally been involved in or experienced violence	1.9	1.5	-0.4
Violence exposure measures mean	**2.2**	**1.7**	**-0.4**
No. times has YP attended hospital/A&E for violence in last 6 months	**0.7**	**0.2**	**-0.5**
I've been feeling optimistic about the future	3.1	3.8	0.7
I've been feeling useful	3.1	3.7	0.6
I've been feeling relaxed	3.1	3.7	0.7
I've been dealing with problems well	3.1	3.8	0.7
I've been thinking clearly	3.0	3.8	0.8
I've been feeling close to other people	3.3	3.7	0.4
I've been able to make up my own mind about things	3.5	4.0	0.5
Wellbeing measures mean	**3.2**	**3.8**	**0.6**

Table 3: Start and end mean scores and mean score change by individual outcome measure. Includes only individuals who completed both start and end assessments

Support networks and relationship scores are recorded on a scale of 1-10 (1 being lowest, 10 being highest).
Violence exposure is based on frequency of exposure to violence and is based on a 4-point scale which has been converted into numerical scores (Never = 1, Rarely = 2, Sometimes = 3, Often = 4).
Hospital / A&E attendance in last 6 months is a numerical figure for number of attendances.
Wellbeing scores are recorded on a scale of 1-5 (1 being lowest, 5 being highest).

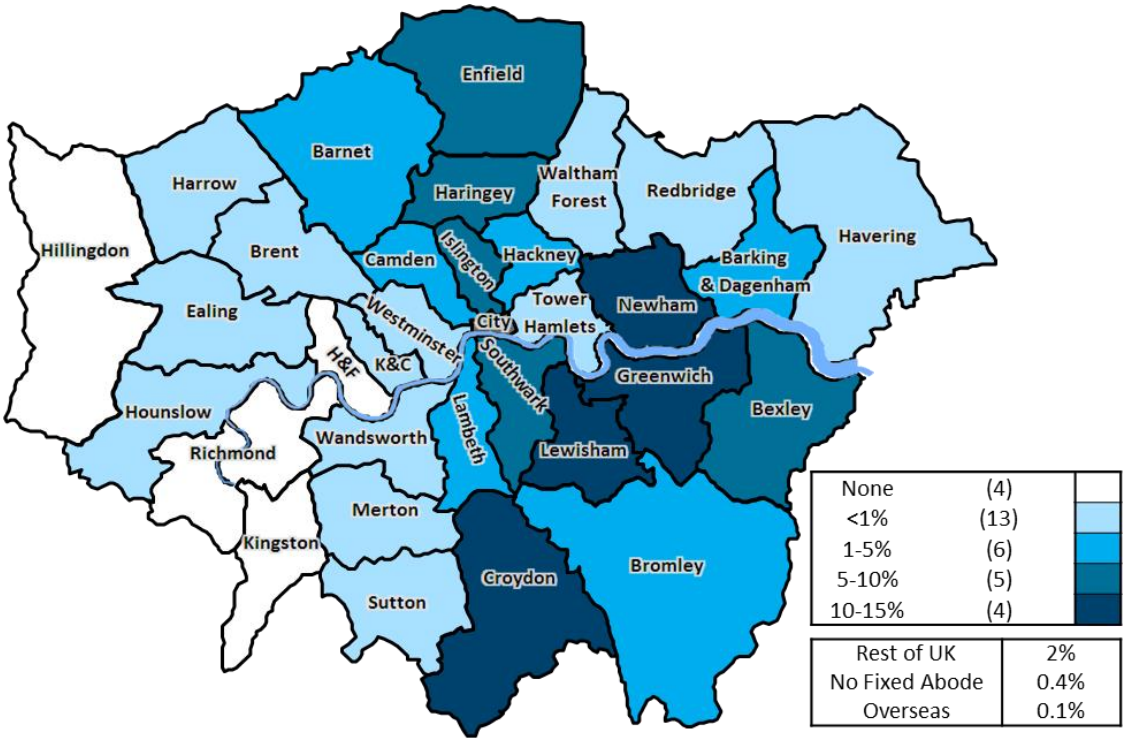
Appendix G: Mean score change by Service Provider and Initial Risk Level

Mean score change (start – end) for outcome measures by Service Provider and Initial Risk Level

