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Evaluation of BLOSM A&E Navigator service

Final report

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List of abbreviations

ACE	Adverse Childhood Experiences
CAHMS	Child and Adolescent Mental Health Service
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CRH	Calderdale Royal Hospital
EPR	Electronic Patient Record
HRI	Huddersfield Royal Infirmary
IMD	Index of Multiple Deprivation
MAV	Medics Against Violence
NEET	Not in Education, Employment or Training
PSM	Propensity Score Matching
SLP	Substance Liaison Practitioners
SNA	Strategic Needs Assessment
YVIP	Youth Violence Intervention Programme

Contents page

Contents

1. Introduction 1
   1.1 Evaluation focus 1
2. Research method 3
   2.1 Limitations 4
   2.2 Service continuity 5
3. Background and context 6
   3.1 The purpose of A&E Navigator services 6
   3.2 Evidence base for Navigator services 6
   3.3 Assessing prevention 9
   3.4 Risk and protective factors 11
   3.5 Serious violence duty 14
4. Overview of service 15
   4.1 Operating model 15
   4.2 Changes made to the model 16
   4.3 Patient journey 18
   4.4 Effectiveness of the model 19
   4.5 Integration into clinical operations 20
5. Operational performance 23
   5.1 Number of patients engaged 23
   5.2 Profile of patients engaged 26
   5.3 Reason for attendance 30
   5.4 Time of attendance 32
   5.5 Location of contact 33
6. Outcomes and impacts 34
   6.1 Time spent with young people 34
   6.2 Discussion summaries 36
   6.3 Onward referrals 40
   6.4 Follow-up support 43
7. Evaluation method 51
   7.1 Evidencing impact 51
   7.2 Methodological approach 51
8. Summary and recommendations 54
   8.1 Summary 54
   8.2 Recommendations 56

List of tables

Table 3.1 Reasons for poor evidence in preventative interventions 11
Table 3.2 Socio-Ecological Model for Violence 12
Table 6.1 Merseyside Navigator Programme: Stages of support 35

List of figures

Figure 4.1: Patient journey 18
Figure 5.1 Time series of attendances by month 24
Figure 5.2 Reason for non consent to BLOSM assessment 25
Figure 5.3 Ethnic profile of young people supported 27
Figure 5.4 Age profile of young people supported 27
Figure 5.5 IMD profile of young people supported 29
Figure 5.6 Primary reason for attendance 31
Figure 5.7 Time of attendance (general) 32
Figure 6.1 Focus of discussions with young people 37
Figure 6.2 Onward referral destination 41
Figure 6.3 Reason for no onward referral 42
Figure 6.4 Follow-up timeframes 44
Figure 6.5 Time of follow-up 45
Figure 6.6 Number of follow-ups 45
Figure 6.7 Days between first and final follow-up engagement 47
Figure 6.8 Focus of follow-up discussions 48
Figure 6.9: Young person engagement level with Community Links 49
Figure 6.10 Rating of the follow-up support received 50

1. Introduction

The West Yorkshire Violence Reduction Partnership (VRP) brings together specialists from health, police, local government, education, youth justice, prisons, probation and community organisations to tackle violent crime and the underlying causes of violent crime.
The VRP is committed to embedding a Public Health approach to reducing serious violent crime, looking at violence not as isolated incidents or solely a police enforcement problem but rather as a preventable consequence of a range of factors, such as adverse early-life experiences, or harmful social or community experiences and influences.

A Public Health approach to violence includes improving outcomes for the population, for example life expectancy and healthy life expectancy, identifying need, understanding the risk and protective factors and root causes of violent crime, implementing an upstream approach and embedding evidence based preventative interventions at all levels which include addressing the determinants of health.

In December 2023 the VRP commissioned Wavehill to undertake an evaluation of the Trauma Informed A&E Navigator Service: BLOSM within Calderdale and Huddersfield NHS Foundation Trust (CHFT). This report presents detail of our process and impact evaluation of BLOSM covering the period from the launch of the service in January 2023 to January 2025.

1.1 Evaluation focus

One of the main aims of the evaluation is to advance an understanding of the implementation of the BLOSM service, assess its effectiveness and contribute to the emerging evidence base for preventing trauma and adversity as a cause and causation of serious violence.

The evaluation also considered throughout the potential to generate evidence and intelligence around how the service supports the VRP in delivering against the three Home Office mandated key success measures, namely:

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

The evaluation has broadly been divided into process and impact evaluation phases, although our team has continued to explore research questions and themes related to delivery processes and their implication for underpinning impacts throughout.

The key objectives for the process evaluation included:

- Examining the process of implementation of BLOSM, identifying areas of good practice and opportunities for further improvement and adaption.
- Ensuring that lived experience is captured and informs the evaluation, from both people supported by BLOSM and staff.
- Supporting project partners and the VRP to continually improve performance monitoring and future evaluations.
- Examining the onward referral processes into local services through Community Links.
- Providing recommendations regarding the future delivery, areas of potential improvement and scaling up of the model.
- Identifying the suitability for a further impact evaluation.

The key objectives for the impact evaluation included:

- Engaging partners, population and workforce to inform implementation and initial delivery.
- Developing and implementing the community links pathways and referral process.
- Understanding how the principles of trauma informed practice[1] influenced implementation and initial delivery.
- Assessing how data and intelligence has supported implementation and delivery.
- Advising on the extent to which the programme can contribute to the Home Office violence reduction success measures.
- Exploring the potential for assessing social return on investment to support future resourcing and sustainability.

[1] Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development.

2. Research method

The research team commenced in December 2023, approximately 12 months following the launch of the service. We have used a mixed-methods approach to deliver both the process and impact evaluation. This has included:

- Review of the evidence base around the impact and efficacy of hospital navigator programmes
- Review of the BLOSM service operating model, including eligibility criteria, assessment processes and referral pathways
- Detailed analysis of the service monitoring data, which includes data relating to the profile and situation of young people supported, the level and focus of support provided and exit arrangements
- Detailed analysis of case notes and discussion logs recorded by the Navigators
- Semi-structured interviews with clinical staff and stakeholders conducted at two phases across the evaluation, including:
    - Process evaluation- 24 interviews
    - Impact evaluation- 14 interviews
- Four on-site visits to engage with the Navigator team and, subject to consent, observe interactions with young people

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

Similar to the experience of other evaluators, and our own experience of evaluating the A&E Navigator service in Leeds and Bradford on behalf of West Yorkshire VRP, we have been unable to gain direct access to supported young people over the timeframe for our evaluation to ensure their voice could be heard. Whilst our team made every effort to make this happen, we have been reliant on young people providing consent for their details to be shared with our team and/or for our team to have permission to attend and observe support sessions delivered by the Navigators (both in the Emergency Department and within the community).

2.1 Limitations

Whilst our evaluation has adopted a mixed methods approach to provide as robust an assessment as possible of the impact of the A&E intervention, there are a range of limitations to our approach. There are difficulties in ensuring that youth voice has been adequately included in our evaluation. As such, we are limited in our ability to understand their experiences of the young people engaged and supported and crucially their situation beyond their exit from the service.

In terms of monitoring, whilst the service has established unique IDs for the young people supported, it has not been possible to establish a mechanism to track the longitudinal journey of young people supported by BLOSM once referred into onward provision (e.g. Community Links or clinical services). This means that there is no follow-up data or assessment around the extent to which young people's underlying support needs have been met or indeed whether they engaged with the services that they were referred to. Consequently, this limits our ability to evidence with greater confidence the contribution that BLOSM is making in addressing risk factors and building protective factors for young people across Huddersfield and Calderdale.

The BLOSM team can make basic assessment of readmission rates through the systems put in place to collect monitoring data, of which details are explained further in the operating model section of this report. The data shows the number of Emergency Department attendances in the three months before their engagement alongside the number of Emergency Department attendances in the 3 months after their referral. Whilst this is useful in identifying changes to the patterns of attendance, the data does not differentiate between reasons for attendance, nor does it indicate individual changes in behaviour. Therefore, the data cannot be used at this stage to understand the extent to which the support is reducing the number of attendances due to violence related injuries or mental health in line with the aims of the service. A recommendation for future delivery would be to assess ways in which this measurement can be drilled down to better evidence impact specific to the aims of the service.

As with our evaluation of the A&E Navigator model in Leeds and Bradford, there are practical and ethical considerations which limit our ability to establish comparison or control groups to assess differences in agreed outcomes for young people engaged in these interventions and those that are not. However, given the work that the BLOSM team have undertaken to integrate the service within the Electronic Patient Record (EPR), there is potential for this to be explored in greater detail in the future. This is something that we have outlined in a later section of this report.

2.2 Service continuity

Since the launch of the BLOSM there have been several changes to the resourcing of the service and its delivery model. Most notably in early 2024 a decision was taken to not renew the contract with Breaking the Cycle who supplied the youth workers but to instead recruit a new team of Youth Navigators. The process of transitioning to the new model led to a period of reduced capacity for the service which lasted from around June to September 2024 when the new team came into post.

Consequently the service has not been static. At the time of writing the new delivery model coinciding with the recruitment of the new team has been in place for less than 6 months. As such, this report needs to be read with this context in mind, given that the current delivery model had in the view of our evaluation team had insufficient time to demonstrate its full potential.

3. Background and context

Summary

- The presence of violence intervention programmes in Emergency Departments is a 'teachable' moment which may increase an individual's motivation to change, with Navigators able to connect patients to issues related to alcohol, violence or drugs to services on discharge.
- In the absence of engagement by a navigator service, there is potential for an individual's risk factors to deepen with associated cost implications for a range of services.
- Building an evidence base for preventative interventions such as BLOSM poses unique challenges as it can be difficult to prove causality for early interventions and, in keeping with a public health approach, the benefits may not be realised for years.
- A recent study found that the Navigator programme was associated with reduced emergency and acute healthcare use in the year following intervention, with increased scheduled outpatient care.

3.1 The purpose of A&E Navigator services

A&E Navigators are a support service for people who find themselves in A&E due to violence. Navigators aim to provide consistent care, advice and support to people who have experienced violence and may be at risk of future violence. Navigators aim to link people with appropriate community support services with a view to assisting people to address the factors that may make them vulnerable to violence.

3.2 Evidence base for Navigator services

One of the earliest service examples of a Navigator service is funded by the Scottish Government and managed by the Violence Reduction Unit in partnership with Medics against Violence, NHS GGC and NHS Lothian. This service has been operating in the Emergency Department of Glasgow Royal Infirmary since December 2015 and from November 2016 in the Emergency Department at the Royal Infirmary of Edinburgh. The service aims to support people to move away from violent or chaotic lifestyles.

Patients who have engaged with the service are often frequent attenders at Emergency Departments, either because of repeated violence (interpersonal or self-directed) or drug and acohol use or with a range of non-specific medical symptoms that may reflect their chaotic lifestyles.

The Navigator intervention starts in the hospital and continues in the community and may involve one or more of community partner organisations.[2] A large proportion of patients who engaged with the service presented with more than one social issue, the most common of which included alcohol use, drug use and violence.

Since the launch of this service in 2015, there has been a steady growth in the number of commissioned Navigator services within Emergency Departments. However, the evidence base on their effectiveness remains limited[3] due to a combination of factors including the methodological and ethical challenges of assessing longer-term impacts and assigning attribution to Navigator services that are commonly characterised by relatively brief interventions. Previous evaluation reports have emphasised the complex interplay of factors that may drive attendances at Emergency Departments.

Research conducted into the Youth Violence Intervention Programme (YVIP) delivered by Redthread, which provides support to Emergency Department teams in tackling youth violence and exploitation, emphasised that youth violence has complex roots within communities and that hospital-based interventions can only make a significant contribution where they are firmly linked to a strong network of community provision and longer-term support.[4] The report also cites a need to measure impacts beyond the hospital episode to support cross-system funding as well as a lack of comparative studies which demonstrate the effect of the service compared to standard Emergency Department care. These findings remain directly relevant for an assessment of the BLOSM service and are explored further in the next sections of our report.

The Youth Endowment Fund's report[5] on emergency department violence interventions outlines that the presence of violence intervention programmes in Emergency Departments is a 'teachable' moment which may increase an individual's motivation to change, with Navigators able to connect patients to issues related to alcohol, violence or drugs to services on discharge. The reference to an individual's 'motivation to change' is an important factor which is also explored later in this approach and provides insight into the ingredients of a successful Navigator service and in particular the skillsets needed by navigators to facilitate the growth of protective factors for patients.

[2] Goodall, C., Jameson, J. & D.J. Lowe (2017)- 'Navigator: A Tale of Two Cities'.
[3] The Behavioural Insights Team (2021)- 'Feasibility study plan: Multi-site evaluation of practices: Hospital Navigators'.
[4] The Health Foundation & Nottingham University Hospitals NHS Trust (2020)- 'Redthread YVIP Adoption and Spread'.
[5] Gaffney, H., Jolliffe, D. & H. White (2021)- 'Emergency department violence interventions'. Toolkit technical report. Youth Endowment Fund. November 2021.

A recent evaluation of Redthread's YVIP delivered across the Midlands found that of all eligible referrals, only approximately one in five were known to other statutory services, while around a third of those who were known to statutory services engaged with those services.[6] This also highlights a potentially important performance indicator for services such as BLOSM, enabling an assessment of their ability to reach and engage people who may have unmet needs and are for a range of reasons not taking up available support to help them in addressing the underlying reasons for their attendance at hospital. In other words, in the absence of engagement by a navigator service, there is potential for an individual's risk factors to deepen with associated cost implications for a range of services.

A rapid evaluation of Redthread's YVIP at University College London Hospital NHS Trust found that the service complemented clinical and other statutory services and what is was well embedded in the paediatric emergency department and adolescent services. The evaluation acknowledged the diverse reasons for individual referrals, the various routes by which young people were identified, and the mix of specific support interventions provided, which together emphasised the complexity of the YVIP intervention and created challenges in implementation and evaluation.

Given the relative unit costs of Redthread and University College London Hospital's inpatient services, the evaluation team estimated that the service would break even if around one third of Redthread interventions resulted in at least one avoided emergency inpatient admission. However, the evaluation was unable to determine a feasible approach to measuring the quantitative impact of the service.[7]

A recent study[8] published in November 2024 explored changes in emergency, inpatient and outpatient healthcare use following support received through an Emergency Department Navigator programme. The study found that the Navigator programme was associated with reduced emergency and acute healthcare use in the year following intervention, with increased scheduled outpatient care. Specifically the analysis, based on 1,056 Navigator programme encounters, demonstrated a 29% reduction in Emergency Department attendances. The authors conclude that there is potential for social support programmes involving Navigators, delivered within Emergency Departments, to change patterns of healthcare use.

[6] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.
[7] Appleby J, Georghiou T, Ledger J, Rolewicz L, Sherlaw-Johnson C, Tomini SM, et al (2023). Youth violence intervention programme for vulnerable young people attending emergency departments in London: a rapid evaluation. Health Soc Care Deliv Res 2023;11(10).
[8] McHenry, R.D. & C.A. Goodall (2024)- 'Changes in emergency healthcare use following intervention by Navigator, an emergency department social support programme: a multi-centre retrospective before-and-after study'. European Journal of Emergency Medicine. December 02, 2024.

The study employed a retrospective before and after study to compare healthcare use in the 365 days following intervention compared to those 365 days prior to intervention.[9] The retrospective before and after study used is a potential model for West Yorkshire VRP and CHFT to consider for assessing the BLOSM service. This is explored in further detail later in this report.

3.2.1 'Reachable' and 'teachable' moments

Navigator interventions were developed on the rationale that a person's presentation in a setting such as in an Emergency Department may act as a 'reachable' moment where the person's chances of engaging with support services or interventions is heightened. This theoretical basis assumes that those who attend an Emergency Department following involvement with violence occupy a state of emotional and physical vulnerability.

Intervention staff based in the Emergency Department can use this 'reachable moment' as a point of contact with the attendant, turning the engagement into a 'teachable' moment whereby they may be more willing to work towards a more stable and positive life course.

In the context of violence-reduction interventions, this may present as the attendant agreeing to be signposted to statutory or community-based support, which may reduce risk factors relating to engagement in violence. [10] There is currently insufficient evidence to support the effectiveness of 'teachable moments' within the context of violence reduction within Emergency Department settings, with meta-analysis studies concluding that most of the research into its effectiveness were conducted on interventions for drug and alcohol addiction rather than for violence prevention.[11]

That said, the absence of evidence does not indicate a lack of effectiveness. It does however emphasise the importance of considering the methodological challenges surrounding assessing effectiveness, both ethically and practically.

3.3 Assessing prevention

A common theme within the evaluative studies for Navigator services is the challenge of generating credible evidence on the impact of preventative interventions. In other words, building an evidence base for preventative interventions such as BLOSM poses unique challenges as it can be difficult to prove causality for early interventions and, in keeping with a public health approach, the benefits may not be realised for years.

[9] The primary outcome in the study was the number of Emergency Department attendances in the year following intervention compared with the year prior to intervention. Secondary outcomes included inpatient admissions, inpatient bed days, outpatient appointments and outpatient appointments where the patient did not attend.

[10] Teachable moments for health behaviour change, Flocke et al., (2014)

[11] Young victims of youth violence, Wortley and Hagell (2021)

Recent research by the Institute for Government and UK Youth looking into a preventative approach to public services[12] stated that there is no agreement in government about what a preventative programme should achieve. The authors suggest that for some the primary goal is to cut demand for acute services and in turn reduce the amount that the government spends on public services. For others, it is as a means of improving outcomes like healthy life expectancy or recidivism rates.

Whilst these goals are not necessarily mutually exclusive, they can at time come into conflict. In the context of navigator services, the reach enabled within the model (as outlined later in this report) may lead to increase reattendance rates for some young people in the short term and increased uptake of early help support and Child and Adolescent Mental Health Service (CAMHS), while likely improving health outcomes and reducing risk factors in the medium to longer-term.

Within this scenario, one of the potential drivers of reattendance may be the absence of youth service provision within Huddersfield and Calderdale and the desire for young people to reengage the youth navigators to help address their needs. What this demonstrates is the interdependencies between different statutory and non-statutory partners and how the provision, or perceived lack of, accessible support services for young people within the community may influence the performance of navigator interventions such as BLOSM. This highlights the importance of selecting the most appropriate metrics and measurement timeframes to credibly assess the impact of preventative interventions. This issue is revisited within the following sections of our report.

The report by the Institute for Government and UK Youth[13] points to difficulties in gathering evidence for some preventative programmes and a potential need for government to be willing to take risks, at least in the short term, while the evidence base grows. However, the authors note that acute pressures crowd out preventative spending when budgets are tight.

This appears particularly pertinent to preventative interventions such as navigator programmes given the financial pressures faced by many NHS Trusts. The report includes a helpful overview on the reasons for a poor evidence base that are more specific to prevention. This is outlined in Table 3.1 over page.

[12] UK Youth and Institute for Government (2024)- 'A preventative approach to public services: How the government can shift its focus and improve lives'.
[13] Ibid

Table 3.1 Reasons for poor evidence in preventative interventions

Reason for poor evidence	Explanation
Benefits may not be realised for years	Some preventative interventions are very long term, with the benefits appearing years after the programme began. Timelines like this make it very difficult for government to determine 'what works' and implement findings. Many services cannot afford to wait decades for the government to decide how best to spend money on prevention.
It is difficult to prove causality for early interventions	It is easier to build evidence for targeted interventions that are close to the point of acute crisis. There are fewer intermediate steps between the intervention and the improved outcomes, and fewer other factors that could affect an individual's life and muddy the causality
Prevention can often be 'transformational' in nature	Prevention requires a fundamentally different approach. They are 'transformational' programmes, which lead to a permanent change in the way that a service is designed or delivered. It might be difficult to measure the amount spent on a new approach, and it would likely involve multiple interventions happening simultaneously. Determining causality for transformational change is therefore harder than for neatly prescribed interventions.

Source: Institute for Government and UK Youth 2024

Given the practical and methodological challenges of generating credible and robust evidence on the impact of navigator services on a range of outcomes, it is important to build consensus across key partners to ensure that realistic expectations are placed on BLOSM to demonstrate its impact. Crucially the service requires sufficient timeframes to demonstrate its contribution to outcomes such reductions in Emergency Department attendances as well as reductions in risk factors and growth of protective factors within young people engaged.

3.4 Risk and protective factors

In 2024 West Yorkshire VRP[14] published an evidence synthesis on influential factors for serious violence. The report acknowledges that there are many contributory factors that need to be considered when delivering a partnership response to reducing violence. Tackling serious violence is a complex and interrelated picture which requires a decisions to be made based on the latest research and evidence.

[14] West Yorkshire Violence Reduction Partnership (2024)- 'Influential factors for serious violence Evidence synthesis'.

The report refers to two main influential factors, namely:

- Risk factors that are associated with a higher likelihood of engaging with or experiencing violence and exploitation.
- Protective factors which can reduce the likelihood of engaging with or experiencing violence and exploitation.

The report includes an important caveat in that neither risk or protective factors directly cause or prevent violence. Having a risk factor does not predict involvement in violence and it is not a predisposition. Consequently these should be referred to collectively as influential factors for violence. The report references the four level social-ecological model to aid understanding of violence and the effect of potential prevention strategies.

This model presents the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. It emphasises that single risk factors do not directly cause violence, instead it is the interaction amongst different risk factors that influences the level of risk. An interpretation of the ecological model, taken from the report, is provided in Table 3.2 below.

Navigator programmes are developed based on a public-health approach, which sees involvement in violence to be the results of aggregate and overlapping social factors operating at the individual, familial and community-level. This approach contends that public health bodies must work to prevent involvement in violence by limiting an individual's vulnerabilities or 'risk factors'.

As outlined in the evidence synthesis on influential factors for serious violence,[15] risk factors increase an individual's chances of involvement in violence. Navigator interventions work by addressing and reducing risk factors in individuals and supporting the development of protective factors, such as re-engagement with education and employment, stabilising mental wellbeing and overcoming maladaptive behaviours.

Table 3.2 Socio-Ecological Model for Violence

	Risk factors	Protective factors
Society	• Gender and racial inequality • High levels of poverty and • socioeconomic inequality • Culture of violence • Difficulties in accessing services	• Gender and racial equality • High standards of living

[15] Ibid

Community	• Poverty, unemployment, and lack of opportunity • Accessibility/acceptability of weapons and substances • Harmful gender norms and cultural practices • Institutional racism • High levels of discrimination based • on protected characteristics • Homelessness and poor housing	• Inclusive institutional and • community policies and practices • Meaningful employment and • training opportunities • Safe recreational areas and • community environments • School and community inclusion • Low levels of poverty • Sense of belonging and connectedness • Community cohesion
Relationship	• Negative peer group norms and social control • Unequal power dynamics in relationships • Disengagement from education • Lack of nurturing relationships and environment • Emotional or physical neglect • Household offending behaviour	• Positive peer group and family norms and relationships • Stable home environment • Strong and consistent parenting
Individual	• Shame, fear, frustration, low self-esteem • Loneliness • Loss and bereavement • Poor feelings of personal safety/fear • Substance use • Adverse childhood experiences • Exposure to violence media • Disability and related stereotypes • Experiences of problem gambling	• Relationships with a trusted adult • Stable, safe and nurturing childhood • High self-esteem, emotional • regulation and good mental health • Prosocial attitude • School readiness

Source: West Yorkshire Violence Reduction Partnership 2024

In contributing towards the formation of protective factors, interventions support individuals and communities to secure stable livelihoods and 'desist' from violence in the longer-term.[16] One of the implications of this for our evaluation of the BLOSM service is the potential to evidence how the interactions with the Youth Navigators is working to identify risk factors and support young people to engage with services and support beyond the Emergency Department that can help to support the development of protective factors.

[16] Adversity, Trauma and Resilience in West Yorkshire, West Yorkshire VRU, pp. 56-57.

Critically the role of the Youth Navigators is 'relatively' brief. The service provides a reach to young people who may otherwise not be on the radar of statutory services and early help provision. It is the potential of the service to support and motivate young people to engage with provision within the community that can drive longer-term benefits for the individual and society.

Our report seeks to evidence the contribution of the BLOSM service to addressing and reducing risk factors and supporting young people to engage with a continuum of support that can develop protective factors. In doing so, the evaluation can at least infer causal links between the intervention provided by the Navigators and the three Home Office mandated key success measures.

3.5 Serious violence duty

Following public consultation in July 2019, the Government announced that it would bring forward legislation introducing a new Serious Violence Duty on a range of specified authorities.[17] The Duty aims to ensure that relevant services work together to share information and allow them to target their interventions, where possible through existing partnership structures, collaborate and plan to prevent and reduce serious violence within their local communities.

The Duty also aims to ensure that agencies are focussed on their activity to prevent and reduce serious violence whilst also providing sufficient flexibility so that the relevant organisations will engage and work together in the most effective local partnership for any given area.

The sharing of information, effective communication and multi-agency coordination are central to enabling action to be taken to engage vulnerable young people and put in place appropriate support and interventions to tackle violence. The Duty outlines that the specific needs and vulnerabilities of children and young people are recognised by frontline professionals and that the three specified 'safeguarding partners', namely the police, health and local authority, work together to safeguard and promote the welfare of children in their area.

Navigator programmes located in Emergency Departments have the potential to identify pattern of vulnerability or risk themes within the patients that they engage. Where a service is engaging higher numbers of patients, the potential to share information and plug intelligence gaps in existing Strategic Needs Assessments (SNAs) may be strengthened. As such, the interactions with children and young people undertaken through BLOSM can highlight trends and information that support the design and development of targeted interventions that can prevent or reduce serious violence. This is explored further in a later section of this report.

[17] Serious Violence Duty

4. Overview of service

Summary

- BLOSM has embedded the principles of trauma-informed practice and care to create a new multi-agency support service across the accident and emergency departments in Halifax and Huddersfield.
- Several changes have been made to the delivery model since commencement. Whilst the changes have brought benefits, it did require a transitional period which has impacted on the capacity of the service to reach and engage young people.
- Clinical staff regard the service model as an effective means of reaching vulnerable young people, identifying the holistic issues that they face and facilitating their access to appropriate community support.

This section of the report provides a brief overview of the operating model for the BLOSM service. This includes detail on changes to the model since launch and how the service is integrated with clinical operations at both Emergency Department sites.

4.1 Operating model

BLOSM is a pioneering new model building on the original Serious Violence A&E Navigator Service, funded by the West Yorkshire Violence Reduction Partnership, and West Yorkshire Health and Care Partnership to ensure all people and particularly young people are getting the best possible 'trauma informed' support and care to prevent further harm. BLOSM stands for:

- Bridging the gap
- Leading a change in culture
- Overcoming adversity
- Supporting vulnerable people
- Motivating independence and confidence

BLOSM has embedded the principles of trauma-informed practice and care to create a new multi-agency support service across the accident and emergency departments in Halifax and Huddersfield. BLOSM aims to support people who come to A&E with complex social issues, identifying ways of improving outcomes for people by working closely with community partners to put support in place and reduce the demand on hospital services, respond to and prevent trauma and adversity.

The first part of the service is the youth navigator pilot, which supports young people aged between 11-25. BLOSM youth workers are on site five days a week, supporting vulnerable young people with complex social issues who have come to A&E. This includes those who have experienced violence or assault, exploitation, issues with school/bullying, drug and alcohol use, mental health and other trauma. Youth workers also offer young people follow-up support when they go home, built around the young person's circumstances and working closely with existing community services. Support for young people may include engaging with them in home, school and public settings (such as cafes or parks) during the Navigator's designated community outreach days each week.

Interview responses with staff members working at Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) indicate that staff understand the service to be an intermediary body which engages vulnerable young people within hospitals, identifies the specific issues they're facing and facilitates their access to appropriate community-based services. BLOSM is viewed as a 'safety net' for young people, as its placement in Emergency Departments leads to the creation of 'reachable moments' where Navigators can engage young people who otherwise may not have sought support for their circumstances, may not have been known to local services and may have difficulty qualifying for other services such as CAMHS or the in-house mental health service.

In reaching the young person, the service has the potential to create a 'teachable' moment whereby young people can be navigated away from a negative life course involving factors such as alcohol or drug use, sexual and criminal exploitation, gang-related violence and mental health difficulties. Staff members view the service as contributing towards the reduction of health inequalities by providing support to young people who are disproportionately living in disadvantaged communities and helping them to build healthier, stable and more sustainable lifestyles.

> "I see it as a multi-factorial preventative service… trying to prevent young people coming to harm, drug and alcohol abuse, sexual exploitation, county lines and also focused in particular on those made vulnerable through lower IMD status, learning disabilities. It's a holistic public health approach… helping people to stop making negative and detrimental life choices later down the line." – Clinical staff member

4.2 Changes made to the model

There have been several changes made to the delivery model since commencement. A significant change was in Navigator provision as of September 2024. Up to that point, navigators were employed on honorary NHS contracts through Breaking the Cycle. From September 2024, navigators were employed as NHS staff.

The transition has afforded a more consistent approach to delivery, through one consistent team of three staff members, with full access to patient information. Further, Navigators felt that clinical staff now had more awareness of specific BLOSM staff and the areas they each specialise in, in turn facilitating increases in referrals.

Whilst this change in delivery model has brought benefits, there was a transitional period between May and September 2024, whereby the Breaking the Cycle team were delivering at reduced capacity whilst NHS recruitment took place. This process was exacerbated due to a recruitment freeze within the NHS Trust. Therefore, it is possible that the programme did not reach all patients that may have benefited within that time.

As of February 2025, Navigators have additionally expanded their role to include liaison with staff at local schools and colleges and started delivering support sessions within educational settings. This addition to Navigators' community-based role was encouraged by the frequency of young people reporting issues such as bullying, harassment and assault occurring within school settings, as well as schools acting as an ideal setting for delivering support to young people already referred into BLOSM.

In addition to this, clinical staff have begun recording the school or college that young people are attending on the Electronic Patient Record (EPR) at Emergency Department attendances, enabling the service to identify hotspots for anti-social or violent behaviour. Navigator staff reported that the development of relationships with local schools was adding value to the service in enabling Navigators to become advocates for young people on their case-load within an educational setting, and increasing reach by allowing them to deliver support where young people feel more comfortable to engage with youth workers.

4.2.1 Monitoring processes

Whilst Navigators were on honorary contracts and had to report to an external team, whilst Navigators still had access to the EPR, monitoring data was recorded on an offline spreadsheet once support provision was in place. As of April 2024, BLOSM assessment data was moved onto the EPR as all reporting was direct to the NHS BLOSM team. With all details of patient interactions with BLOSM available on the EPR, clinical staff can view navigator information when looking at patient records, affording additional detail and context that may support interactions with the patient.

There have also been further improvements to the data available to monitor BLOSM. The BLOSM team have embedded a data dashboard on a Qlick system, summarising information from the EPR system daily. This enables live updates regarding how many patients have been referred and details of their support, aiding case management and follow up delivery, through more visual representations of patient profile and current caseloads.