	Initial Risk Level		Service Provider	
	HIGH RISK	MEDIUM /LOW RISK	St Giles	Oasis
I feel supported by my family/ parents/ carers	1.2	0.6	0.8	0.8
I like most young people that I spend my time with	0.9	0.8	0.6	1.1
Young people I spend my time with have a positive influence on my life	1.3	0.8	0.5	1.3
I could ask my family or friends for help if I needed it	1.2	0.7	0.7	0.9
I could ask professionals for help if I needed it	1.7	1.3	1.0	1.7
Support networks and relationships mean	**1.2**	**0.8**	**0.7**	**1.1**
I feel safe when I am at home	1.1	0.5	0.3	0.9
I feel safe when I am out in my local area	0.8	0.7	0.6	1.0
I feel safe at school/ college/ university/ where I work	1.0	0.7	0.3	1.1
I am aware of the spaces/ places that may not be safe for me	1.3	0.7	0.6	1.0
I trust that services can keep me safe	1.8	1.2	0.9	1.7
Safety measures mean	**1.2**	**0.7**	**0.5**	**1.1**
How often have you witnessed any form of violence	-0.6	-0.3	-0.1	-0.8
How often have you personally been involved in or experienced violence yourself	-0.5	-0.2	-0.2	-0.6
Violence exposure measures mean	**-0.5**	**-0.3**	**-0.2**	**-0.7**
I've been feeling optimistic about the future	0.9	0.7	0.7	0.8
I've been feeling useful	0.7	0.5	0.6	0.6
I've been feeling relaxed	0.5	0.7	0.7	0.7
I've been dealing with problems well	0.6	0.7	0.7	0.6
I've been thinking clearly	0.8	0.9	0.7	0.9
I've been feeling close to other people	0.2	0.5	0.6	0.3
I've been able to make up my own mind about things	0.6	0.6	0.6	0.4
Wellbeing measures mean	**0.6**	**0.7**	**0.6**	**0.6**

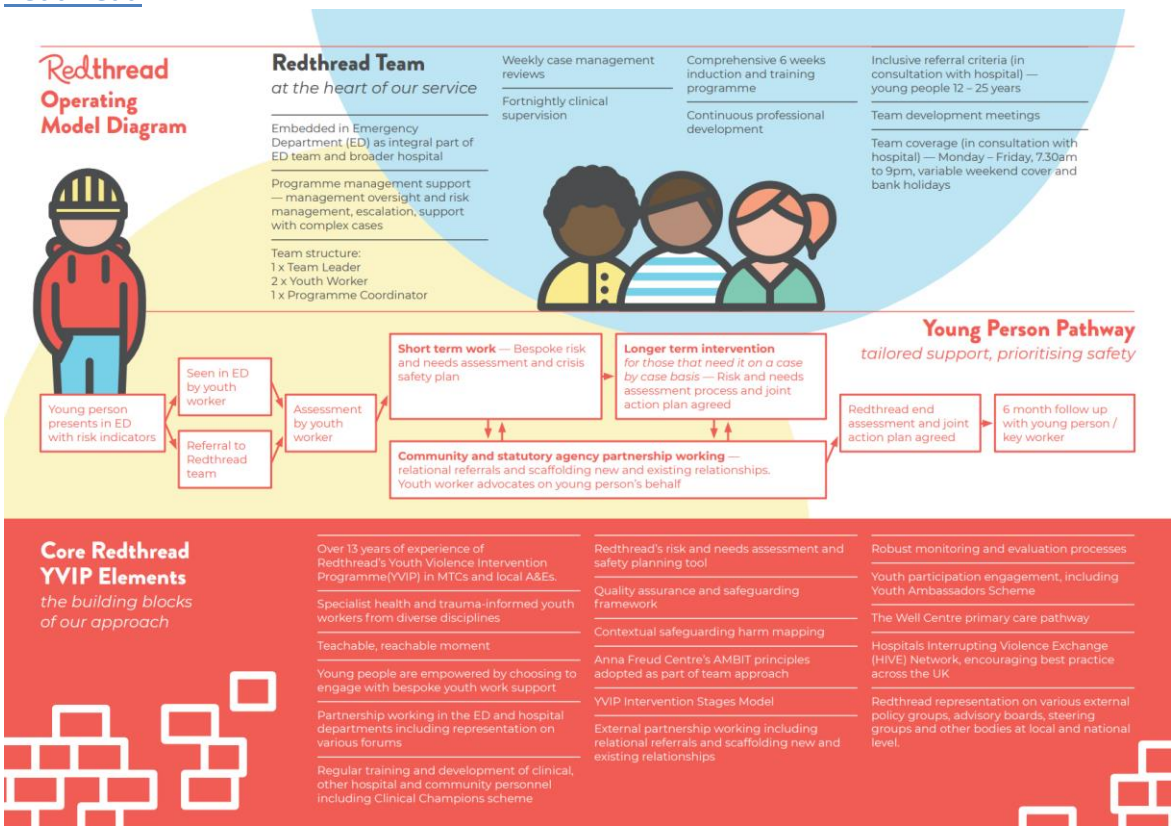
Support networks and relationship scores are recorded on a scale of 1-10 (1 being lowest, 10 being highest).
Violence exposure is based on frequency of exposure to violence and is based on a 4-point scale which has been converted into numerical scores (Never = 1, Rarely = 2, Sometimes = 3, Often = 4).
Hospital / A&E attendance in last 6 months is a numerical figure for number of attendances.
Wellbeing scores are recorded on a scale of 1-5 (1 being lowest, 5 being highest).

Appendix H: Borough of residence of young people offered the service (percentage of young people per borough across all service providers)

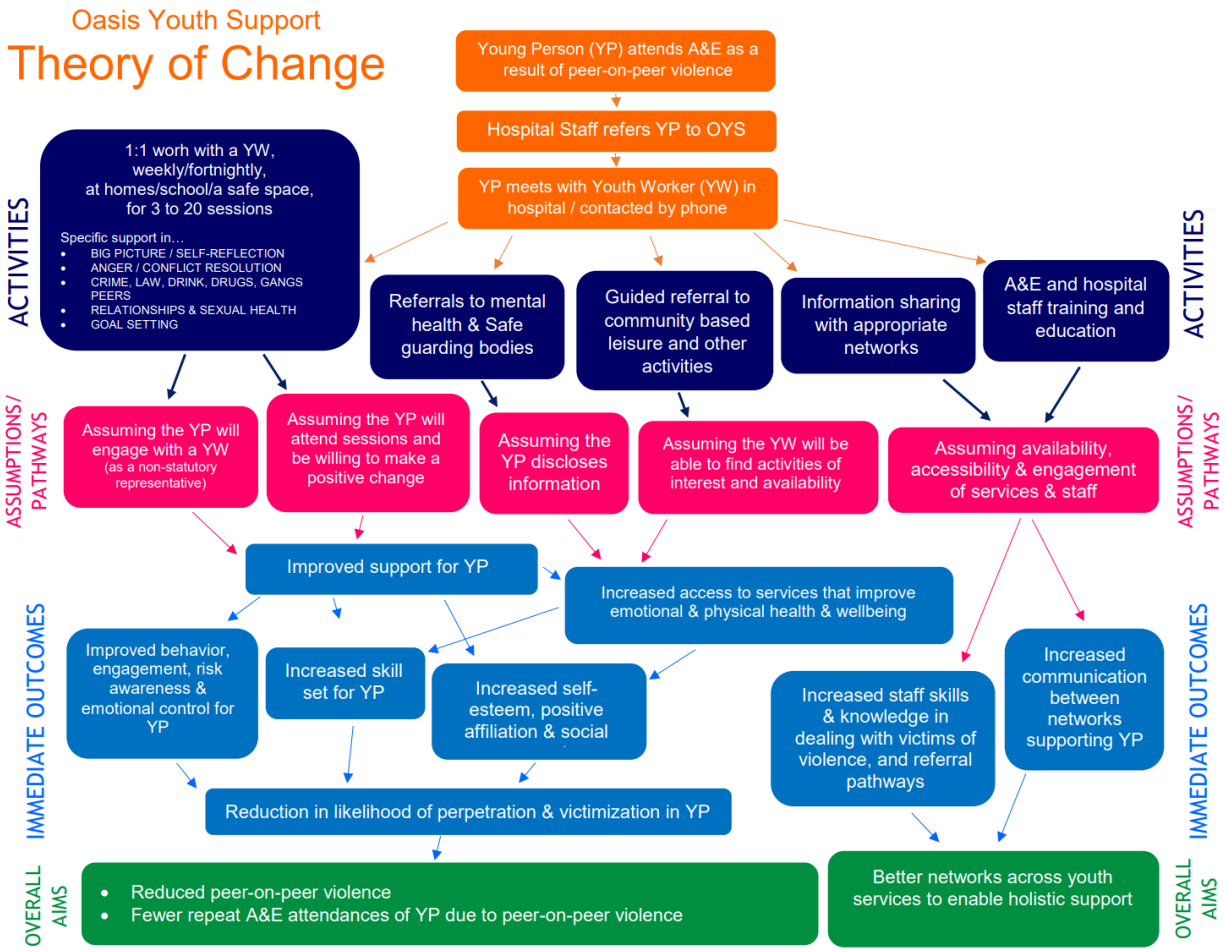


Appendix I: Operating Models from service providers

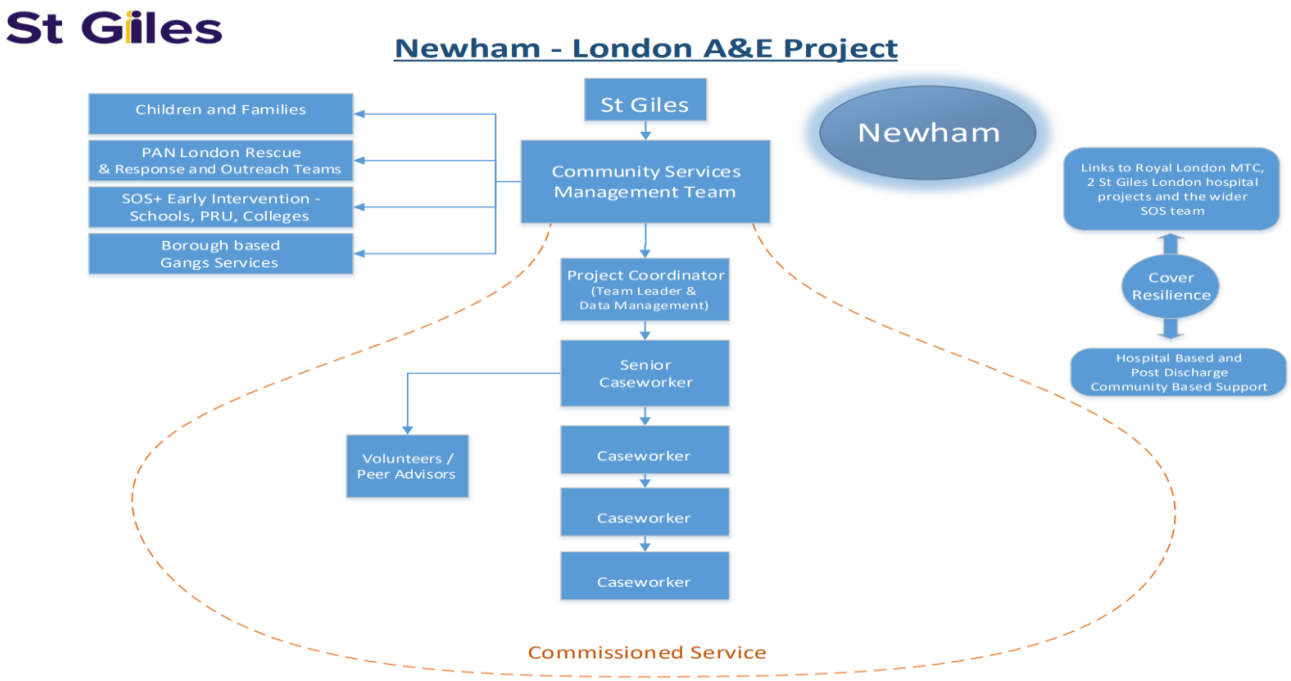
Redthread



Oasis



St Giles



References

[1] MOPAC, (2017). Mayor's Knife Crime Strategy mopac_knife_crime_strategy_june_2017.pdf (london.gov.uk).
[2] Office for National Statistics (ONS), (2022). Offences involving the use of weapons, year ending March 2022 https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/crimeandjustice/datasets/offencesinvolvingtheuseofweaponsdatatables/yearendingmarch2022/offencesinvolvingtheuseofweaponsfinalv2.xlsx.
[3] Office for National Statistics (ONS), (2022). Homicide in England and Wales: year ending March 2021 Homicide in England and Wales - Office for National Statistics (ons.gov.uk).
[4] Violence is prevented and reduced dashboard, London Datastore (2022). Violence is prevented and reduced dashboard – London Datastore
[5] House of Commons, Home Affairs Committee, (2019). Serious Youth Violence https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/1016/1016.pdf.
[6] MOPAC Evidence and Insight Team, (2022). A Problem Profile of Violence, Gangs And Young People PowerPoint Presentation (london.gov.uk).
[7] GLA Strategic Crime Analysis Team & MOPAC Evidence and Insight Team, (2021). Understanding serious violence among young people in London https://data.london.gov.uk/download/serious-youth-violence/b9b4258a-5d02-4677-9dd6-374f55fd167f/Crime%20speech%20report%20December%202021.pdf.
[8] Dowd D., et al, (1996). Hospitalizations for Injury in New Zealand: Prior Injury as a Risk Factor for Assaultive Injury. *American Journal of Public Health*, (86), 929-934.
[9] Redeker N., et al, (1995). Risk factors of adolescent and young adult trauma victims. *Am J Crit Care*, (4), 370–378.