4.2.2 Integration of the Drug and Alcohol use Team

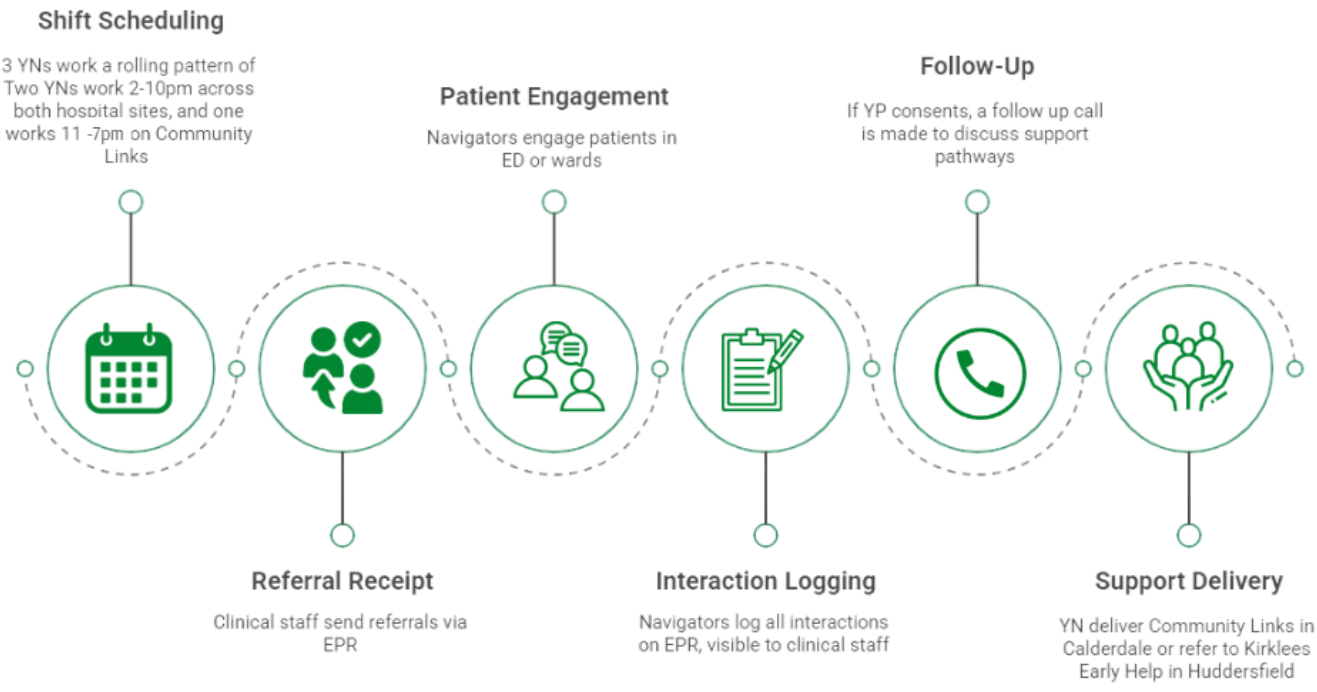
In line with the transition to NHS employed navigators, BLOSM integrated Substance Liaison Practitioners (SLPs) into the team, employed on honorary contracts across both hospitals. There are currently two full-time members of staff (since June 2024) in Calderdale, and one part-time member of staff in Huddersfield (since January 2025). Their role is to identify and support patients into community support services for drug and alcohol use, facilitating referral links with such services. The SLPs deliver a similar referral and delivery model to the navigators, and have access to the EPR system to support identification of patients.

Whilst working within the BLOSM team, SLPs operate with a slightly different age range, only supporting those over 18 in Huddersfield and over 21 in Calderdale. Where patients are identified with drug and alohol use support needs below these age brackets in respective hospitals, Navigators will provide support.

4.3 Patient journey

A brief overview of the patient journey is illustrated below.

Figure 4.1: Patient journey



Navigators work across both hospital sites and within the community, Monday to Friday. Where they are not present, clinical staff are still able to refer through the EPR system, to be picked up by navigators on their next shift. Staff are flexible across both sites depending on the patients present in the Emergency Department, and travel between them as required. Whilst there are set Community Links shifts, these can be flexible based on the preference of the young person, as well as caseload levels.

Whilst the navigators in post are equipped to support a wide range of need, they have specialist areas in which they provide support:

- Sexual violence and female support provision
- Mental health
- Criminal exploitation

Patients taking up support will be split between the team based on these specialisms, where appropriate. Navigators will also often support each other with their case load, dependent upon capacity and preferences of the young person.

The navigators explained that when engaging with referrals, much of the discussions taking place include parents and guardians, owing to the age of many patients. In some cases this has been key in facilitating effective engagement, especially where there has been mistrust of services. Further, family involvement in engagement is a protective factor, as it encourages awareness of both the needs of the young person and the support services available.

To further facilitate identification of need amongst patients, the team have a daily call with CAMHS. This is an opportunity to share key details amongst the teams, which navigators can then also relay to the families of the young people they are supporting, supporting a multi-agency approach to support.

The Community Links element of BLOSM is delivered by the Navigators for those engaging in Calderdale, and by the Kirklees Early Help Team in Huddersfield. Where an individual consents to an onward referral with the Navigators but lives in Huddersfield, Navigators will refer them to the Early Help Team via email, rather than completing the community support themselves.

4.4 Effectiveness of the model

Clinical staff have reflected on the service model as an effective means of reaching vulnerable young people, identifying the holistic issues that they face and facilitating their access to appropriate community support. Respondents report that the model is well-designed for its purposes and contributes significantly towards bridging the gap between hospital and community services; a perspective which will be further explored in the below sections on the service's integration within hospitals and their profile amongst hospital staff.

Clinical staff referred to several highlights of the model's design, including the youth work background of the Navigators and their ability to successfully engage with young people presenting at the Emergency Department. Interview responses reflected that the Navigators are effective in identifying underlying social need in young people, and building rapports with young people whereby young people feel comfortable to disclose factors leading up to their presentation.

Interactions with Navigators demonstrates that the service is succeeding in creating 'reachable' moments with vulnerable young people and helping to reduce health inequalities. Clinical staff reported that the referral process is simple and easy to understand, with staff being able to refer to BLOSM through the EPR in accordance with general hospital procedure.

Clinical staff reported feeling able to make informal referrals by engaging Navigators directly on-site or contacting them by telephone, demonstrating the value of the service being based on-site. It was also highlighted that the transition towards sourcing Navigators from NHS staff in September 2024 acted as a significant improvement to the model. The introduction of three primary Navigators with regulated on-site shift patterns has enabled clinical staff to identify them more easily and has facilitated the development of stronger, more consistent relationships.

It is recognised that the service team acts as dedicated resource towards developing relationships with local bodies and services including schools, and holds expertise in negotiating appropriate community support plans for young people following discharge. Clinical staff noted that the service provides a referral destination for staff when they identify a young person in need of community support, but are not clear of which provision may be available.

The Navigators' expertise in youth work and ability to engage young people through outreach facilitates the development of trusting relationships with young people, enabling young people who may previously have been reluctant to access support services. This suggests the service is acting as a 'safety' net for young people who may otherwise had fallen through the gaps of the local support landscape, facilitating their access to community service caseloads.

> "BLOSM can deliver a low level intervention for young people which can reassure them about consenting to a CAMHS referral and avoid some of the stigma around acknowledging a mental health support need or prepare them for CAMHS (holding the space between referral and take up). BLOSM work closely with other services such as drug and alcohol or gang violence and this is important given that young people (under 18) usual present with multiple support needs" – Clinical staff member

4.5 Integration into clinical operations

Interviews with clinical and operational staff reveal that the service adds significant value to the wider hospital service and serves to alleviate capacity pressures on Emergency Department staff, as well as those working within the mental health, paediatric and safeguarding departments.

Within the Emergency Department, the holistic and supportive role delivered by Navigators helps to supplement the fast-paced and urgent nature of roles delivered by clinical staff, ultimately producing value for both staff and patients. In most cases Emergency Department staff are not equipped with the time or specialist knowledge to address the wide ranges of issues affecting young people. Navigators act as dedicated resource towards identifying wider issues and developing a support plan going forward, enabling clinical staff to focus on delivering urgent care and reducing the likelihood of reattendance.

Navigators' ability and resource to investigate individual support needs is valued by other departments as the information collected can be incorporated into patient case notes. When Navigators engage with patients, they can record notes around their personal circumstances and engaging with other services into the EPR to enable review by clinical staff. Furthermore, Navigators can contact community services accessed by a young person and gather information on their support or treatment plan, enabling hospital teams to see their plan going forward and enabling them to make better-informed choices around their care. In this way the service acts as a connecting body, collating intelligence from both hospital and community services to optimise patient care and in-house service delivery.

Clinical and operational staff generally reported that the service has been well-integrated with other services and interventions within the hospital, and has established clear referral pathways with bodies such as the Mental Health Liaison team, Paediatrics, Safeguarding and the Drug and Alcohol team. Respondents noted that BLOSM integration with the latter service has been especially successful, with the SLPs being embedded into the BLOSM team to provide a multi-agency support team, with on-site presence for any clinical staff who want to access expertise and one umbrella team to refer into.

The service's integration alongside other hospital services can be identified by the BLOSM team's contributions towards clinical staff's ongoing learning and development, and their role in spearheading the trust's transition into a trauma-informed practice. Interview responses have reflected positively on the service team's delivery of updated and bespoke safeguarding training to Emergency Department staff, which focused specifically on identifying risk factors in young people and employing a trauma-informed approach to their care. Feedback from staff undertaking the training have reported increases in confidence responding to safeguarding concerns around children and young people and referring to BLOSM. This ensures that this approach to care can be sustained beyond the service's scope and lifetime.

Clinical and operational staff report that the service has good visibility within the hospital and amongst other services, with staff from other departments generally being aware of its rationale. Staff fed back that awareness-raising activities and inter-service engagement was embedded throughout delivery, with team members showcasing the service through 'BLOSM Awareness' days and demonstrating its value to hospital staff. Operational staff maintain visibility via sitting on multi-disciplinary and strategic meetings , therefore using their profile and specialist knowledge towards promoting the service at organisational level.

BLOSM is generally perceived alongside other services as a point of contact and information around community services and is seen as an important aspect of the patient offer, specifically for young people presenting with social issues.

> "Emergency Department and on the wards… they're seen as a key service for any form of social need." – Clinical staff member

Clinical staff hold an understanding that the service has mapped out the community services available and which services are appropriate for each young person, and therefore acts an authority on addressing young people's holistic needs. This view has also been supplemented by the service's contributions towards the bespoke safeguarding training, which has reinforced their reputation as having specialist knowledge on identifying and addressing young people's support needs.

4.6 Suggested improvements to the model

Interviews with clinical staff identified potential areas of improvement to the service model. Some suggested a review of the flexibility of Navigator support and limitations on the amount of time young people are on service caseloads. There is currently no limit to the length of time young people can be supported by Navigators, which has led to Navigators themselves acting as primary sources of support to young people over a longer-term period as opposed to community services. This may suggest the need for limitations or guidelines around the length of time young people can be supported by Navigators before discharge to ensure that sufficient resource is allocated towards other aspects of the service, such as community engagement and relationship building.

Whilst clinical staff reflected positively on the service's integration with wider services, some also reported that there was some ambiguity around the scope of Navigator's role, including where their role as mediatory bodies ends and the role of other hospital services begins. There had been some instances where it was unclear where the responsibility for patient treatment and follow-up was held by BLOSM or by other services such as Safeguarding. This suggests that there may be a need for standardised and established guidelines around triaging young people and mapping out the scope of both the BLOSM service and other hospital services.

5. Operational performance

This section of the report presents an overview of the operational performance of the BLOSM service since it well live in January 2023. The analysis is based on service and operational data provided by the BLOSM team.

5.1 Number of patients engaged

Summary

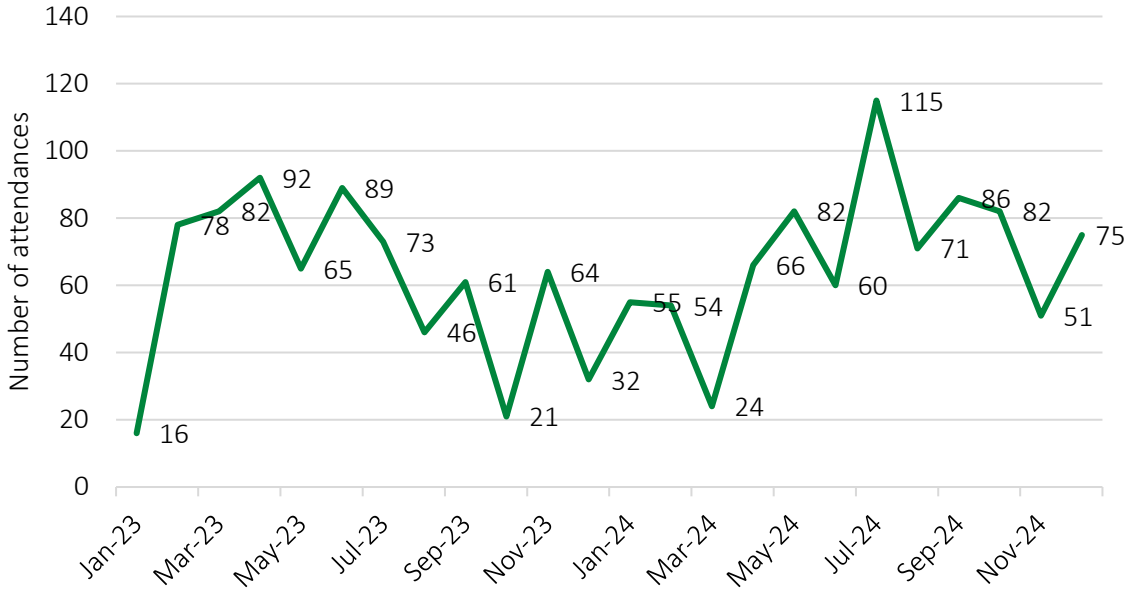
- Since January 2023 the service has engaged 1,540 young people. A review of comparable hospital navigator programmes suggests that the volume of engagements logged by BLOSM is higher than those located in other areas.
- Data captured by the BLOSM team demonstrates that three quarters of young people offered an initial assessment by the service consent to this. Based on the evaluation reports available for comparable hospital navigator service, this consent rate is high.
- A quarter of young people were already known to or have previously received support from the BLOSM team. A wide range of factors may drive reattendance and it is important that the service is open to supporting young people that have already been assessed.

Since January 2023 the service has engaged 1,540 young people (Figure 5.1 over page). This equates to around 64 patients per month. Time series analysis of the service engagements highlights considerable variation in the number of patients, ranging from 16 to 115 per month. This potentially reflects seasonal variation in attendances at the Emergency Departments but also changes to the operating structure of the service since launch, most notably changes to the staff team.

A review of comparable hospital navigator programmes suggests that the volume of engagements logged by BLOSM is higher than those located in other areas. For example, in the YVIP programme delivered across the Midlands, the Queen Elizabeth Hospital in Birmingham recorded an average of 23 engagements per month and Queen's Medical Centre in Nottingham an average of 22 engagements per month.[18]

[18] Queen Elizabeth Hospital based on 1,092 eligible referrals between April 2018 and March 2022 and Queen's Medical Centre 1,039 eligible referrals over the same time period. Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.

Figure 5.1 Time series of attendances by month



Source: BLOSM

Across the Merseyside Navigator Programme the service recorded 17 engagements per month.[19] Whilst caution must be taken in comparing BLOSM directly with these programmes given differences in their focus, profile of presenting needs and delivery structure, this does suggest at least that the volume of eligible referrals and attendances recorded by the service is strong. This provides an indication of both the level of need and demand for support evident across the Emergency Departments in Halifax and Huddersfield. It also highlights how effectively the service has been integrated into the two Emergency Departments with clinical teams identifying eligible young people and referring them into the BLOSM pathway.

The operating model requires young people to consent for an initial assessment by the BLOSM team, commonly following a referral by the clinical teams within the Emergency Department. Data captured by the BLOSM team demonstrates that three quarters (74%) of young people offered an initial assessment by the service consent to this.[20] Based on the evaluation reports available for comparable hospital navigator service, this consent rate is high and suggests that the service is both well embedded in the respective Emergency Departments and that the Navigators are skilled at building trust and rapport with young people. For example, for the Midlands programme the evaluation suggests that 61% of referrals were successfully engaged.[21] The figure from the Merseyside programme was lower at 21%.[22]

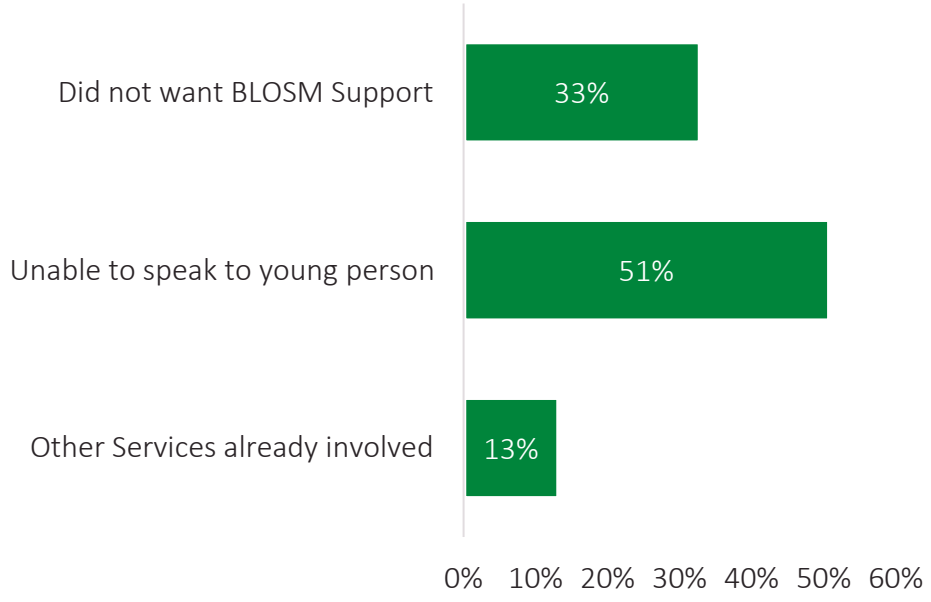
[19] The Navigator programme received 209 eligible referral between July 2022 and June 2023. Harris et al (2023)- 'Service evaluation of the Merseyside Navigator Programme: July 2022-June 2023'.
[20] Based on 1,500 patient records where consent status was logged between January 2023 and December 2024.
[21] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.
[22] Harris et al (2023)- 'Service evaluation of the Merseyside Navigator Programme: July 2022-June 2023'.