[10] Cheng TL., et al, (2003). Adolescent assault injury: risk and protective factors and locations of contact for intervention. *Pediatrics*, (112), 931–938.
[11] Cunningham R., et al, (2009). Before and after the trauma bay: the prevention of violent injury among youth. *Ann Emerg Med*, (53), 490-500.
[12] Cunningham R.M., et al, (2015). Violent re-injury and mortality among youth seeking emergency department care for assault-related injury: a 2-year prospective cohort study, *JAMA Pediatrics*, (169), 63-70.
[13] Sims D.W., et al, (1989). Urban trauma: a chronic recurrent disease, *J Trauma*, (29), 940–946.
[14] Borowsky I.W. and Ireland M, (2004). Predictors of future fight-related injury among adolescents, *Pediatrics*, (113), 530-6.
[15] McBride C. M., et al, (2003). Understanding the potential of teachable moments: the case of smoking cessation. *Health Education Research*, (18), 156-170.
[16] Lawson P. J. and Flocke S. A., (2009). Teachable moments for health behavior change: a concept analysis, *Patient education and counseling*, (76(1)), 25–30.
[17] Johnson S. B., et al, (2007). Characterizing the teachable moment: is an emergency department visit a teachable moment for intervention among assault-injured youth and their parents? *Pediatric Emergency Care*, (23), 553-559.
[18] Cohen D. J., et al, (2011). Identifying teachable moments for health behaviour counselling in primary care, *Patient Education & Counselling*, (85), 8-15.
[19] Wortley E. and Hagnell A., (2020). Young victims of violence: using youth workers in the emergency department to facilitate 'teachable moments' and to improve access to services, *Arch Dis Child Educ Pract Ed*, (106), 53-59.
[20] Royal College of Nursing, (2022). In-Hospital Violence Reduction Services: A Guide to Effective Implementation, Violence Reduction Programme London, March 2022 In-Hospital-Violence-Reduction-Services-A-Guide-to-Effective-Implementation-FINAL.pdf (england.nhs.uk).
[21] Travers C. and Hann G., (2018). The impact of a youth violence intervention programme on reattendance rates and young people's wellbeing, *Archives of Disease in Childhood*, (103), A136.
[22] DeMarco J., et al, (2016). Improving mental health and lifestyle outcomes in a hospital emergency department based youth violence intervention, *Journal of Public Mental Health*, (15(3)), 119-133.
[23] Potter S., et al, (2016). The impact of a dedicated youth worker in a paediatric accident and emergency, *Archives of Disease in Childhood*, (101), A133-A134.
[24] MOPAC Evidence and Insight Unit, (Unpublished). Redthread Youth Violence Intervention program, year 2 report, August 2017.

[25] Middlesex University, (2016). Evaluation of Oasis Youth Support violence intervention at St. Thomas' hospital in London, UK, Final Report 2010-2016 http://www.oasiswaterloo.org/wp-content/uploads/2019/11/Final-report-15-Nov-2016_Evaluation-of-St-Thomas-OYS-intervention-1.pdf.

[26] Farrington D.P., (1986) Age and crime. In: Tonry M, Morris N (eds) Crime and justice: an annual review of research, vol 7. Chicago University Press, Chicago, pp 189–250.

[27] MOPAC Evidence and Insight, (2022). A Problem Profile of Violence, Gangs And Young People PowerPoint Presentation (london.gov.uk).

[28] London Datastore (2022), Violence is prevented and reduced dashboard Violence is prevented and reduced dashboard – London Datastore

[29] Dawson P. and Stanko B., (2013). Implementation, implementation, implementation: Insights from offender management evaluations, *Policing: A Journal of Policy and Practice*, (7(3)), 289-298.

[30] Ramshaw N., et al, (2018). Youth Voice Survey 2018 https://www.london.gov.uk/sites/default/files/youth_voice_survey_report_2018_final.pdf.