This consent metric is significant for any assessment of a navigator intervention as only by securing consent can services work to understand and explore the drivers behind the young person's attendance. There is no teachable moment without reach. As outlined later in this report, there is evidence through the Navigators interactions that the needs of young people can be unmet where they are either unaware of support services available to them or they lack the trust, confidence or motivation to consent to support.

Where a young person has not provided consent for an initial assessment by the service, the most common reasons were that it was not possible for the Navigators to speak to the young person (51%) or that the young person did not want support (31%). For around one in eight young people offered an assessment by BLOSM, the reason for not providing consent was due to the fact that they were already involved with other services (Figure 5.2 below).

In cases where young people are already on the CAMHS caseload, Navigators discuss their presentation with a representative of CAMHS every on-site shift through the partnership meeting, enabling regular knowledge and information sharing between services.

Figure 5.2 Reason for non consent to BLOSM assessment



Source: BLOSM; n351

The data captured by the service between January 2023 and December 2024 reveals that a quarter (24%) of young people were already known to or have previously received support from the BLOSM team. This is relatively in line with other Navigator services, such as the YVIP delivered across the Midlands where the respective figure was 20.7%.[23] Further exploration of the reasons for re-engagement would be helpful to understand what community support this cohort of young people took up (if any) following their first engagement.

[23] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.

What this demonstrates is the reattendance rates for some young people presenting at the Emergency Department presents an opportunity for the intervention. It highlights the importance of the service being open to supporting young people that have already been assessed. It also highlights that a wide range of factors may drive reattendance and the fact that a young person may already have received an assessment or support does not guarantee that they will not reattend the Emergency Department.

As outlined in the next section of this report, it may be the second or third engagement by the BLOSM team where the young person feels able and comfortable to disclose the underlying issues behind their attendance which may differ from their presenting need logged by the clinical teams.

The absence of such disclosures can limit the ability of the Youth Navigators to coordinate support beyond the Emergency Department. As such, reattendance alone as a metric for assessing the performance of any navigator service can be misleading without wider context. Reattendance may be necessary and desirable to ensure patient safety and support positive health outcomes.

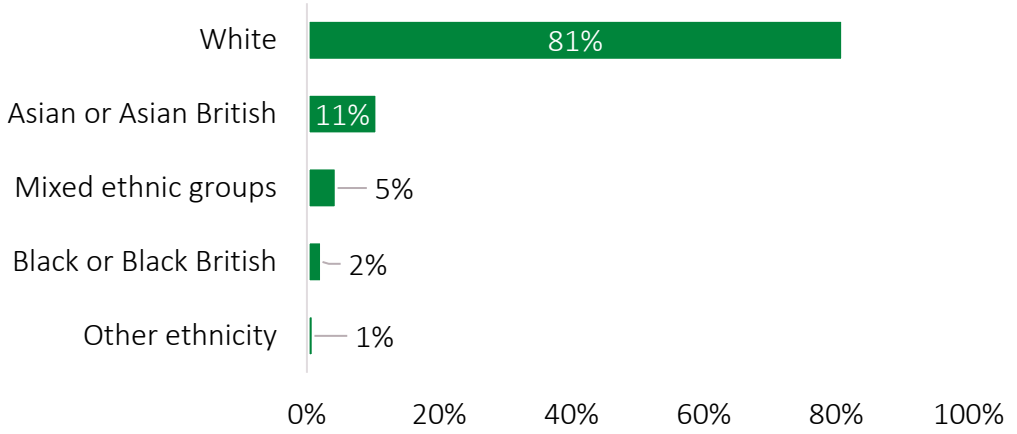
5.2 Profile of patients engaged

Summary

- The majority of young people engaged by the service have been of statutory school age accounting for 70% of all supported.
- Just under half of those supported were recorded as having experienced Advice Childhood Experiences.
- One quarter of young people supported were recorded as not being in education, employment or training at the point they accessed the service.
- Just under half of young people supported are drawn from the most deprived 20% of areas in the UK.

Based on the monitoring data captured, the service has engaged and supported a broadly equal number of female (51%) and male (49%) patients. Around four in five (81%) patients identified as White British, with one in ten (10.8%) Asian or Asian British, and smaller proportions from other ethnic groups (Figure 5.3 over page). Further work is required to compare the profile of young people engaging with the BLOSM service against the profile of all young people presenting at the Emergency Department. This would help to identify patterns of over or under-representation in the patient group supported.

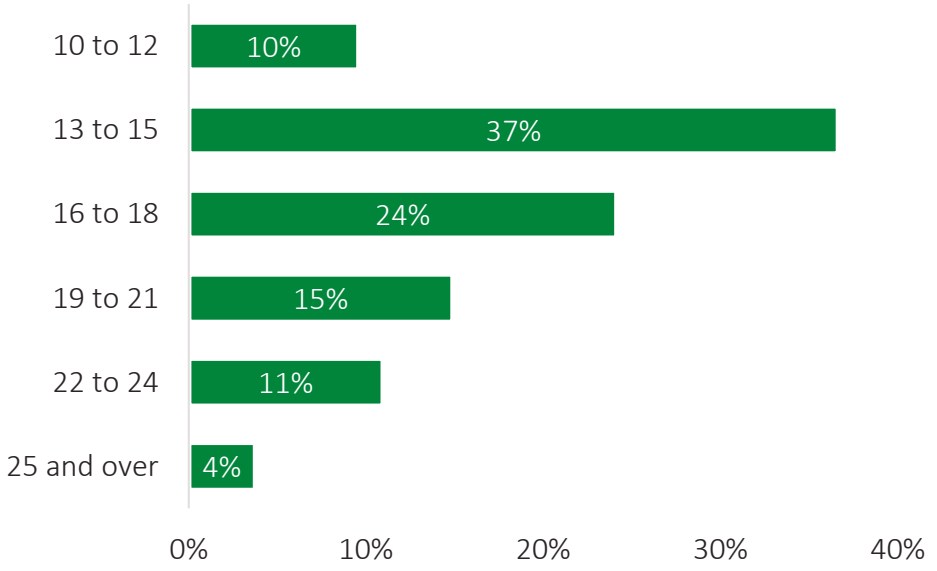
Figure 5.3 Ethnic profile of young people supported



Source: BLOSM; n1,144

The majority of young people engaged by the service have been of statutory school age (up to 18 years), which accounts for 70% of all supported (Figure 5.4). Only a small proportion of those supported have been aged 25 and over. As outlined later in this report, the service has captured insight on patterns of attendances based on schools attended to try and understand what may be driving presentations at the Emergency Departments.

Figure 5.4 Age profile of young people supported



Source: BLOSM; n1,168

The age profile of young people engaged reflects the trend that they often present to the Emergency Department accompanied by parents or family members who may engage with Navigators on their child's or family member's behalf. During engagements family members may disclose negative circumstances affecting the household to Navigators, meaning that the service not only supports presenting young people but their family units, which will be further explored in the section on outcomes and impacts.

The profile data captured by the service shows that just under half (47%) of those supported were recorded as having experienced Adverse Childhood Experiences. This in in line with national figures, with a meta-analysis of ACE prevalence across English and Welsh populations finding that 48% of adults reported having at least one ACE.[24] The monitoring data provided by BLOSM does not provide details on the number of ACEs recorded or confirm what assessment tool or approach is used to detect these.

Previous research has highlighted that trauma, resulting from an adverse childhood experience, can have an enduring negative impact on many aspects of a child's life as they grow up and transition into adulthood. Adverse childhood experiences can impact on both physical and mental health, and life opportunities including education and career potential. They increase risks associated with many aspects of adult life including maternal health, the chances of developing chronic diseases and early death caused by cancer, diabetes, heart disease, and suicide. There is a clear link between the frequency/number of ACEs that a child experiences and the likely impact on that child's adult life.[25] In other words, engaging and supporting young people with recorded ACEs represents not just an opportunity to prevent violence, but also as a public health intervention in its own right.

One in five (20%) were recorded as being neurodiverse[26] and around one in ten (12%) were recorded as being a looked after child.[27] Two thirds (66%) of those accessing the service were recorded as being in education, and just over one quarter were recorded as not being in education, employment or training (NEET). This reflects the high proportion of young people of statutory school age engaging with BLOSM. A further 7% stating that they were currently in employment.[28]

Whilst the direct links between being NEET and violence are not well explored, the risk factors for becoming and remaining NEET overlap with the risk factors identified as driving violent crime and the protective factors which can mitigate violence have also been found to be relevant to reducing the impacts of being NEET. Risk factors include disengagement from education, including poor housing, health, drug and alcohol dependency, special educational needs, bullying, caring responsibilities, domestic violence, gang culture, peer pressure, or a cultural context which doesn't value learning.[29]

[24] Health and financial burden of adverse childhood experiences in England and Wales: a combined primary data study of five surveys

[25] Crowe, M. Devereaux, J. & M. Jobson (2021)- 'Adversity, Trauma and Resilience in West Yorkshire – a review of life-course evidence, approaches and provision to support the transformation to a trauma informed health and care system by 2030'. West Yorkshire Health and Care Partnership.

[26] Based on 398 records where this data was recorded

[27] Based on 458 records where this data was recorded

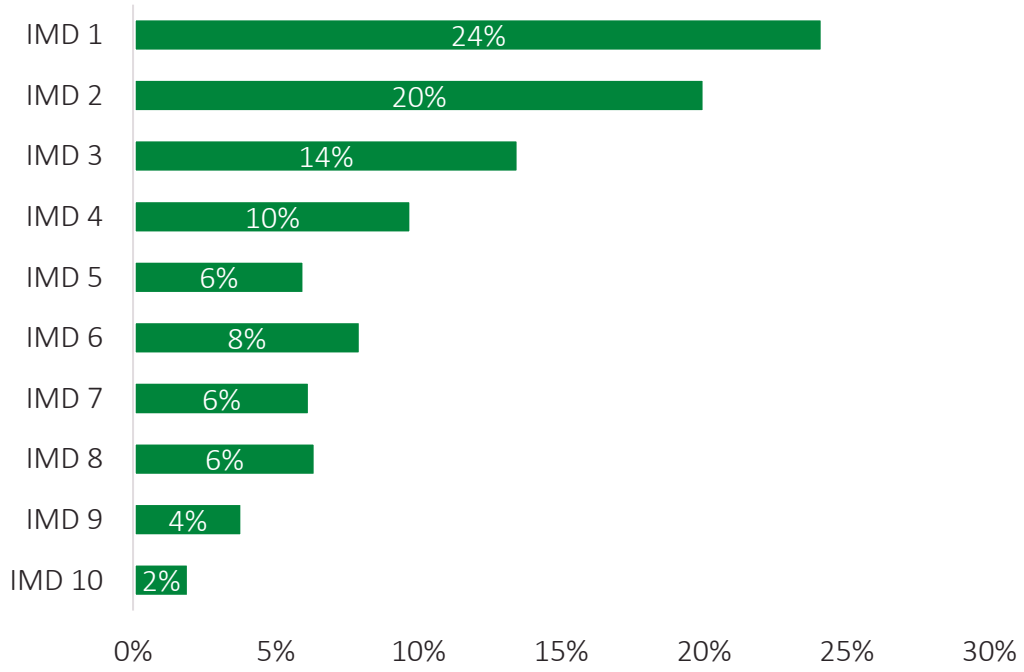
[28] Based on 1,056 records where this data was recorded

[29] NEET: Young people not in education, employment, or training and violent crime: Literature Review, p.19

Given that an outcome within the theory of change is to ensure engagement in education or training, longitudinal monitoring exploring the extent to which NEET patients were able to engage in education, employment or training would be required moving forward. With that said, the navigators are engaging, for the majority, those that are already in education or training.

Patients have also been mapped against the Index of Multiple Deprivation (IMD) deciles as a measure of relative deprivation. IMD surveys the socioeconomic measures impacting a specific neighbourhood or small area (income, employment, access to healthcare etc.) to determine its deprivation ranking. Using this measure, just under half (44%) of young people supported are drawn from the most deprived 20% of areas in the UK (Figure 5.5).

Figure 5.5 IMD profile of young people supported



Source: BLOSM; n1,013

The influential factors for serious violence report[30] highlights that although the terms deprivation and poverty can often be used interchangeably, there are distinctions. Namely, deprivation refers to a general lack of resources and opportunities meaning unmet needs, whereas, poverty can be viewed as an outcome of deprivation, such as not having adequate money to get by because of limited resources and opportunities. Studies have demonstrated that hospital admissions for violence increase exponentially with increasing deprivation of residence[31] and that injury in violence involving children intensified with increasing deprivation in UK cities.

[30] West Yorkshire Violence Reduction Partnership (2024)- 'Influential factors for serious violence Evidence synthesis'.
[31] Bellis MA, Hughes K, Wood S, et al (2011)- 'National five-year examination of inequalities and trends in emergency hospital admission for violence across England. Injury Prevention 2011;17:319-325.

However, further research will be required to fully determine to what extent such findings are attributable to the services' ability to engage with its target population, and to what extent they reflect the manner by which young people from deprived backgrounds are more at risk of involvement in violence in the context of this provision compared to those from more advantaged backgrounds.

5.3 Reason for attendance

Summary

- The main reasons for attending the Emergency Departments were mental health accounting for half of the attendances, followed by physical injury/assault accounting for a third of attendances.
- The disclosed reason for attendance at initial presentation may not be the main cause or driver of attendance. The resource and specialism of the Youth Navigators in building trusting relationships with young patients can facilitate subsequent disclosures about the underlying reasons for attendance, leading to more appropriate ongoing support and referral.

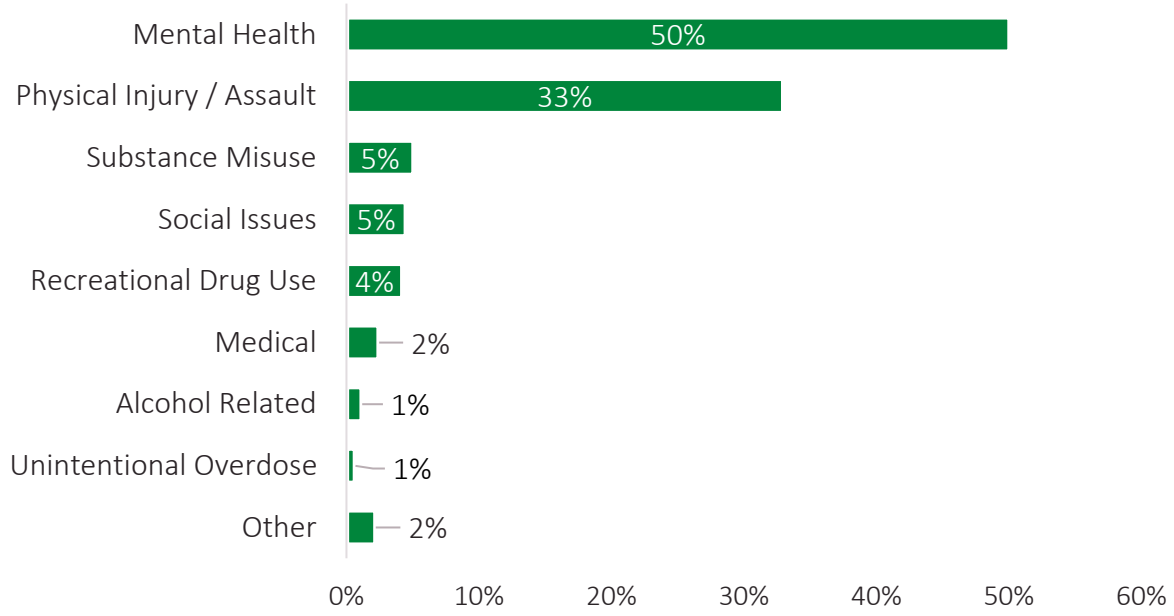
The monitoring data captured by the service records the main reason for attendance at the Emergency Department. This demonstrates that the most prevalent presenting reason is mental health accounting for half (50%) of the attendances, followed by physical injury/assault accounting for a third (33%) of attendances (Figure 5.6 over page).

The reason for attendance recorded by the BLOSM service differs from comparable hospital Navigator programmes. Within the YVIP service delivered across the Midlands, the most common reasons for attendance triggering a referral to the programme was assault with a fist or other body part, followed by assault with a knife or bladed object.[32] In Merseyside, the Navigator scheme recorded that the primary reasons for referral into the service as 'actuated physical injury', 'serious youth violence' and 'bullying.[33] And in South Yorkshire, the primary reasons for attendance were recorded as assault, domestic abuse, stabbings and assault with a weapon.[34]

Monitoring data from BLOSM indicates a difference between female and male patients' reasons for attendance; for example, almost two-thirds of female patients (62%) presented with mental health needs, with the respective figure for male patients being 28%. Similarly, male patients were over twice as likely than female patients to attend because of physical assault or injury, with the figures being 48% and 22% respectively.

[32] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.
[33] Harris et al (2023)- 'Service evaluation of the Merseyside Navigator Programme: July 2022-June 2023'.
[34] A&E Navigators South Yorkshire Police

Figure 5.6 Primary reason for attendance



Source: BLOSM; n1,176

As outlined in the next section of this report, it is worth noting that the disclosed reason for attendance at initial presentation may not be the main cause or driver of attendance. Evidence from the interaction logs maintained by the Navigator team demonstrate that for some young people their mental health has been affected by experiences of violence. Where data has been recorded, there has been police involvement in 5% of attendances.[35] What this suggests is that for most of the attendances, including those presenting with a physical injury/assault, the police are not involved. Data available from Kirklees Early Help team indicates that between October 2023 and December 2024, 6% of those referred had previous criminal justice involvement, further suggesting minimal police involvement.

Young people have also been recorded as presenting at A&E with a self-inflicted or accidental injury, who later reveal that their attendance was driven by physical assault or interpersonal violence following their engagement with the Navigator team. The ambiguous nature of attendances for injury is reflected in the code encompassing both injury and physical assault. This highlights that the Navigators have the resource and specialism to build trusting relationships with young patients and facilitate honest disclosure, leading to more appropriate ongoing support and referral.

For these young people, BLOSM is providing a route for them to confidentially discuss their circumstances and concerns with a trained Navigator. These interactions and conversations can serve to generate intelligence of relevance to the police where patterns of injury or assault become apparent. This is illustrated further in the next section of the report.

[35] Based on 703 records where this data was recorded.

5.4 Time of attendance

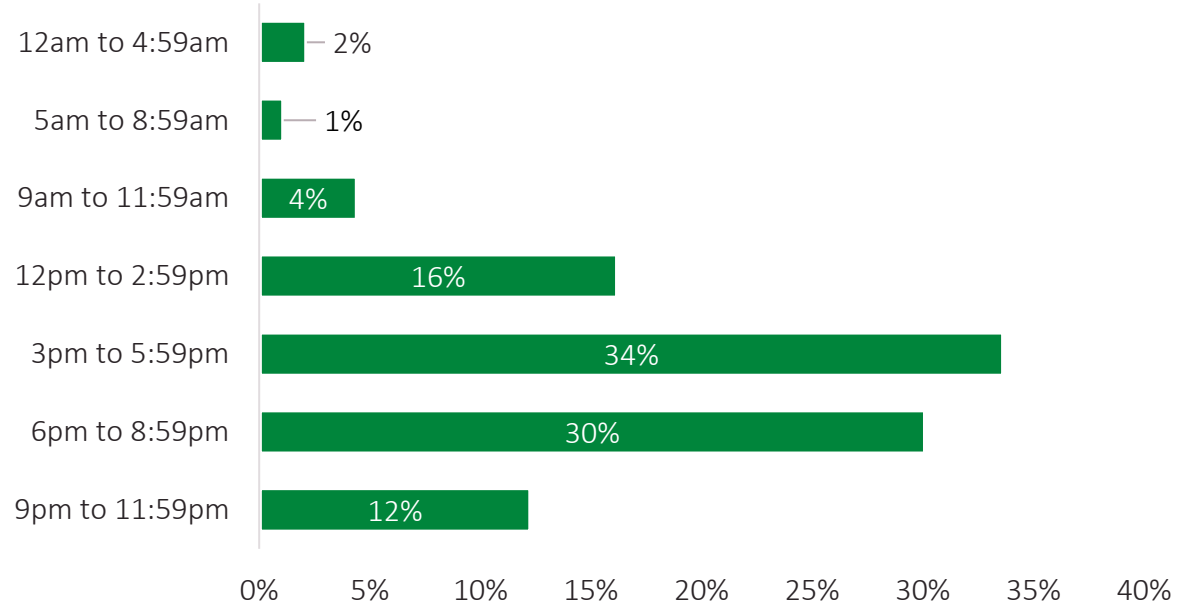
Summary

- Analysis of the time of attendance for young people supported by the project shows that most attendances occur between 3pm and 9pm.
- Consensus across interviewees that many of the drivers behind attendances are linked to issues that young people are facing at school.

Analysis of the time of attendance for young people supported by the project shows that most attendances occur between 3pm and 9pm (Figure 5.7 below). This may support a suggestion raised during stakeholder consultations that many of the drivers behind attendances are linked to issues that young people are facing at school (such as bullying and assaults), with a spike in attendance at the end of the school day. This notion may be supported by a cross-tabulation looking at the relationship between reasons for and the time of attendance; for example, monitoring data indicates a jump in young people presenting because of physical injury or assault in the hours following the end of the school day (e.g. 3pm to 6pm).

The prevalence of risk factors developing within schools demonstrates the importance that the service is maintaining ongoing dialogue schools across Huddersfield and Halifax and working alongside school staff to minimise risks to young people.

Figure 5.7 Time of attendance (general)



Source: BLOSM; n1,530

An additional analysis was undertaken to determine the proportion by which young people attended Emergency Departments during times covered by Navigator shifts. Just over three quarters of young people (77%) attend during times whereby Navigators are working on-site, which is between the hours of 2pm to 10pm. This suggests that the shift patterns for on-site work are aligned with peak times in the day for Emergency Department attendance and are well-placed for engaging young people.

5.5 Location of contact

Summary

- Most young people were engaged within the Emergency Department, which is consistent with the operational model for a service
- Service staff and clinical staff report that the Navigator team has good visibility within Emergency Department and across different wards including Paediatrics and Pathology.

The monitoring data shows that most (96%) of young people were engaged within the Emergency Department, which is consistent with the operational model for a service that is embedded within the department. However, 4% of young people were contacted following admittance to the hospital on the wards.

During on-site shifts, Navigators engage young people in non-clinical clothing featuring branded lanyards in representing the BLOSM service. This ensures that whilst Navigators will not be identified with clinical staff or social services, they can still be easily identified by clinical staff. During engagements, young people are brought by Navigators into spare rooms within wards to maintain confidentiality; project staff have reported that whilst spare rooms are largely available within HRI during shift times, there is sometimes insufficient space to facilitate confidential conservations in Calderdale. This may result in varying levels of engagement from young people between the two sites.

Both service staff and clinical staff report that the Navigator team has good visibility within Emergency Department and across different wards including Paediatrics and Pathology, with clinical staff understanding reasons behind Navigator presence on their wards and their use of spare rooms. This visibility facilitates smooth and efficient service delivery during patient engagements.

6. Outcomes and impacts

This section of the report presents detail on outcomes and impact delivered by the BLOSM service. It draws on the monitoring data provided by the service as well as feedback from the Navigator team, clinical staff and wider stakeholders. As outlined in the research method section, there are limitations with regards to what is known about the medium to longer-term outcomes for young people supported and the implications for this on both the Home Office key success measures and metrics associated with reattendance rates. This remains an area for development and opportunity for the service, most notably by establishing a process of longitudinally tracking young people who take up support from other agencies through a referral by the Navigators. Another key metric that is missing from the BLOSM monitoring data is accurate information on what proportion of young people are known to statutory services.

Hospital Navigator services are intentionally designed as relatively brief interventions, focusing on reaching eligible patients within Emergency Departments and using a trauma informed approach to build trust and get to know the needs of young people. Whilst relatively brief interventions can deliver positive outcomes in their own right, commonly for Navigator programmes outcomes are derived by young people being support to take-up available support beyond the Emergency Department. Consequently, and in keeping with the public health approach to tackling violence, a broader range of services and agencies have a role in securing positive outcomes for the young people engaged with the BLOSM service. It is important to bear this in mind when reading this section of the report.

6.1 Time spent with young people

Summary

- The data captured by the service highlights its role as a brief intervention, with 43% of engagements lasting under 15 minutes and around half (48%) lasting between 15 and 60 minutes.
- Engagements lasting over 60 minutes are relatively uncommon, however the operational model enables sufficient flexibility for this with around one in ten young people engaged through interactions lasting longer than 1 hour.
- One in five of young people have been repeat attenders with the BLOSM service, with young people presenting with mental health needs being overrepresented within this group.
- For some young people, repeat attendances are likely to be necessary to enable the Navigators to work through a complex interplay of factors that may be driving their presentation at the Emergency Department.

The data captured by the service highlights its role as a brief intervention, with 43% of engagements lasting under 15 minutes. Around half (48%) of engagements are recorded as lasting between 15 and 60 minutes.[36] Combined this demonstrates that for nine in ten young people, the Navigators spend less than 60 minutes building trust and rapport and attempting to explore reasons behind their presenting need.

It should be noted that the amount of time Navigators are able to engage with each young person is dependent on a wide range of factors outside of their immediate control, including if a young person is intoxicated, in an unstable emotional state and their level of comfort disclosing personal details (potentially with family members on-site).

The model employed within the Merseyside Navigator service makes a distinction between 'crisis and safety support', 'stabilisation support' and 'maintenance support'. In this model, summarised in Table 6.1 below, the initial engagement is focused on building trust and encouraging the young person to consent to a more intensive phase of support. Consequently, the BLOSM model is consistent with comparable services where the initial stage of support aims to progress the young person to a position where they feel comfortable to disclosure their support needs.

Table 6.1 Merseyside Navigator Programme: Stages of support

Crisis and safety support	The Navigator will either approach young people and their parent guardian at the hospital (if they are in a stable position) or via telephone/email/letter following discharge from hospital. A key aim of the initial contact is to build trust, develop a relationship with the young person, and assess immediate risks, safety, support networks, and the support the Navigator programme can offer.
Stabilisation support	A phase of intensive support including assessment of existing statutory service involvement, one-to-one support, needs assessment, goal setting, and development of a co-designed action plan to enable referral to wider community partners.
Maintenance support	Young people are referred to community partners to enable a bespoke menu of interventions with the Navigator, tracking and assessing distance travelled and any wider support needs three months post referral. Young people exit when no further support is required.

Source: Harris et al (2023)

Engagements lasting over 60 minutes are relatively uncommon within BLOSM, however the operational model enables sufficient flexibility for this with around one in ten (9%) of young people engaged through interactions lasting longer than 1 hour. This is a necessary aspect of the delivery model as Navigators need to have capacity to provide the support at a pace appropriate for each young person.

[36] Based on 1,150 records where this data was recorded.

However, this initial engagement is not designed to focus on a more detailed assessment akin to the stabilisation support phase used within the Merseyside Navigator model.

Analysis of the unique IDs recorded by the service highlights that one in five (19%) of young people have been repeat attenders with the BLOSM service, with young people presenting with mental health needs being overrepresented within this group. This provides an indication of the success of the Navigators in building trust and a positive rapport with young people who regard them as a safe source of support, and potentially as a source of emotive and therapeutic aid.

For some young people, repeat attendances are likely to be necessary to enable the Navigators to work through a complex interplay of factors that may be driving their presentation at the Emergency Department. Without this, the service is likely to be less effective in navigating young people to the right services and support to meet their needs.

The average number of attendances is 1.23 per young person. A small cohort of fourteen young people have engaged with the service on more than five occasions. One young person has engaged the service fifteen times.

6.2 Discussion summaries

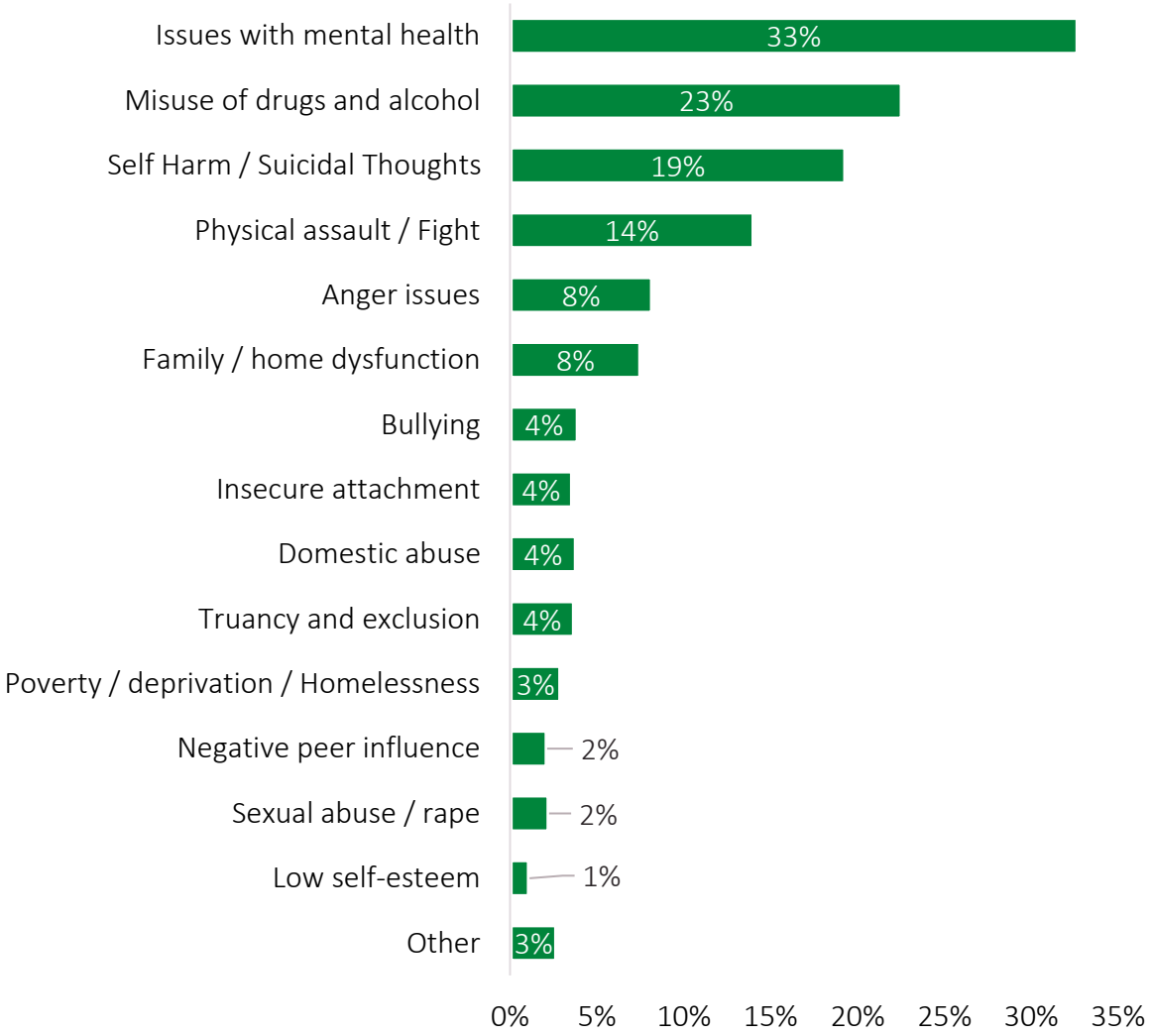
Summary

- Analysis and coding of these anonymised discussion summaries reveals that issues with mental health was the most common focus followed by issues connected to the use of drugs and alcohol and concerns around self-harm and suicidal thoughts.
- The high incidence of young people presenting with mental health needs is supported through the service's daily meetings with CAHMS, where both parties discuss support for those already on latter's caseload who are waiting to be taken on.
- The Substance Liaison Practitioners on-site position alongside the Navigator team is facilitating the sharing of specialist knowledge around approaches to alcohol and drug use cases.
- The discussion summaries present a range of youth vulnerabilities and traits related to mental health, family dysfunction, drug and alcohol use, and trauma, of which many can be mapped onto the risk factors outlined in the Socio-Ecological Model for Violence.
- More detailed analysis of the Emergency Care Data Set for the reason for attendance for young people engaged by BLOSM would help to evidence the extent to which the Navigators had secured further disclosure or explanation over and above that reported on arrival.

The monitoring data provided by the service records summary details of the focus of the discussions between the young person and the Navigator. This provides a valuable source of information on the content of discussions which can be mapped onto key risk factors. Analysis and coding of these anonymised discussion summaries reveals that issues with mental health was the most common focus of discussions followed by issues connected to the use of drugs and alcohol and concerns around self-harm and suicidal thoughts (Figure 6.1 below).

Available data from Community Links referrals to the Kirklees Early Help team shows a similar pattern, with the largest proportion (38%) being referred for mental health, and 23% being for issues with drug and alcohol use.[37]

Figure 6.1 Focus of discussions with young people



Source: Wavehill; n1,162

[37] Based on available data for 101 individuals referred between October 2023 and December 2024.

The prevalence of young people presenting for the above reasons constitute the rationale for the service's integration and relationships with other departments within the Trust and with community services. To reflect patient profile, the service team have delivered up-to-date safeguarding training to clinical staff across both sites to aid with patient identification and to facilitate a trauma-informed approach to patient treatment.

The high incidence of young people presenting with mental health needs is supported through the service's daily meetings with CAHMS, where both parties discuss support for those already on latter's caseload who are waiting to be taken on. The Drug and Alcohol Worker's on-site position alongside the Navigator team additionally facilitates the sharing of specialist knowledge around approaches to alcohol and drug cases, as well as a direct referral pathway into BLOSM for young people under 18 presenting with drug and alcohol concerns.

What is striking from the analysis of the discussions is the broad range of experiences and issues covered in the interactions between the Navigators and young people. The discussion summaries present a range of youth vulnerabilities and traits related to mental health, family dysfunction, drug and alcohol use, and trauma, of which many can be mapped onto the risk factors outlined in the Socio-Ecological Model for Violence.

Discussions with one in seven (14%) young people cover incidents involving physical assaults and fights, often occurring within school environments or in public settings such as clubs, pubs and shops. In addition to being the primary reason for presentation for some young people, it should be noted that involvement in or witnessing violence can serve as the pretext for those presenting for other reasons such as mental health or issues with addiction. This can be the case regardless of whether the person was victim, perpetrator or observer, with these categories often overlapping within the context of safeguarding children and younger people.

Whilst less prevalent, the Navigators are also supporting young people who have disclosed serious crimes against a person including domestic abuse or rape and sexual assault. It is unknown to what extent these allegations or incidents have been reported to the police and it is not possible to determine from the discussion summaries whether these relate to recent or historic incidents. There is evidence of further support for these experiences being delivered by Community Links.

Nevertheless, they are a factor in influencing young people's decision to attend the Emergency Departments. These reasons for presentation justify the rationale for Navigators having specific areas of focus for their caseloads, such as female Navigators handling cases involving factors disproportionately affecting women and girls (such as sexual and domestic violence).

Closely connected to issues regarding mental health were themes such as self-harm and suicidal ideation, alcohol and drug use and family dysfunction. Whilst factors around self-harm and alcohol and drug use often manifest because of poor mental health in an individual, unstable home environments and family units were often identified to be a primary underlying cause behind young people's poor mental wellbeing.

Issues surrounding family units included parents suffering from mental health concerns, deprivation, insecure housing situations and estrangement from family members. This prevalence suggests that in many cases, family units must be supported to pursue stable and positive courses to allow the presenting young person to do the same. Members of the Navigator team have reported supporting members of a young person's family through emotional support and signposting to relevant community services, helping to meet a family's holistic needs as opposed to addressing solely individual needs. This demonstrates the wider influence of the service on families and communities across Calderdale and Halifax.

More detailed analysis of the Emergency Care Data Set for the reason for attendance for young people engaged by BLOSM would help to evidence the extent to which the Navigators had secured further disclosure or explanation over and above that reported on arrival.[38] However, anecdotal feedback from the Navigators emphasised the importance of the brief intervention in getting a better understand of the cause or trigger behind a young person's attendance. For example, whilst the presenting issue may be recorded as alcohol intoxication, depressive feelings or feeling suicidal, the cause of this may be due to factors including bullying, coercive control, family dysfunction or sexual assault.

A common theme raised by clinical staff was the high value they placed on the Navigators having both the capacity and skillset to engage young people within the Emergency Department to better understand their needs. It was generally acknowledged that this was not something that the clinical teams had the time to do or the skills to deliver to the same quality. However staff viewed the dedicated resource delivered through the Navigator role as having a wider impact than taking capacity pressures off clinical teams; they also viewed it as reducing risks following a young person's discharge and the likelihood of readmission.

The themes evident in the consultations with clinical staff align closely with those reported in the evaluation of the YVIP service across the Midlands. The evaluation of the service highlighted that clinical staff welcomed the additional support available through programme and the value of its proximity to clinical teams. Clinicians stated that the programme enabled the hospitals to offer stronger wrap around care and that the Navigators had better knowledge of and stronger links with additional services that hospital staff may not be aware of.

[38] Within the ECDS codes are provided for the 'chief complaint' of those presenting at Emergency Departments.

Having the programme integrated within Emergency Departments aided the clinical staff in not just treating patient's presenting symptoms but also working to identify and address underlying causes, drivers and vulnerabilities. This not only provided better outcomes for young people but also had a positive impact on clinical staff morale and job satisfaction.[39] These are all sentiments shared by clinical staff located in the Emergency Departments where BLOSM is delivered.

As acknowledged by clinical teams, by exploring underlying reasons for presentation with young people and offering on-going support, it gives reassurance of a support plan going forward, therefore removing the impetus for continuous Emergency Department attendance. Prior to the service young people may not have been offered follow-up support, leaving them vulnerable to further risk. In summary, the BLOSM service is viewed as a valuable tool in helping clinical teams to both treat and support patients, contributing towards the Trust's approach of addressing health inequalities and supporting efforts to reduce attendance levels in the short to medium term.

6.3 Onward referrals

Summary

- A high rate of onward referral is a useful metric to assess navigator programmes as it demonstrates that the service is not just identifying support needs, which may have been previously unmet, but it is motivating and supporting young people to take-up support from other specialist services.
- Just over three quarters (77%) of young people engaged with the service recorded an onward referral.
- As some services have waiting lists before young people can be seen, the Youth Navigators play and important role in 'holding the space' by maintaining contact until other services or agencies can engage.
- No consistent data has been captured on the attrition rates for young people referred into any agency or service beyond the Emergency Department.

The navigator model operates as a continuum with BLOSM working closely with clinical teams to extend reach into eligible patients who present with injuries that are assessed as requiring support from a non-clinical team. The Youth Navigators work to understand the circumstances and support needs of young people that provide consent and then, where necessary, direct them to appropriate services and sources of support beyond the Emergency Department. Within the continuum, the referral process acts as a mechanism to transition young people from a reachable moment to a teachable moment.

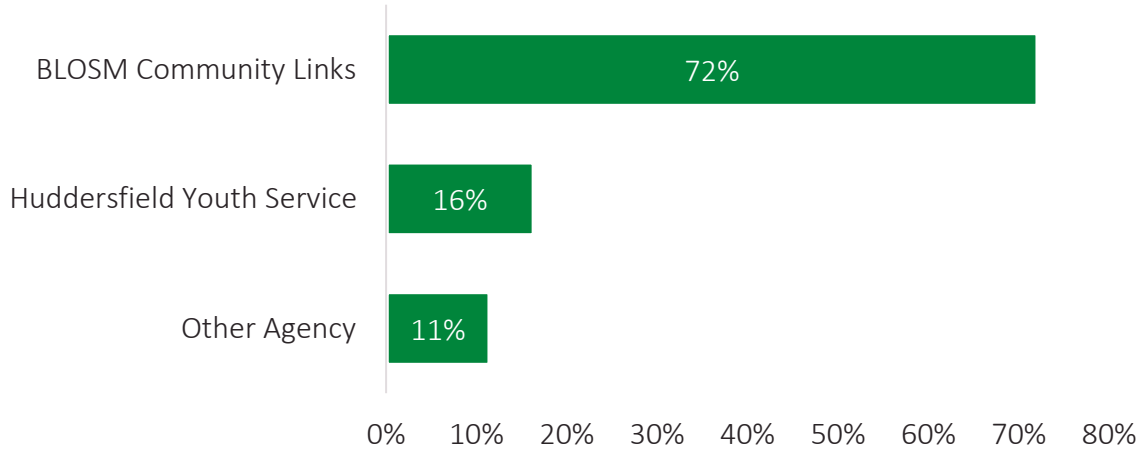
[39] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.

A high rate of onward referral is a useful metric to assess navigator programmes as to demonstrates that the service is not just identifying support needs, which may have been previously unmet, but it is motivating and supporting young people to take-up support from other specialist services (the maintenance support phase of the Merseyside model). These services in turn have the potential to address identified risk factors and build protective factors through further support.

Just over three quarters (77%) of young people engaged with the service recorded an onward referral.[40] Of this sample, just under three quarters (72%) were recorded as being referred into Community Links, which indicates ongoing support and engagement with the Navigators. A further 16% were referred to the Huddersfield Youth Service (Kirklees Early Help Team) and the remaining 11% were referred onto other agencies such as CAMHS, Breaking the Cycle and other hospital and community services. In other words, a high proportion of young people are engaging with support with other services and agencies, which in turns increases the prospects that their risk and vulnerability will be addressed.

As some services have waiting lists before young people can be seen, the Youth Navigators play and important role in 'holding the space' by maintaining contact until other services or agencies can engage. This helps to manage attrition so that more young people take-up the referral they have consented to. The monitoring data recorded by BLOSM reveals that the majority of young people have been referred into Community Links or Huddersfield Youth Service. (Figure 6.2 below).

Figure 6.2 Onward referral destination

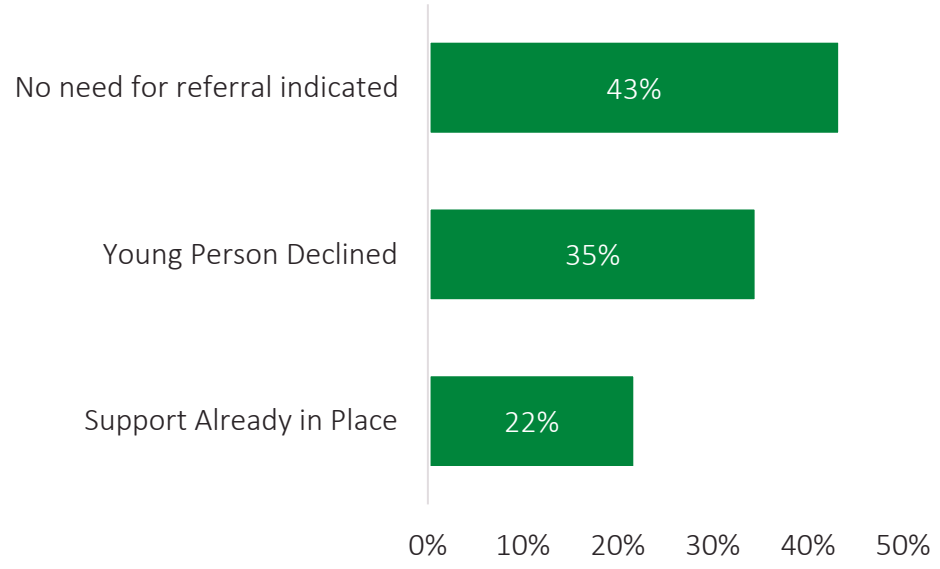


Source: BLOSM; n818

[40] Based on 1,065 records where this data was recorded.

Where no onward referral was recorded, this was mainly due to the service assessing that there was no need for a referral, the young person declined a referral or support was already in place (Figure 6.3).

Figure 6.3 Reason for no onward referral



Source: BLOSM; n274

No consistent data has been captured on the attrition rates for young people referred into any agency or service beyond the Emergency Department (i.e. what proportion both attended and engaged with the support). Moving forward this is one of the sources of information that BLOSM should capture and log within the monitoring system. This requires the creation of a feedback loop of communication from referred to services to aid demonstration of the role of BLOSM of progressing young people into appropriate support services.

At the time of reporting the service has progressed towards evidencing BLOSM's longer term impact by setting about developing feedback loops with some referral partners such as Branching Out, which will be essential for assessing patient outcomes following onward support.

Community Links data available from Kirklees Early Help team provides an overview of the level and type of support provided to young people referred into their Community Links provision from the BLOSM service. The data provided to the evaluation team covers the period Q3 2023/24 to Q2 2024/25 and shows that the Early Help team recorded 101 referrals from BLOSM. Of these 60% did not have an existing plan with the Early Help team and 35% were previously not known to agencies. This provides a demonstration that BLOSM is being successful in reaching young people who are not currently receiving support from the Early Help team in Kirklees and is encouraging them to take up the support available.

6.4 Follow-up support

Summary

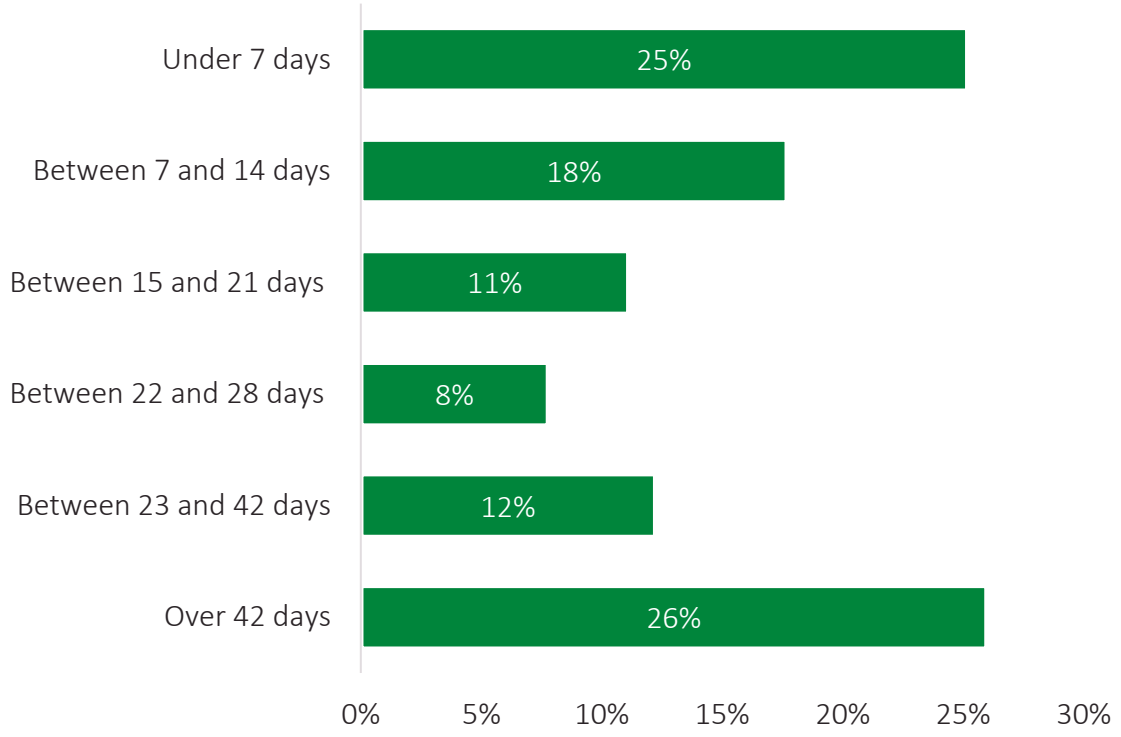
- Providing prompt follow-up support for young people initially engaged in the Emergency Department forms an important part of the service model. The monitoring data shows wide variation in the time between initial attendance and the provision of follow-up support.
- The support needs and preferences of young people engaged beyond the Emergency Department differ depending on a range of factors. Whilst around four in ten young people have been supported by one follow-up contact by the Navigators, the monitoring data shows that around one in five have been supported by four of more follow-ups.
- The amount of time spent supporting young people is likely to be influenced by the contact method with three quarters (74%) of young people contacted by telephone and most of the remaining (21%) by SMS or WhatsApp. Only a small proportion of young people (5%) have been engaged face-to-face.

Providing prompt follow-up support for young people initially engaged in the Emergency Department forms an important part of the service model, as this can motivate and encourage those supported to engage with other services that can help to address unmet needs and the underlying reasons for their presentation.

The monitoring data shows quite wide variation in the time between initial attendance and the provision of follow-up support. Whilst a quarter (25%) of young people were re-engaged within 7 days of their discharge from the Emergency Department, a similar proportion (26%) were reengaged over 42 days from discharge (Figure 6.4 over page).

This variation is influenced by a range of factors, most notably the ability of the Youth Navigators to contact a young people following discharge, but also the Navigator team's capacity and potentially a young person's engagement with other services.

Figure 6.4 Follow-up timeframes



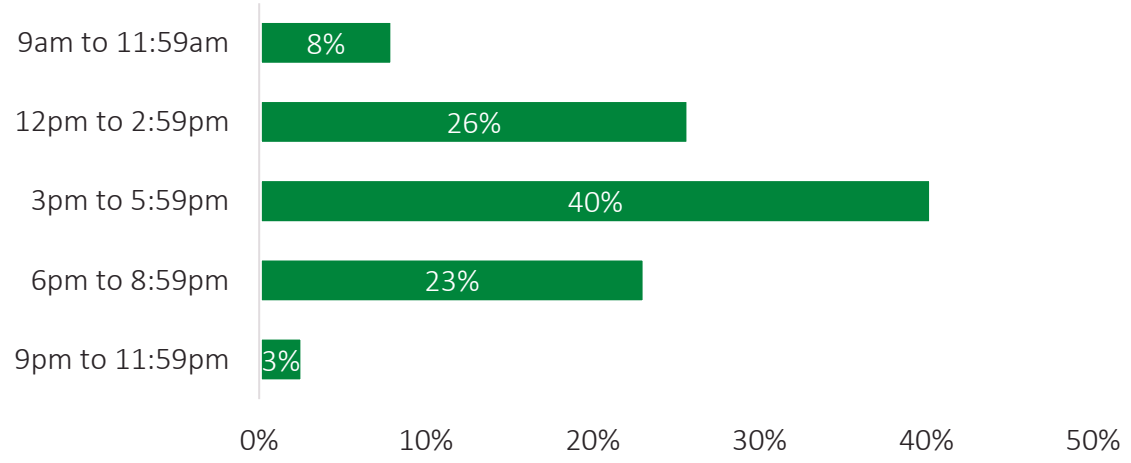
Source: BLOSM; n989

For comparison, the YVIP service operating across the Midlands recorded an average case length of 75 days, with half of all cases engaging in the programme for between 2-3 months and just under one third for over 3 months. Only a small proportion (18%) of cases engaged for less than one month.[41]

The time of follow-up highlights the importance of the flexibility within the service model to enable the Navigators to attempt contact with and engage young people at times that are preferred by them. Analysis of the time of follow-up shows a spread of contact times throughout the day (Figure 6.5 over page). Ultimately this flexibility supports the Youth Navigators to maintain contact with young people. With over a quarter of follow-up contacts taking place after 6pm, this highlights the importance of the service operating at times that are conducive for engaging a diverse profile of young people. There is flexibility within the hospital shifts for Navigators to use their time completing calls for those engaging through the community shifts, along with those on community shifts being flexible to engage in hospital engagement throughout their shift as needed. There may be scope therefore to review the Navigator's community shift pattern which currently operates 11am-7pm as further flexibility may be required to accommodate a later finish if this is needed to retain engagement of young people.

[41] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.

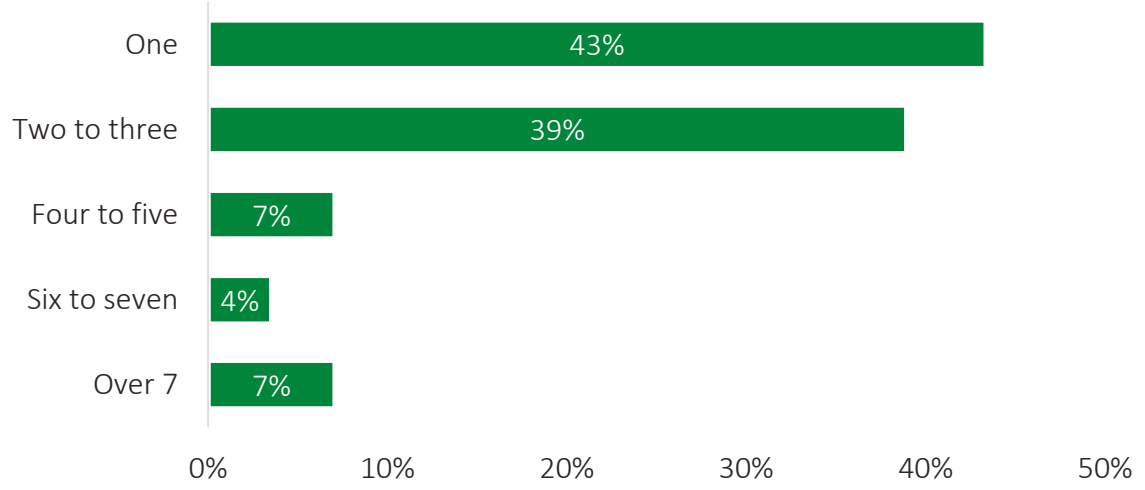
Figure 6.5 Time of follow-up



Source: BLOSM; n873

The support needs and preferences of young people engaged beyond the Emergency Department differ depending on a range of factors including their personal circumstances and whether they are currently in contact with other services. Whilst around four in ten young people have been supported by one follow-up contact by the Navigators, the monitoring data shows that around one in five (18%) have been supported by four of more follow-ups (Figure 6.6 below). It is important to note here that earlier iterations of the service model did not record follow-up interactions in the same way, which may have skewed the data towards a lower number of follow-ups recorded.

Figure 6.6 Number of follow-ups



Source: BLOSM; n226

What this highlights is the importance of the Youth Navigators having the necessary capacity to follow-up multiple times if necessary to ensure that the needs of the young person are met. From a workload planning perspective this can be difficult to determine the capacity needed for follow-up support contacts as this is dependent on the individual needs of each young person.

As outlined earlier, given the waiting times for access to other support services, these follow-up contacts can play an important role in maintaining engagement of young people up to the point that the referred to service or agency can support them. Feedback from the Youth Navigators has highlighted that the follow-up contacts can elicit disclosures from young people which aid understanding of the underlying reasons behind their presentation at the Emergency Department.

This is facilitated by the ability of the Youth Navigators to develop trust and a positive rapport with young people as well as ensuring consistency of contact from the Emergency Department (i.e. the same Youth Navigator is maintained as the point of contact for the young person). The monitoring data captured by the service records the amount of time the Navigators have spent supporting young people following their discharge from the Emergency Department.

Analysis of this data reinforces the fact that the service provides brief interventions for young people with Navigators spending under 15 minutes with around six in ten (58%) of young people and between 15 to 60 minutes for around four in ten (38%) of young people.[42] Interventions lasting over 60 minutes are relatively uncommon, accounting for 5% of total interactions.[43]

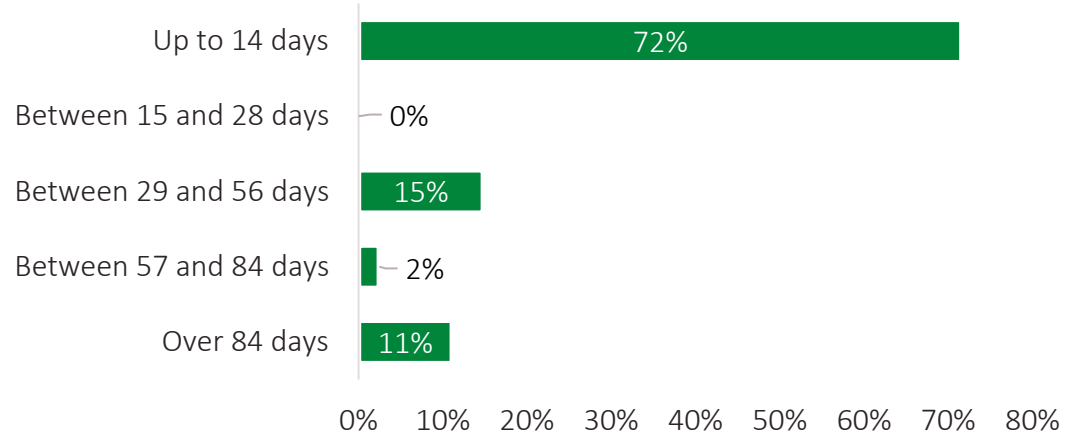
The amount of time spent supporting young people is likely to be influenced by the contact method with three quarters (74%) of young people contacted by telephone and most of the remaining (21%) by SMS or WhatsApp. Only a small proportion of young people (5%) have been engaged face-to-face.

This finding indicates a comparatively low proportion of face to face engagements when compared with other Navigator services; for example the evaluation of the YVIP service across the Midlands recorded equal proportions of the young people engaged via phone and through face-to-face with each representing 44% of engagements. This may reflect the preference of the young people towards text or online engagements and the capacity limitations and logistic considerations for the Navigator team. It may however raise questions around the extent to which non-face to face engagements represent the same opportunities for building up trusting relationships and facilitating discussions of underlying issues with young people.[44]

[42] This includes text message and voicemail interactions, so can't be seen as full indicator of time spent rapport building as each communication sent may be listed separately.
[43] Based on 1,123 records where this data was recorded.
[44] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.

For most (72%) of young people in receipt of follow-up support, the duration between their first and final engagement is up to 14 days (Figure 6.7 below). This shows that the service is working to conclude engagements and, where appropriate, refer onto other specialist or community based support as soon as the young person is ready and consents to this.

Figure 6.7 Days between first and final follow-up engagement



Source: BLOSM; n81

The majority (83%) of young people provide consent to community follow-up, suggesting that the service is generally successful in securing follow-up support in for those who have agreed to be referred into BLOSM.[45]

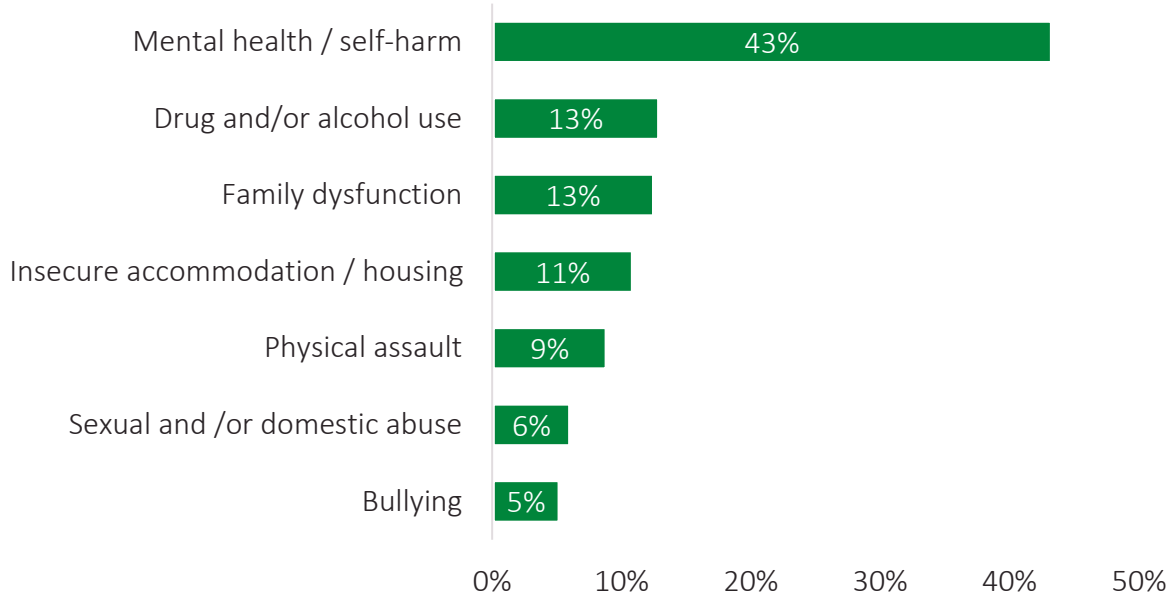
At the time of reporting, there are no mechanisms for recording the extent to which young people engage with the community services they have been referred into. This may be due to a lack of unique identifiers (such as ID) for each young person being shared and utilised by referral partners to enable the tracking of young people following their discharge from BLOSM. Figures produced by evaluations of other Navigator services may set precedent for expected levels of follow-up engagement. For example the evaluation of the YVIP service found that just over a third of young people engaged with longer-term support.[46]

The monitoring data incorporates a log of the focus of discussions and engagements between the Navigators and young people. This is valuable as it highlights the willingness of the young people to continue to discussions with Navigators beyond the Emergency Department. It also presents evidence of the focus on working to address risk factors that may be driving attendances at the Emergency Department.

Whilst the follow-up discussion log features similar risk factors to those featured in the initial attendance discussion log, the frequencies at which they are mentioned differ slightly to those highlighted at initial attendance (Figure 6.8 over page).

[45] Based on 579 records where this data was recorded.
[46] Butler,N. et al (2022)- 'Service evaluation of Redthread's Youth Violence Intervention Programme (YVIP) across the Midlands.' Public Health Institute. Liverpool John Moores University.

Figure 6.8 Focus of follow-up discussions



Source: BLOSM; n247

Whilst issues with poor mental health had been mentioned in 33% of accounts at initial attendance, the respective figure for discussions at follow-up stands at 43%. Furthermore, mentions of drug and / or alcohol use and physical assault feature less frequently in accounts recorded at follow-up, whilst mentions of family dysfunction and insecure housing feature more frequently within follow-up accounts compared to those recorded at attendance.

This suggests that there is a difference in the profile of young people presenting at the Emergency Department and the profile of young people referred to the BLOSM service. For example, young people experiencing with risk factors such as poor mental health, dysfunctional home environment and insecure housing may be more likely to agree to BLOSM support compared with young people who have had involvement with violence or drug and alcohol use.

This may be because factors in the former group are viewed by both those presenting and youth workers as longer-term risk factors which require ongoing support by community services, whereas experiences with assault and alcohol / drug use are more likely to be short-term or one-off instances.

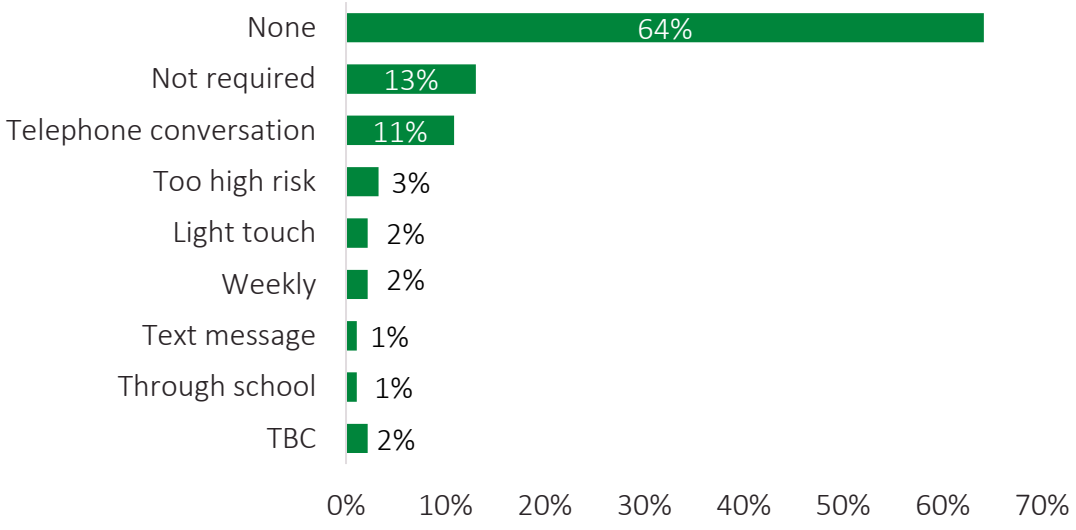
Despite this, mentions of physical assault still featured in discussions for one in ten young people who had been referred into BLOSM, reflecting similar themes around assault within school settings. At follow-up Navigators could be seen taking on an advocate role in relation to school safeguarding teams, acting as a mediator between young people, their families and schools and working towards implementing appropriate plans to safeguard young people from harm within school.

Findings such as these demonstrate the ways in which BLOSM youth workers are well-placed to work alongside statutory and non-statutory youth and safeguarding services to develop and implement support plans for young people, with the potential to alleviate capacity and resource pressures on other services. They can additionally help parents and family units by helping young people access the appropriate support, alleviating stress and reassuring parents that their child will get the support which is right for them.

Where data on next steps has been recorded by the service, approaching two thirds (62%) of young people were transitioned to Community Links, a quarter (25%) were discharged and around one in ten (12%) referred into another agency,[47] which was most commonly the Early Help Team at Kirklees Council, Breaking the Cycle or another youth service provider. What this highlights is that the Youth Navigators are helping to build the capacity and confidence of young people to engage or re-engage with other support interventions within their community.

Limited outcome data is available from referred to organisations or services and this is a significant gap in knowledge relating to the impact of the service. Data recorded for Community Links by the Early Help Team at Kirklees Council, for example, indicates that 94% of the young people referred from BLOSM have not recorded an outcome. Data provided by the Early Help Team at indicates that of those referred, the largest proportion (64%) are not engaging with any Community Links services (Figure 6.9 below). However, the data further indicates that 73% of this cohort are engaging in some way with agencies (48% of which are reported to be receiving weekly support). Anecdotally, the Early Help Team indicated that across all referrals, only 11% did not take up support, with some of those engaging with services already. Whilst there is ambiguity in the data regarding with which services they are engaging, it does suggest that these young people are engaging with services in some way.

Figure 6.9: Young person engagement level with Community Links



Source: Kirklees Early Help Quarterly Monitoring data n=92

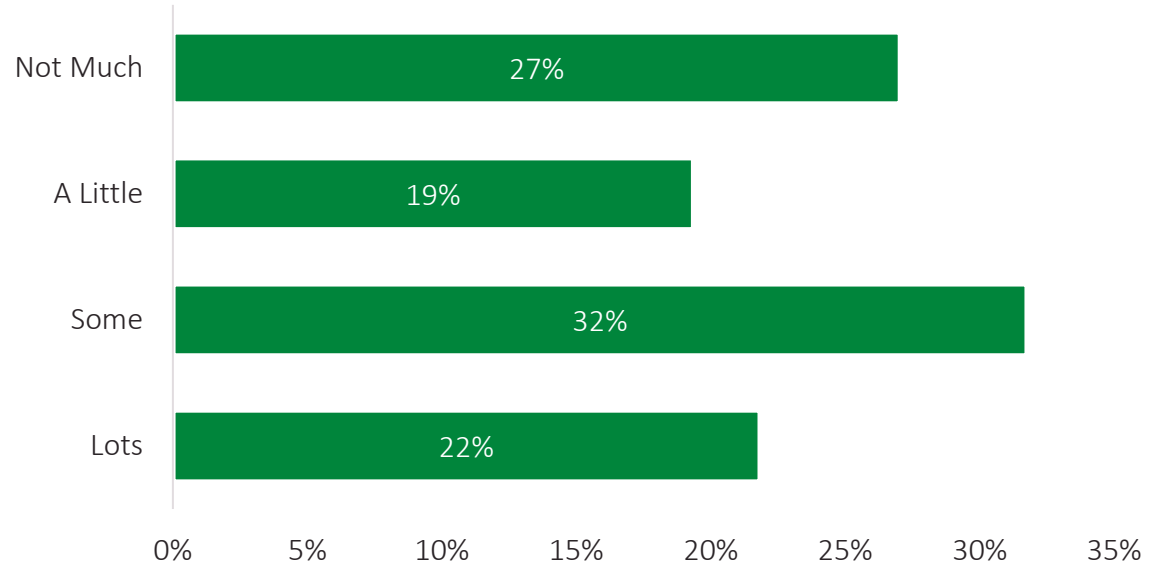
[47] Based on 743 records where this data was recorded.

Given the ambiguity of available referral data regarding engagement levels and existing relationships with services, future delivery should look to better evidence these pathways, including clear monitoring of attrition and penetration rates of referrals. This would enable better identification of propensity to identify and improve risk factors. Further, there is scope to formalise feedback loops between navigators and referred to organisations, to better identify those already receiving support and those new to agencies.

The service captures feedback from young people in receipt of follow-up support to determine to what extent it has helped them. It is important when interpretating this feedback to acknowledge the complex issues that many young people are facing and the extent to which an internationally designed brief intervention can 'resolve' what are likely to be more deep-seated issues and unmet support needs.

What the data does demonstrate is that the support helped around a quarter of young people (22%) a lot, and helped around one third (32%) in some way (Figure 6.10 below). Although this means that just under a half (46%) of young people stated that the follow-up support helped either a little or not much, it is their potential engagement with other support provision/agencies that can help to provide the level of help they require.

Figure 6.10 Rating of the follow-up support received



Source: BLOSM; n286

Moving forward, it will be helpful for BLOSM to consider options to undertake feedback from all young people engaged who have consented to receive contact and where contact details have been provided.

7. Evaluation method

Summary

- There is limited published evidence of robust and statistically significant methods within evaluation approaches of existing navigator services.
- Assessment of the evidence base reinforces the need for a holistic, mixed-method approach to evaluating the impact of navigator interventions, to ensure identification of individual outcomes alongside progress towards implementing a public health approach.
- There is currently no follow-up data available to identify longer-term impacts supported by BLOSM once patients have been referred into community services.

If the project receives further funding, there are considerations for data capture and analysis which can build on existing methods to better evidence progress against aims and impact.

7.1 Evidencing impact

Whilst there are multiple Navigator interventions funded through the same Home Office funding stream, there is no standardised model of delivery or assessment. Subsequently, there is limited published evidence of robust and statistically significant methods within evaluation approaches of existing navigator services.

The short-term nature of funded interventions hinders the ability to measure long-term behaviour and lifestyle change, therefore limiting the evidence base of 'what works' owing to a time-lag between intervention delivery and emergence of impact. This is compounded by the difficulty in assessing causality as such outcomes and impacts may not be realised in the short-term.[48] Further, prevention is often 'transformational,' leading to permanent change in the delivery of a service in due course, making it harder to specifically identify causality.[49]

7.2 Methodological approach

Assessment of the evidence base reinforces the need for a holistic, mixed-method approach to evaluating the impact of navigator interventions, to ensure identification of individual outcomes alongside progress towards implementing a public health approach. Temporal factors[50] may influence engagement, and are hard to identify solely through quantitative methods. The changing situations and lifestyles of patients may impact their engagement patterns, alongside the availability of alternative provision in the area and fluctuations in the prevalence of violence and other issues faced.

[48] A preventative approach to public services, UK Youth and Institute for Government, 2024
[49] Managing Public Money, HM Treasury, 2023
[50] Temporal factors refer to the influence of time-related elements on behaviour, such as time of day, seasonality, or specific events.

Such factors can impact the need for navigator interventions, and impact the level or length of support required before impacts can be observed. The success of navigator interventions is often measured through attendance at Emergency Departments, in line with Home Office broader aims for violence reduction. Looking at these, as this model broadly monitors currently, supports the assessment of success of the public health approach, but cannot be used as a credible indicator of progress without considering wider context.

A similar method of measuring reattendance at Emergency Departments was delivered by Medics against Violence (MAV) in Scotland. Whilst BLOSM identifies changes in attendance for engaged patients within a three month period, accounting for the long-term nature of behaviour change, this is not a long enough timeframe to provide robust evidence. MAV compared attendance in the 365 days prior to the first intervention with navigators, compared to the 365 days after. The analysis also included outpatient data, to identify any changes to outpatient appointments as well as attendance at Emergency Departments, as this may provide further insight into behaviour patterns relating to health. Results were obtained via a binomial regression analysis, accounting for the fact that variables were not normally distributed. It would be of benefit for the BLOSM team to engage the hospital data teams and West Yorkshire ICB to discuss the possibility of accessing this data.

To improve credibility, as referenced in the limitations section of this report, several criteria must be added to the data to deliver a more robust contribution analysis. For example, the BLOSM team could create an inclusion criteria for presenting needs as recorded on the EPR, in line with the patients they engage, such as mental health, violent injury or assault. The inclusion criteria should also exclude any patients outside of the age range and geographical scope of the service. Such data will inform the comparator group to better assess reattendance rates through the BLOSM dashboard.

To conduct statistically significant analysis of observational data such as this, a propensity score matching (PSM) technique would enable estimation of the effect of an intervention whilst accounting for factors that impact propensity to engage. PSM allows the analyst to arrive at two groups, control and intervention, that have similar characteristics with the only thing making them different being the fact that they were, or were not, subject to the intervention. It enables 'like for like' comparison where the only change is engagement in the intervention or not.

To conduct PSM, EPR data from individuals that have engaged with the service are matched with those that have not, with several variables such as age, presenting need, IMD score, ethnicity and health determinants including smoking and alcohol use (where available). Using this matching technique prior to running analysis increases the statistical power, creating more representative results that account for the ranging characteristics of patients.

As further mentioned when discussing limitations, there is currently no follow-up data available to identify longer-term impacts once patients have been referred into community services. Again considering the long-term nature of behaviour change, evidence outcomes from referral partners would better identify the impact the service is having on patients, as well as the sustainability of this impact. Moving forward, the BLOSM team should discuss methods in which to formalise the sharing of outcome assessments between themselves and referred to partners, namely the commissioned Community Links partner in Kirklees.

8. Summary and recommendations

8.1 Summary

BLOSM is a pioneering model which builds on the original Serious Violence A&E Navigator Service, funded by the West Yorkshire Violence Reduction Partnership, and West Yorkshire Health and Care Partnership to ensure young people are getting the best possible 'trauma informed' support and care to prevent further harm.

The presence of violence intervention programmes in Emergency Departments is a 'teachable' moment which may increase an individual's motivation to change, with Navigators able to connect patients to issues related to alcohol, violence or drugs to services on discharge. In the absence of engagement by a navigator service, there is potential for an individual's risk factors to deepen with associated cost implications for a range of services.

Building an evidence base for preventative interventions such as BLOSM poses unique challenges as it can be difficult to prove causality for early interventions and, in keeping with a public health approach, the benefits may not be realised for years. However, a recent study found that Navigator programmes can be associated with reduced emergency and acute healthcare use in the year following intervention, with increased scheduled outpatient care.

BLOSM has embedded the principles of trauma-informed practice and care to create a new multi-agency support service across the accident and emergency departments in Halifax and Huddersfield. There have been several changes made to the delivery model since commencement. Whilst the changes in the delivery model has brought benefits, it has required a transitional period which impacted on the capacity of the service to reach and engage young people.

Clinical staff have reflected on the service model as an effective means of reaching vulnerable young people, identifying the holistic issues that they face and facilitating their access to appropriate community support. Since January 2023 the service has engaged 1,540 young people. A review of comparable hospital navigator programmes suggests that the volume of engagements logged by BLOSM is higher than those located in other areas.

Data captured by the BLOSM team demonstrates that three quarters of young people offered an initial assessment by the service consent to this. Based on the evaluation reports available for comparable hospital navigator service, this consent rate is high. This is a positive finding given there is no teachable moment without effective reach.

The majority of young people engaged by the service have been of statutory school age accounting for 70% of all supported. Consensus across interviewees that many of the drivers behind attendances are linked to issues that young people are facing at school. The recent expansion of the Navigator role to include liaison with staff at local schools and colleges can aid changes in support available for young people to prevent a need for attendance at the Emergency Departments.

Just under half of those supported were recorded as having experienced Advice Childhood Experiences. One quarter of young people supported were recorded as not being in education, employment or training at the point they accessed the service and just under half of young people supported are drawn from the most deprived 20% of areas in the UK. This profile aligns closely with influential risk factors that are associated with a higher likelihood of engaging with or experiencing violence and exploitation.

The main reasons for attending the Emergency Department were mental health accounting for half of the attendances, followed by physical injury/assault accounting for a third of attendances. However, the disclosed reason for attendance at initial presentation may not be the main cause or driver of attendance. The resource and specialism of the Youth Navigators in building trusting relationships with young patients can facilitate subsequent disclosures about the underlying reasons for attendance, leading to more appropriate ongoing support and referral.

The data captured by the service highlights its role as a brief intervention, with 43% of initial engagements lasting under 15 minutes. One in five of young people have been repeat attenders with the BLOSM service, with young people presenting with mental health needs being overrepresented within this group. For some young people, repeat attendances are likely to be necessary to enable the Navigators to work through a complex interplay of factors that may be driving their presentation at the Emergency Department.

The high incidence of young people presenting with mental health needs is supported through the service's daily meetings with CAHMS, where both parties discuss support for those already on latter's caseload who are waiting to be taken on. The Substance Liaison Practitioners on-site position alongside the Navigator team is facilitating the sharing of specialist knowledge around approaches to alcohol and drug use cases. This provides a positive demonstration of how BLOSM is working alongside other NHS services to support the presenting needs of young people.

The discussion summaries present a range of youth vulnerabilities and traits related to mental health, family dysfunction, alcohol and drug use, and trauma, of which many can be mapped onto the risk factors outlined in the Socio-Ecological Model for Violence. More detailed analysis of the Emergency Care Data Set for the reason for attendance for young people engaged by BLOSM would help to evidence the extent to which the Navigators had secured further disclosure or explanation over and above that reported on arrival.

The content of the discussions summaries can provide intelligence and information to support the VRP's future strategic needs assessment as well as providing statutory agencies with insight into the risk factors prevalent in the lives of many young people from across Kirklees and Calderdale. They also highlight that the process of addressing identified risk factors and building protective factors requires effective input from a wider range of agencies and services. It is problematic to assess the performance of BLOSM in isolation given the necessary dependencies on the quality, availability and effectiveness of support beyond the Emergency Department. A shift in approach and mindset is needed to understand the wider system and determine the role of BLOSM in navigating young people into a position where they are motivated to change.

Just over three quarters (77%) of young people engaged with the service recorded an onward referral. A high rate of onward referral is a useful metric to assess navigator programmes as to demonstrates that the service is not just identifying support needs, which may have been previously unmet, but it is motivating and supporting young people to take-up support from other specialist services. As some services have waiting lists before young people can be seen, the Youth Navigators play and important role in 'holding the space' by maintaining contact until other services or agencies can engage.

However, no consistent data has been captured on the attrition rates for young people referred into any agency or service beyond the Emergency Department. As such, there are limits to what is known about the outcomes that these services are achieving for young people.

There is limited published evidence of robust and statistically significant methods within evaluation approaches of existing navigator services. Assessment of the evidence base reinforces the need for a holistic, mixed-method approach to evaluating the impact of navigator interventions, to ensure identification of individual outcomes alongside progress towards implementing a public health approach. It would be of benefit for the BLOSM team to engage the hospital data teams and West Yorkshire ICB to discuss the possibility of accessing data that enables robust statistical analysis of the impact of the intervention on reattendance rates and patterns of healthcare use following support.

8.2 Recommendations

A small number of recommendations are provided below to inform future decisions on the design and delivery of the BLOSM service.

- Introduce data inclusion parameters when comparing Emergency Department reattendance of navigator patients and those not engaging, with the potential inclusion of Propensity Score Matching analysis methods. This would enable a more robust analysis of the relationship between navigator interventions and Emergency Department attendance relating to assessing a public health approach, and better account for the varying needs of patients.

- Formalise feedback loops with referred to organisations, to facilitate better data collection of attrition rates beyond the Emergency Department and aid demonstration of the role BLOSM plays in progressing young people into appropriate support services. Such information should be captured on the BLOSM monitoring system, to provide a broad indication of the complete patient journey.
- Feedback loops should include information sharing regarding confirmation of receipt and action of referral from referred to organisations, as well as if the patient is known to services. This would improve efficiency of support as navigators would have a clear picture of the support available to the young person, and subsequently be able to close them off their case load, or develop a support plan.
- Identify appropriate outcome evidencing methods that referred to organisations can report into the VRP or the BLOSM team, to further understand longer-term impacts. Discussions with referral organisations should take place to identify any outcome data collection already taking place internally that could be shared, such as final destinations, and outcomes relating to identification of protective factors or improvements in wellbeing.

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